

forum

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

UNC WHITE COAT CEREMONY:
KEYNOTE ADDRESS 2000
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President's Message

Elizabeth P. Kanof, MD

The Physician as Colleague and Teacher

As Colleague

In these challenging times, when physician autonomy is eroded, litigation is an ongoing threat, patients are better educated and vocal, and the media are omnipresent in many aspects of our professional lives, where can the physician turn to minimize burnout and maximize satisfaction from the practice of medicine?

Some of us would turn to a supportive spouse or partner, involvement with our children, and/or religious faith, others to adherence to a regular routine of physical

activity, participation in hobbies, and/or recreational and community activities.

I propose that our professional lives are more rewarding when we actively seek collegiality with our fellow physicians, medical students, and allied health colleagues. Our professional lives are enhanced when CME courses serve not only for the exchange of information but also for sharing experiences and lessons learned from our individual medical practices. Strangers become familiar faces to seek out year after year at these events.

Maintaining a link with an academic medical center, when geographically feasible,

“Where can the physician turn to minimize burnout and maximize satisfaction from the practice of medicine?”

is stimulating, the teacher gaining as much as the student. The medical students of today are actively engaged in community activities and take an interest in organized medicine at a much earlier stage of their professional development than those of an earlier generation ever did. Their enthusiasm needs to be shared and nurtured.

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Andrew W. Watry

From the Executive Director

Economy of Scale

Merriam-Webster's defines the term “economy of scale” as a reduction in unit cost brought about especially by increased size of production facilities. We have a rather dramatic example of economies of scale in continuing development of our Web site at www.ncmedboard.org. We have provided substantially improved mechanisms for public access to information and more efficient processing of physician registration. There is no question as to the benefit to the public from these enhancements. However, they also make sense from a cost/benefit standpoint.

Enhanced Access on the Web

First, we provided improved mechanisms for looking up medical practitioners. The consumer can either query an individual name or query based on other variables such as city and specialty. The latter mechanism serves consumers who do not know specific physicians by name and are searching for a physician by other criteria.

Additionally, this site returns useful information, including copies of any public Board orders. These Board orders may be immediately downloaded by those making a query. This substantially reduces the overhead, both to the person requesting the document and to the Board. More importantly, consumers are enabled with this informa-

“We have provided substantially improved mechanisms for public access to information and more efficient processing of physician registration”

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Primum Non Nocere



forum

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

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

North Carolina Medical Board

Elizabeth P. Kanof, MD
President
Raleigh
Term expires
October 31, 2002

Kenneth H. Chambers, MD
Charlotte
Term expires
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Greensboro
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Editor
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Assistant Editor
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Vice President
Greenville
Term expires
October 31, 2003

John W. Foust, MD
Charlotte
Term expires
October 31, 2001

Aloysius P. Walsh
Greensboro
Term expires
October 31, 2003

Mailing Address
Forum
NC Medical Board
PO Box 20007
Raleigh, NC 27619

John T. Dees, MD
Secretary-Treasurer
Cary
Term expires
October 31, 2003

Hector H. Henry, II, MD
Concord
Term expires
October 31, 1999

Martha K. Walston
Wilson
Term expires
October 31, 1999

Street Address
1201 Front Street
Raleigh, NC 27609

George C. Barrett, MD
Charlotte
Term expires
October 31, 2002

Stephen M. Herring, MD
Fayetteville
Term expires
October 31, 2001

Andrew W. Watry
Executive Director

Telephone
(919) 326-1100
(800) 253-9653
Fax
(919) 326-1130

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

Helen Diane Meelheim
Assistant Executive Director

Bryant D. Paris, Jr.
Executive Director Emeritus

Web Site:
www.ncmedboard.org
E-Mail:
info@ncmedboard.org

Publisher
NC Medical Board

Physician as Colleague and Teacher

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Frustrations and unresolved problems become less threatening for those of us who join and participate in our specialty, county, state, and national organizations. Unity of the profession has a profound impact on the legislature, managed care organizations, hospitals, the pharmaceutical industry, and allied providers. Positive results are achieved when we agree to work with others in good faith and with mutual respect. In this state, I believe the medical specialty and professional societies are strong and effective advocates for both physicians and patients. Meanwhile, the North Carolina Medical Board, under the law, regulates the practice of medicine for the benefit and protection of the people and thereby ensures the integrity of the medical profession.

Your Medical Board becomes very much concerned when actions of a small number of physicians undermine relationships within the profession and have a profoundly negative effect on the public. The most common shortcoming is poor communication skills, ie, physicians perceived as being rude, arro-

gant, and lacking empathy. Equally disconcerting is the disruptive physician, a person who sees himself or herself to be a non-conformist but who, in reality, cannot relate appropriately to others over an extended period of time.

Misleading advertising is becoming a more significant threat to collegiality. We have seen ads that overtly or tacitly imply a given physician's skills are superior to his or her colleagues in the same specialty. Such ads have led to escalating and hurtful rebuttals. It is equally damaging to the profession when a listing in the Yellow Pages does not accurately reflect specialty training.

Your Medical Board also sees the deleterious effects when physicians fail to develop adequate support systems and become confrontational with their colleagues and staffs, exhibit burnout and depression that lead to a greater risk of drug and alcohol abuse and erosion of competency.

Our North Carolina Physicians Health Program, one of the best in the nation, is an

indispensable resource for the Medical Board. Self-reporting in early phases of impairment is enormously beneficial; it increases the likelihood of access to appropriate help, of a shorter recovery time, of anonymity, and of avoiding a report to the National Practitioner Data Bank. Collegiality is enhanced, not diminished, when we assist colleagues who are impaired to become rehabilitated.

As Teacher

Our academic medical centers no longer greet first year students with the adage: "Look to the left and to the right. One of you will not be here next year." Intimidation has been replaced by nurturing and mentoring. Students are encouraged to participate in clerkships in physicians' offices, in community activities, and in organized medicine. They have a say in the curriculum; activism unheard of in earlier generations.

However, the 1999 Medical School Graduation Questionnaire reveals problems still unresolved. Thirty percent (30%) of clinical faculty, residents, and nurses claim to have experienced mistreatment, an increase in 1999 as compared to 1998. Eighty-five percent (85%) of these individuals did not report the incident(s) to a designated faculty member or member of the medical school administration empowered to handle such complaints. Twenty to sixty percent (20-60%) were very dissatisfied, feeling there were no non-threatening or easily accessible mechanisms for the submission and processing of complaints and no means to investigate adequately. There was also a failure to adjudicate complaints. Twenty-five to forty percent (25-40%) stated their rights were not appropriately protected.

One hundred percent (100%) of medical students who graduate have outstanding educational loans they are legally required to pay. The average debt for 83% of students who graduated in 2000 was \$93,000. Of all students with debts, 29% owed \$100,000 or more. These figures suggest the need for thoughtful and meaningful changes if we are to continue to attract bright and well motivated young people to pursue medicine as a career. The number of applicants to medical school has declined in the last few years. The American Medical Association Alliance raises millions of dollars annually to offset these debts; we are indebted to them for their assistance.

One of the resolutions adopted by the 2000 Interim Meeting of the AMA calls for the protection of medical student privacy and confidentiality in the context of physical

"All of us need to nurture our medical students and assist them in any way we can."

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Physician as Colleague and Teacher

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diagnosis classes by adopting the following principles.

1. Students should be free to decide whether or not to participate as patient models in physical diagnosis classes, with no penalty for refusal to participate as patient models for any reason.
2. If abnormal physical findings are found during a physical diagnosis class, the student should not be used as a model of abnormal findings without his or her explicit, meaningful, and non-coerced consent.

No information regarding abnormal physical findings encountered in a medical student during a physical diagnosis class should be transmitted to any third party (by instructors or fellow students) without the student's explicit, meaningful, and non-coerced consent.

All of us need to nurture our medical students and assist them in any way we can. Those of us who approach them with an attitude of doom and gloom only add to their burden.

Hippocrates, in the fifth century BCE, was one of the first to articulate the importance of collegiality among physicians and the role of the physician as teacher. His oath states that those who taught him the art of medicine were "equally dear to me as my parents." He recognized the importance of teaching others "this art, if they wish to learn it, without fee or stipulation. . . by precept, lecture, and every other mode of instruction."

Being aware of and successfully addressing these issues will enhance our own professional lives and will help to ensure attracting compassionate and committed young people to become future generations of physicians. ♦

Economy of Scale

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tion. Simple "yes/no" responses regarding public Board orders are not enough. A patient seeking medical care may not choose a practitioner if he or she can only immediately determine if there is a public record. Many physicians with public Board orders are perfectly capable of practicing medicine safely. A good example is a physician recovering from alcohol or drug addiction. I would have no hesitation seeking care from one of these professionals who is in good recovery. Having come in contact with

many recovering professionals over the years, I am impressed with their diligence, commitment, and positive attitude. (I will address this important point in more detail in a *Forum* article soon.) A copy of a Board order enables a consumer to make an informed choice in this area. My principal focus for this article, however, is the mechanism for consumer notification.

Impact of Web Access

The old, manual process for responding to a consumer inquiry started with a telephone call, fax, or letter. On our side, a staff person would have to answer the telephone, take a request for a public document, go to a hanging file of such documents, make a photocopy, and forward it via U.S. Mail or fax.

"Over the period from October 26 to November 26, 2000, we responded to 120,422 requests"

Multiply these events several thousand times a year. Clearly, the advantages of these recent changes have been quite substantial. It would be difficult to measure qualitatively how this improved access has served the average citizen. We do have an indication of the quantitative impact in the increased public response that has been generated by virtue of requests from our Web site. Requests are defined as those contacts where there was successful retrieval of content. This excludes a certain amount of double counting that occurs when simply considering hits on a Web page. Following certain media coverage in recent months, we had requests which peaked as follows: November 9 (13,318), November 13 (14,135), November 14 (10,526), November 24 (5,588). Over the period from October 26 to November 26, 2000, we responded to 120,422 requests. This shows a substantial increased response to North Carolina citizens and others.

If we take one of these peak days where there were 14,135 successful requests, we can compare that to an old system of responding by telephone. A telephone contact ranges from 30 seconds, where an individual requests information relatively quickly by providing identifying information, to the more typical 3-minute conversation, where a person may be unsure of the spelling or the full name or other identifying data. If we look at each of these contacts, we find the following. Assuming a 30-second contact, one employee can respond to 960 requests working full time without interruption. This would require 14 full time people to handle the peak load of over 14,000 daily

requests. Taking the more typical, longer telephone contact at 3 minutes, one person could handle 160 requests a day, which would translate to 88 staffers. If we lopped off the peaks and serviced the monthly load, we would need 4 positions — assuming 30 second contacts. The total staffing complement of the Medical Board right now, including investigators and attorneys, is 39 persons. So this is an example of providing substantially improved services to our citizens at a very nominal cost. It certainly would not be cost effective to establish staffing levels to service the peaks!

A second point I would like to make is that the Board is not making more information public now than it was previously. For example, any of the public orders you can now retrieve on line have always been available from the Board; we are simply providing a more efficient mechanism for serving the public.

Other Efficient Mechanisms

In addition to these mechanisms, we provide a subscription service to customers such as hospitals and insurance companies. These entities, through the subscription service, can develop a "favorites list" wherein they can routinely query the Board with a minimum of overhead. Consider the example of a rather large hospital or medical education facility that has 2,000 or more physicians to periodically check to determine whether their licenses

"Now over 34,000 licensees can register annually with the Board over the Internet"

are current and whether there are any public Board orders. In the old days, someone sat down at a terminal and individually keyed in one individual after another to check such information, and in the very old days this was done by telephone or correspondence. This effort was repeated at intervals, usually annually. Now, through this subscription service, which we call DataLink, these customers can build a list of people whom they frequently check, usually their entire medical staffs, and query the Board electronically. Also, now over 34,000 licensees can register annually with the Board over the Internet, substantially reducing both their burden and the Board's in this process. What formerly took weeks from start to finish takes only minutes.

In my mind, these enhancements are the result of three basic elements. First, a progressive Medical Board that understands its

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Economy of Scale

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responsibility to the public and constantly strives to provide the best possible service. Second, a funding mechanism that is relatively progressive compared to appropriations processes in many other states: none of our licensing revenue is siphoned off for other functions of government. Last, but not least, we have an extremely dedicated and creative staff.

Moving Forward

It should be noted that not one penny of the Board's operation comes out of general tax revenue; all revenue for the Board is generated from annual registration fees and license application fees. As of a year ago, the median fee for medical licensing boards across the country was \$132 per year. (Some fees in other states: California — \$300; Arizona — \$200; Connecticut — \$450.) Our present fee in North Carolina is \$100 per year. Within practical financial constraints, the Board intends to do all it can to maintain its momentum in achieving economies of scale. As the Board considers the future, it has plans for development in the following areas that would require new revenue.

"It should be noted that not one penny of the Board's operation comes out of general tax revenue"

- **Physician Health Program:** North Carolina is fortunate to have a nationally recognized Physicians Health Program, substantially funded by Medical Board revenues. This program is now in need of additional funding. The goal of this program is to improve the quality of health care to the people of North Carolina through assurance of healthy medical professionals. It does this principally by helping physicians and other health practitioners impaired with chemical dependency, mental illness, and physical illness. Those who are identified as being impaired but have the potential to practice medicine with reasonable skill and safety find professional treatment and guidance available to them, and most are successfully returned to practice. If you need more information about this program, it may be reached at 800-783-6792.
- **Investigative Staff:** We need to increase our investigative staff. We have areas of the state where we would like to increase our coverage with investigators. Additionally, consistent with the topic of efficiency, we can investigate

more cases and investigate the cases we have more quickly through development of this resource.

- **Probation/CME Monitoring:** We now have a continuing medical education requirement with virtually no additional resources available for monitoring. Additionally, we are looking for ways of improving our ability to monitor those licensees the Board has determined can safely practice but who need oversight through probation monitoring. Those on probation need regular and timely Board contact to protect the public. This is also in the best interest of the licensee and the profession as a whole.
- **Paperless Office:** I have described above one effort to move away from less efficient and cumbersome paper mechanisms. Another significant effort is the registration process, which may now be completed in less than a few minutes time on a computer terminal with a credit card. This significantly reduces the paperwork burden for over 34,000 of our licensees. Other enhancements we would plan for the future would include less paper in the application process and more use of electronic record storage.
- **Legal Department:** We would like to expand our Legal Department; this will have the distinct benefit of improving timeliness in the handling of cases.
- **Assessment/Remediation:** There is a significant national movement to improve the quality of medical care. Some of the data available paint a bleak and, in my opinion, often exaggerated picture of the nature of the problem. For example, the Institute of Medicine reports that there are between 44,000 and 98,000 deaths nationally due to medical error and that medical error represents the sixth leading cause of death (http://books.nap.edu/html/to_err_is_human/). These data are extrapolated, perhaps too vigorously. The results of studies in three states were extrapolated to cover 33.6 million hospital admissions to U.S. hospitals in 1997. There are certainly medical errors, but I for one question whether medical errors account for more deaths than motor vehicle accidents as indicated in this report. If this is true, medical boards should be awash in cases of medical error leading to death. We are not. However, one thing that medical boards are working on is an Assessment/Remediation Program for practitioners with clinical skill deficiencies

that may or may not rise to the level of prosecutable disciplinary offenses. For example, a physician may suffer a clinical skill deficiency that is identified by a hospital that may not warrant revocation or suspension of a medical license and, in fact, is remediable. The Federation of State Medical Boards has a contractor in Colorado (formerly known as the Colorado Physicians Evaluation Program and now known as the Institute for Physician Evaluation) that offers an effective program for assessing such physicians. Once these assessments are done, however, there needs to be a mechanism for remediation and for monitoring and overseeing those being remediated. These are costly enterprises.

Conclusion

I have presented here a few examples of economies of scale in the Medical Board's office that have made significant differences over the past year or so. I have suggested some further economies of scale that will contribute measurably to improving the Board's work and its ability to protect the public in the future. We would be interested in your input about what we have been able to do and what we hope to do. ♦

No Preprinted Names of Controlled Substances on Prescriptions

*Donald R. Pittman, Field Supervisor
NCMB Investigative Department*

North Carolina physicians have been known to use prescription blanks with a specific drug name preprinted on them. If the drug is a controlled substance, Schedules II through V, the use of such a prescription blank is in violation of the North Carolina Controlled Substances Act. According to 45G.0307 of the act, "the preprinting of or use of preprinted prescription blanks with the name of Schedule II through V Controlled Substances shall be prohibited." Please make a note of it! ♦

UNC White Coat Ceremony: Keynote Address 2000

C. Stewart Rogers, MD

Professor of Medicine

University of North Carolina at Chapel Hill School of Medicine

Moses H. Cone Memorial Hospital, Greensboro



Dr. Rogers

Among the innovative programs supported by the Arnold P. Gold Foundation is the White Coat Ceremony. The first was held at the College of Physicians and Surgeons at Columbia University in New York in 1993. The purpose is: to clarify for students, prior to their entrance into the medical community, that a physician's responsibility is to both take care of patients and also to care for patients. In other words, doctors should care as well as cure.

Capturing students attention "at a strategic and impressionable moment," the Gold Foundation considers it important that family members and friends attend the ceremony. An inspiring address by an eminent physician sets the tone for the ceremony in which distinguished faculty and administrators from the medical school cloak students with their first white coats. Students recite a form of the Hippocratic Oath appropriate to their status as students, pledging to lead lives of compassion, uprightness, and honor. The ceremony is designed to stress the importance of the doctor-patient relationship and to foster a psychological contract in which the student accepts responsibility to be technically excellent, committed to the profession, and compassionate with patients. The ceremony was introduced at the University of North Carolina at Chapel Hill School of Medicine in 1996.

The following speech by Dr. Rogers keynoted the UNC White Coat Ceremony on September 16, 2000. The ceremony honored the Medical School's Class of 2004.

This is a rite of passage, a ceremony of induction into a great profession, one you have sought and worked hard to achieve for many years already and one for which you are highly qualified. Now, you are up against it. Your arrival at this school, your recent plunge into the medical curriculum, and this ritual today are important transitions from your years of general preparation to the focused study of medicine that lies directly before you. In this next hour, you will be invested in a traditional emblem of

the physician and will be invited to accept the principles of diligence and respect without which you cannot learn your craft with honor. You will read the words of an oath, and I am confident that every one of you will embrace these words with optimism and honest intent to comply. I am equally certain that each of you will struggle over many years to accomplish what you pledge today. I have a copy of this oath and it is loaded with challenges for the most dedicated physician and for a lifetime of learning. After you begin to learn what this oath really entails and master some millions of facts (of which several hundred will prove useful), I'll see you back here in four years for your graduation.

That's the oath. What about the white coat? The white coat, of course, is a symbol of the physician and represents the Mantle of Hippocrates. That's what I'm supposed to say and I don't mind saying it — rituals connect us to the ideals that ennoble our work. And this is an idealistic profession — there is no calling, in its essence and its ordinary work, that so well blends the virtues of intelligence and compassion as does medicine. Notwithstanding the frustrations (which you will discover in due course), the opportunities to make a diagnosis, to reassure, or to give bad news with sensitivity and comfort are peak experiences that lie ahead for each of you and validate the rhetoric of this program.

But for those of you who have no patience with ritual, who find it pretentious, and reach instead for what is directly useful and real, be assured that your white coat will have practical value as well. The white coat is an apron, a satchel, and a badge. Like cooks and blacksmiths, we have a messy job and we need an apron to keep the stains off our street clothes. Fluids and feelings, blood and tears, are part of our business and our work is up close and very personal, but we need to stay clean and calm — for the next patient, for our families, for our peace of mind. We have to worry, after all, about our own blood and our own tears and we assume a white coat of detachment and

equanimity for professional distance—work space for our techniques of healing and a defense against “burn-out.” At the same time, we cannot heal without empathy; the distress of our patients must echo somewhere in our own experience, our reading, our imagination, or we will fail to understand and our response will be misdirected or fall short. So the white coat is an apron, not a suit of armor, and you'll appreciate the design — it opens over your heart.

The coat is white, of course, to show the stains or, rather, to back-light your purity. Never forget that the worst stains spill from your own character: from neglect, impatience, or greed. These spots are best seen at night when you take off the coat — that's why it's white on the inside.

The white coat is also a satchel. You will soon find and appreciate the large pockets, which, for most modern doctors, have replaced the black bag. You won't have much to place in those pockets today, but one of your principal tasks in training will be to load them with the tools and manuals that are most useful when you see your patients. The tools, in general, enhance your senses; the manuals annex and enlarge your memory. I've noticed, in myself and others, that patient care decisions are largely determined by the tools, skills, knowledge, and attitudes that we have selected to carry with us as we work. For the next few years, you will rotate through many disciplines and the contents of your coat pockets will be dictated by others and will have short half-lives, but gradually you will focus, dig in somewhere, and load your own pockets. There will be no shortage of advice about what is most important to have about you, but today is my turn and I have three suggestions, not in any way exhaustive or even prioritized, but ones that are sometimes overlooked.

My first suggestion is simple gratitude. Your tuition at this school covers a small fraction of the cost of your medical education. Most of the rest is paid for you, directly or indirectly, by taxpayers, including millions of low-wage workers who comprise the large majority of the uninsured. You are already several weeks into a career debt to these people; stick a reminder somewhere in your white coat today and get it out when you set the access to your future practice.

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White Coat Ceremony

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A second resource for your coat pocket is a proper appreciation for the social history of your patients. We are not veterinarians — our patients are fellow humans with much shared experience that can be used to build trust and mutual respect. Often social circumstances will suggest clinical risks and exposures or may have a large impact on the patient's attitudes toward questioning and medical care. Finally, in most settings, implementing your care plan requires mental, social, and financial resources that may well be deficient, and a biologically sound plan may founder on social limitations. Can your patient even afford what you prescribe? Don't you think you should ask?

My last suggestion concerns the neurological exam and specifically what is called "mental status." This dimension of clinical inquiry, uniquely human, largely determines the experience of illness yet is rarely emphasized in physician reports; when mentioned at all, it is often reduced to those aspects that we share with other livestock, like alertness and agitation. I seldom hear the mental faculties fully described. I almost never hear of a patient's creativity, conscience, humor, kindness, generosity, or courage. Are these clinical issues? Perhaps not, but some thoughts in these directions might enhance your sensitivity to suffering and to the meanings and goals of your work.

Finally, the white coat is a badge, a hall pass in the medical center, and a token of prerogative in society. Its meanings are many: some are trivial or pretentious, others are practical or even noble.

It can say, "I burned up the MCAT."

Or, it can say, "I'm here to help."

It says, "Don't slow me down."

Or it says, "You are the only person who matters right now."

It says, "If you were more like me, you wouldn't have that problem."

Or it says, "Let's see if my strength can serve your need. Next time our roles may be reversed."

These are some of the uses and some of the meanings of the white coat that you are about to receive. There is also a warning, in fine print, that some of you may forget to read: "This coat will fit better and last longer if you do not wear it all the time." Remarkable as it is, your white coat will not

exhaust all your talents or meet all your needs. So hang it up sometimes, even during medical school. Walk over to this beautiful campus, go to the gym, take in a concert or play, call up a friend, read a book. Wear your old coats, and, from time to time, go out and shop for a new one. And when you do wear your white coat, as my father always said when I got new clothes, "Wear it in good health." ♦

Edwin A. Rasberry, Jr, MD, Former NCMB President, Dies

Dr Edwin Albert Rasberry, Jr, of Wilson, died on December 1, 2000, following a brief illness. He was born in Greene County, NC, in 1916, and was a graduate of the University of North Carolina, Chapel Hill. He received his MD from the University of Pennsylvania in 1941, and served in the South Pacific as a U.S. Navy flight surgeon with the "Bateye" Night Fighter Squadron from 1943 to 1947. In 1949, he entered the practice of internal medicine in Wilson. He was named a clinical professor of medicine at the University of North Carolina Medical School in 1953.

During his distinguished career in medicine, Dr Rasberry served as president of the medical staff at Wilson Memorial Hospital, president of the Wilson County Medical Association, and president of the Seaboard Medical Association. He was a member of the North Carolina Medical Board, then called the Board of Medical Examiners, from 1956 to 1962, serving as president of the Board in 1960-61. He was also a member of the Wilson County Board of Health and a founder and first president of the Wilson County Heart Association. Active in organized medicine, he was also well known for his work in his church and in civic and charitable organizations.

Conversion from UPIN Numbers to DEA Numbers for Medicaid Prescriptions

*Sharman Leinwand, MPH, RPh
DUR Coordinator; Program Integrity, DMA*

As previously mentioned in the *Forum*, NC General Statute 106-134.1(a)(4)a, reads: "written prescriptions must bear the printed or stamped name, address, telephone number, and DEA number of the practitioner in addition to his legal signature." For Medicaid purposes, our program requires the referenced information be on a prescription blank whether the prescribed drug is a controlled substance or non-controlled substance (legend drug).

The Division of Medical Assistance (DMA) requires DEA numbers on all pharmacy prescriptions — eliminating the universal provider identification number (UPIN) for prescription processing. Providers must have their DEA Registration on file with Electronic Data Systems (1-800-688-6696 or 919-851-8888). If a prescriber does not have a DEA number and needs to issue prescriptions to Medicaid recipients, the prescriber must contact the Drug Utilization Review (DUR) section of Program Integrity at 919-733-3590. At that time, an identification number (ID) will be issued in lieu of the DEA number. The ID number, following the same format as the DEA number, will always begin with a Z — for example: ZF1234567. Prescribers will place the Z number on their Medicaid prescriptions. This number is referred to as a Medicaid identification number (MIN) and should not be referred to as a DEA number. ♦

Dialogue on Public Health

Public health issues are a concern, not only for the medical community, but also for individuals and families all across North Carolina. Now there's a forum to discuss many of those issues and to provide accurate information to the public. A 12-month series of call-in programs on the Open Public Events Network (OPEN) began on November 16, 2000. The call-in series, which is sponsored by the Division of Public Health in the Department of Health and Human Services, is continuing on the second Thursday of every month at 9:00 PM on public health topics.

OPEN programs give citizens an opportunity to call in and talk with public officials about a range of topics every Tuesday and Thursday evening from 8:00-10:00 PM. For a list of cable systems carrying OPEN programs, or if you would like to receive monthly program schedules, please call 919-733-6341, send your e-mail request to open@ncmail.net, or go to www.doa.state.nc.us/doa/apt/cablelst.htm. ♦

A Personal View: Medical Errors and the IOM

Question the Illogical and Rely on Common Sense and Personal Experience

William D. Daniel, MD, Executive Director
American Society of Forensic Obstetricians and Gynecologists

I: America's Favorite Pastime

Unless there has been another players' strike or owners' lock-out by the time you read this, baseball probably still reigns as the traditional favorite pastime of untold numbers of summer and fall couch potatoes/sports fans. I've always been intrigued by the seemingly inconsistent reactions of fans, managers, sportscasters, and players to baseball umpires and scorers. Both make judgment calls that may be questioned, yet the umpires get booed, have their shoes scuffed with dirt and spat on, and get managers in their faces yelling and spraying them with tobacco spittle, while the scorers only get occasional groans or headshakes accompanied by frowns and quizzical looks. Why the difference?

For one thing, scorers determining and assigning errors have no effect on who wins or loses, whereas umpires' calls directly influence game outcomes. Scorers in the press box mainly compile player statistics regarding hits, runs, and errors for the record book publishers and baseball card manufacturers using standard guidelines, while umpires keep the game on the field running according to standard rules of play. Probably the most important reason is that recording individual player errors is inconsequential to the final score, while calling balls, strikes, foul balls, outs, and safes are the exact opposite.

We in medicine today face a somewhat different conundrum: apparently our errors, even trifling slips of no consequence to patient care outcomes, are more important than whether we win the game, ie, cure our patients. You're all familiar by now with the dustup over errors in medical care that first surfaced in the late 1970s, grew among patient advocates during the 1980s, became legitimized by the Colorado/Utah and Harvard studies during the 1990s, and culminated in the 2000 Institute of Medicine (IOM) report. Politicians recently trampled each other in their stampede to climb on the

bandwagon before it left without them, various patient advocates and activists have decried these apparent crimes against society from the rooftops, and some of our most prominent physician leaders and national medical organizations have begun exploring very expensive solutions while crying *mea culpa*. For what? A problem that may not even exist and, if it does, is apparently of much smaller importance than originally proclaimed.

The first voice of reason to be heard came from three colleagues at the Regenstrief Institute, Indiana University Center for Aging Research, Indiana University School of Medicine in Indianapolis, and spoke from the pages of the prestigious *Journal of the American Medical Association* (McDonald CJ, et al. Deaths Due to Medical Errors Are Exaggerated in Institute of Medicine Report. *JAMA* Vol. 284, No. 1, 5 July 2000, p. 93). In the interest of unbiased journalism, *JAMA* had one of the authors of the Harvard study reply (Leape LL. Institute of Medicine Error Figures Are Not Exaggerated. *JAMA* Vol. 284, No. 1, 5 July 2000, p. 95).

The gist of it is, the guys from the Speedway City claim the chaps from Cambridge don't know their statistical stethoscopes from third base, and instead incited widespread panic by irresponsibly throwing around phrases like "Preventable adverse events are a leading cause of death" and "at least 44,000, and perhaps as many as 98,000, Americans die in hospitals each year as a result of medical errors." More objective statements like "Although some hospital deaths are preventable, most will occur no matter how many 'accidents' we avoid" were heard from the Pacers' home court.

Only an idiot would hold that errors never occur in our care of patients, an even bigger idiot that physicians never make mistakes. Mistakes are a part of life: "To err is human." But there is no excuse for not integrating

"There is no excuse for not integrating available non-human technology into our patient care whenever possible"

"The guys from the Speedway City claim the chaps from Cambridge don't know their statistical stethoscopes from third base"

available non-human technology into our patient care whenever possible. Properly designed and operated machines seldom make mistakes, and the less input we fallible humans have the better they function. Computer technology has revolutionized almost every aspect of our life today, both on and off the planet. Manufacturing and practically all areas of science, including medicine, use digital technology in ways unimaginable just 10 years ago. The exception is direct patient care, which, in comparison, lags far behind hospital inventory control and accounts receivable in computerization.

Most of the preventable medical errors I have seen were related to pharmaceutical treatment. The most common problem has been illegible prescriptions and doctors' orders. I addressed the first years ago by phoning in all prescriptions whenever possible. This gives me the benefit of communicating directly with a trained pharmacist who can answer questions about costs, newer formulations, effective dosages, adverse reactions, and generic alternatives. Living in a small town makes it easier because I usually know the druggist personally and enjoy the chance to chat.

"Today, with computer oversight and approval, almost every medication error is preventable, even in the ER and L&D"

I've never worked in a hospital with computerized medical records that required physicians to type their orders, but that's obviously the best solution to illegibility. In the alternative, I did try to write as legibly as possible. Most importantly, I always took the order sheet to the patient's nurse and asked her to read my orders before I left the nurses' station, encouraging questions.

The next most frequent medication errors I have seen were due to patient misidentification, most commonly in the Emergency Department or Labor and Delivery, where occasionally unmanageable workloads were used to justify hastily conferred verbal instead of written communications. This one's a no-brainer. The Veterans

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Administration has already literally got it wired with a bar code on their patient identification bracelets and another on their unit doses, both read at the bedside before administration with portable laser scanners just like at WalMart. If all systems aren't go and everything kosher, the pharmacy computer will not approve administration. It knows what every patient's medications and allergies are, their drug dosages, and the proper times for administration. This also eliminates shift change double dosing caused by a nurse forgetting to write a dose on the Medication Administration Record. Thirty years ago, the unit dose system was a big step forward in hospital administration of drugs, but it didn't go far enough. Today, with computer oversight and approval, almost every medication error is preventable, even in the ER and L&D.

Another frequent and preventable error is misidentification of patients' laboratory specimens, again amenable to bar coding of identification bracelets and specimen containers. Some labs already use computer generated bar code labels printed at the site where the specimen is obtained. The same is true of identifying patients for diagnostic imaging studies, not to mention patients in the OR suite and recovery room.

None of these solutions addresses the problem of physician errors due to faulty subjective reasoning, lack of expertise, lack of attention, or simple failure to properly discharge patient care responsibilities. There are no computers to prevent such mistakes, nor will government regulation, oversight, or mandatory reporting stop them. Instead, we must rely on responsible credentialing procedures, being our brother physician's literal keeper via effective and fair peer review, commitment to a philosophy of risk management focused on eliminating future recurrences of preventable adverse events and not on covering our backsides post facto, advocacy for identification of impaired health care workers via routine drug screening with an emphasis on rehabilitation, and, of course, professional licensing. There will still be instances when individuals or entities decide such solutions are too expensive to implement and don't apply to their special circumstances anyway. For these, there will also still be smart and dedicated medical plaintiff attorneys to make business as usual, with its inevitable mistakes, too costly to continue.

The whole thing reminds me of Dad's warning years ago about people trying to

convince me it was raining while they peed on my shoes. It's always wise to question the illogical, instead relying on common sense and personal experience.

II: The Sky Isn't Falling, but It Could

It seems I'm not the only one so concerned about the hysteria ignited by the IOM's report on errors in medicine. In a guest editorial in *Ob.Gyn.News*, A.E. Miller, MD, a solo practitioner from rural Idaho, questions the same report and its resultant rush to judgment. Dr Miller trots out the expected criticisms, but adds one I hadn't heard before, and it's pretty significant.

The Harvard Medical Practice Study, basis for the IOM report, made a least one very biased assumption. If you were a terminal, critically ill, severe multisystem trauma, or otherwise at-death's-door patient, and your demise was in any way related to or coincident with what was retrospectively judged to be a medical mistake, you were counted among the "99,000 deaths from medical errors" alleged to occur each year.

We all know patients past reasonable chance of salvage are frequently used as clinical

"We all know patients past reasonable chance of salvage are frequently used as clinical material for teaching technical procedures to students, residents, and fellows"

material for teaching technical procedures to students, residents, and fellows. While this may raise the ire of some patient advocates, it's a cold, hard fact of life that everyone must develop their professional skills on a learning curve whose slope can get mighty slippery. Better this gaining of experience at the expense of those already on their way to the end than a 25-year-old mother of four toddlers.

While obviously overstating the case, this clearly makes a valid point. All life is valuable and should be saved when possible and within reason to do so. Without the first condition, there's no alternative. If both conditions exist, it's a no-brainer, but that's not always the case. Often, expertise and technology are available but their use defies reason. We have the ability to send a manned space mission to the sun to explore its surface but to do so would be ridiculous. Coding a ventilator-dependent, comatose 55-year-old with a chest full of inoperable lung cancer is not only dumb, it's an assault on her physical person and spiritual dignity

unless there's some benefit to be realized, something to be learned that will increase the inexperienced respiratory therapist's, nurse's, or physician's chances of successfully resuscitating future patients under their care. If mistakes must be made, and they must in order to learn, try to at least let them be made where they don't significantly influence the ultimate outcome.

But there's always a very necessary caveat to this attitude. "First, do no harm." To me, this means not causing pain without reasonable chance of cure. It also means respecting

"If mistakes must be made, and they must in order to learn, try to at least let them be made where they don't significantly influence the ultimate outcome"

and appreciating the sacrifices our dying and dead patients make to advance our knowledge and ability. This attitude does not give *carte blanche* to those in training to try, willy-nilly, whatever they please without consultation with and supervision by someone experienced and capable in the procedure, but it does recognize the value of

"practice, practice, practice" in more than just getting to Carnegie Hall.

I've made plenty of mistakes over the years; we all have. I've also been extremely fortunate in that none of my mistakes as a physician killed anyone, at least that I know of. Some of my patients have died, but not directly from my mistakes, and I don't think anyone, short of the Lord himself, could have given them a better chance. Some patients have experienced unnecessary complications or expense, but all have been salvaged, albeit more than occasionally with the consultative assistance of other physicians.

The flood of demands for government interference and regulation have already begun, as has acquiescence to these demands. My own American College of Obstetrics and Gynecology has created a subcommittee of its Committee on Quality Assessment to "study errors in ob/gyn and develop strategies to reduce them."

It's my opinion that the most dangerous errors in medicine are the result of worker inexperience, unconcern, ignorance, or impairment, whether it be on the part of a physician, nurse, technician, clerk, the person mopping the floor, or any other health care worker. Fortunately, such workers are the exception, not the rule, and their failures usually of little consequence, but they are

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still disasters looking for a place to happen.

Medicine's most common errors, with or without serious consequences, are errors in system functions easily amenable to prevention using available technology and management techniques already employed for years by manufacturing industries worldwide. Some of us have held this opinion for ten or twenty years, but no one has yet effectively considered the hospital and its peripherals as a manufacturing operation, subject to the same problems and solutions as any other factory.

Even if we become Demming Disciples embracing short-cycle manufacturing or "Just in Time" principles, we still must identify those potentially disastrous workers and motivate, educate, rehabilitate, or eliminate them. It's time to do it and do it right, not with halfhearted lip service and buzzwords but with a hard and honest look at our workforce, total dedication to the philosophies of continuous quality improvement, and immersion in eliminating system errors; in short, what Japanese manufacturers started doing in the early 1950s. Unfortunately, the naysayers will use the same excuse our American industries did: "But we can't afford to do that!" The point is that now, like General Motors and Ford, we can't afford not to.

"It's my opinion that the most dangerous errors in medicine are the result of worker inexperience, unconcern, ignorance, or impairment"

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North Carolina Medical Board



1-800-253-9653

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

The Cow with Zits: It Never Hurts to Get a Second Opinion

*Walter J. Porjes, MD
Vice President, NCMB*



Dr Porjes

She was not an ordinary cow. She was still a calf when my wife rescued her during the floods last year. But that's another story: her being pulled behind a motor boat in the dusk as the rest of the herd bellowed in despair. In spite of our efforts, the swirling waters eventually drowned twelve of our helpless animals.

Our neighbor, Johnnie, first spotted the warts: ugly, grayish, rough marbles defacing the soft, shiny surfaces of her black face. Otherwise she seemed to be fine, but the specter of a communicable disease spreading through our herd gave us a chill. I rapidly took some pictures and Johnnie set off to talk to his favorite extension agent and our large-animal vet.

Johnnie was glum when he returned. "The agent, and you know he really knows cows, said that he heard that the old folks used to take pliers to twist those sores off followed with an application of 'piney oil. But he also said that he had no idea if the treatment worked." The veterinarian was even less encouraging, according to Johnnie. "He said it was a virus that starts with 'P', that it is infectious, and that there were some injections that could be given but it took a lot of medicine and was expensive. . . . And then he said that sometimes it's easier to get rid of a problem than to resolve it." It was not a lot of fun to load her into the trailer and take her off to the stockyard. We were pretty depressed on the way back home.

The decision, however, did not sit right with me. Did we really do the right thing? Maybe we should have gone for a quarantine and the injections? Why not call NC State and see if they have any ideas? Through the wonders of the Internet, I soon had Dr Barrett Slenning, associate professor of ruminant/production medicine, on the

phone. Yes, of course, he was familiar with the problem. The lesions, caused by a papilloma virus, appear on adolescent cows of certain breeds, are self-limited, and clear with the maturation of the immune system after two or three months. Oh yes, there are a lot of treatments and all of them work but doing nothing works even better. No, they do not present a hazard to the herd. I thanked him profusely.

Now what about the cow? The auction was scheduled for the next morning and she almost certainly would end up as hamburger. Johnnie agreed we had made a terrible mistake but there was no way to get her back. No way. That's just not done with stockyards. And so on. Absolutely not.

My wife did not agree. Surely we did not intend to sacrifice a cow that she had rescued because of a few zits? She called the stockyard at once and happened to get the wife of the owner. "Yep, you can get her back"; "yep, come any time, we're here all night," and when Mary Ann asked if other folks ever change their minds, the lady's laconic answer was "yep, women sometimes do."

The stockyard was frightful. The place stank in the dark, four dead hog carcasses lay in two of the small corrals, and a few lights delineated the shapes of the condemned animals. We did not see our cow, but she certainly saw us. As soon as the trailer was backed up and the gates opened, she ran, yes, actually ran about 30 yards to jump back into that familiar, rusted contraption. Some folks say that cows don't grin, but that one did — ear to ear — as did we. When I walked into the office to apologize to the owner, he accepted no payment and said, "I've had wives and I've had girlfriends and I understand."

She rode back in dignity, moored loudly as we entered the pasture, and enjoyed some loud moos from the herd as she stepped out of the trailer. A few nuzzles back and forth — she was back home.

The lesions are now gone. We've also given the cow her own name — the best life insurance a farm animal can get — Papilloma Picasso. It has a certain ring.

It never hurts to get a second opinion.

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Public Records, Other New Search Features, Now Available on NCMB's Web Site: www.ncmedboard.org

Andrew Watry, executive director of the North Carolina Medical Board, has announced that the public now has full access to the Board's public records of disciplinary and related actions on the Board's Web site: www.ncmedboard.org. The Board has always been committed to making public record documents available as quickly and efficiently as possible, Mr Watry said. In the past, this has meant copying (at no cost to the person making the request) and mailing or faxing the material. Of course, people could also come to the Board's office and examine the records directly, but that is not convenient for most people.

"DocSearch" Feature Now Includes Records

Now, the documents, including notices of charges against licensees, consent orders, board orders revoking or suspending licenses, and related materials, are available in the section of the Board's Web site titled "Lookup a Physician, Physician Assistant, or Nurse Practitioner." Click on that item on the home page menu, then click on the "DocSearch" feature in the next menu that appears. That will take you to a screen that asks for the name of the licensee you are interested in (you can also designate the particular profession if you wish: physician, PA, NP). Submit the name and you will get a search result providing the full name, license number, status, and address of the person. If there is more than one person with the name you are searching, all the options will appear and it's at this point you should be able to use the added information on the screen to ensure you have the right John Doe. Click on the selected person's name and you will get a page containing still more details, such as education, specialty, date of birth, etc. AND, if the Board has taken an action related to that person, the public documents will be listed right on the page. Open and read any of them with a click.

All public file documents will be posted to the Web site on the same day they are placed in the formal record. The only items not included are the word-for-word transcripts of hearings, which are usually hundreds of pages in length and would add little to the usable information the average person seeks in the public file. The charges leading to the hearings, answers to the charges, and the Board orders and decisions coming from the hearings are all there, however. (Full hearing transcripts can be seen at the Board's office and copies are available to anyone.)

"QuickCheck" Feature Eases First Search

Another new feature on the Board's Web site is the addition of a section called "QuickCheck." It is also found in the Web site menu under "Lookup a Physician." It is an alphabetical directory of all those individuals who have public files with the Board. Using this directory, anyone can quickly and easily check one or more names to determine if a public file exists related to them. To help with identification, each person listed is identified by location, date of birth, specialty, and license number. If the person is listed in the directory, the actual documents can then be examined by using the "DocSearch" feature described above.

"Physician Locator" Feature

There are times when someone needs to know who is practicing a certain specialty (such as internal medicine, orthopedics, obstetrics, etc) in a particular area. The new "Physician Locator" feature, found in the Web site menu under "Lookup a Physician," makes it possible to call up a list of all those in a town or city who practice in a specific specialty. You simply enter the name of the town or city, select the profession you are interested in, such as physician, physician assistant, or nurse practitioner (or ALL of those together), and pick the specialty you want from the list that is made available on screen. Click on "submit" and, if that specialty is represented in that location, the list will appear, giving the practitioners' names, status, license numbers, and addresses. Click on the name of the person you are interested in and you will open the "DocSearch" file on that person. (Remember, specialties are self-designated by the practitioners. They are not verified by the North Carolina Medical Board.)

Contact the Board with Questions

"The Board is pleased that it can make these valuable informational resources more readily available to the people of North Carolina," Mr Watry said. "We are committed to using new technologies as effectively as we can to meet the needs of the public we are here to serve." He also encouraged anyone with questions to e-mail the Board at info@ncmedboard.org. They can also call the Board at (919) 326-1100, or toll-free from in-state, at (800) 253-9653. For a detailed look at the Board's complete Web site, click on the "Site Map" item on the home page menu. ♦

NCMB Elects Officers: Elizabeth P. Kanof, MD, President; Walter J. Pories, MD, Vice President; John T. Dees, MD, Secretary-Treasurer

In October, Andrew W. Watry, executive director of the North Carolina Medical Board, announced the Board's election of its officers for the coming year: **Elizabeth P. Kanof, MD**, from Raleigh, **Walter J. Pories, MD**, from Greenville, and **John T. Dees, MD**, from Cary. They took office on November 1, 2000, and will serve until October 31, 2001.

Elizabeth P. Kanof, MD, President



Dr Kanof

On November 1, **Elizabeth P. Kanof, MD**, of Raleigh, became president of the North Carolina Medical Board, replacing Wayne VonSeggen, PA-C, of Winston-Salem. Dr Kanof was appointed to the Board in 1996, was

reappointed in 1999, and has served as secretary-treasurer and vice president of the Board.

Dr Kanof, a native of New York, received her BA from Mount Holyoke College and her MD from New York University. She did an internship at Kings County Hospital Center and residencies in dermatology at New York University-Bellevue Medical Center and Duke University Medical Center. She is a fellow of the American Academy of Dermatology and a diplomate of the American Board of Dermatology. She holds appointments as assistant clinical professor of dermatology at the Duke University School of Medicine and as adjunct clinical professor of dermatology at the University of North Carolina School of Medicine.

Very active in organized medicine, Dr Kanof served as president of the Wake County Medical Society in 1984 and of the North Carolina Medical Society in 1994. She has served on or chaired numerous

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Medical Society committees and currently serves as a Medical Society delegate to the American Medical Association. Over the years, she has also been a participant in a wide range of community and charitable groups.

She has published several articles and, in 1996, was co-author of "Overcoming Barriers to Physician Involvement in Identifying and Referring Victims of Domestic Violence," published in the *Annals of Emergency Medicine*.

Dr Kanof has served on the Board's Malpractice, Physician Assistant, Physicians Health Program, and Liaison Committees, and has been chair of its Complaints, Scope of Practice, and Alternative Medicine Committees.

Walter J. Pories, MD, Vice President



Dr Pories

Walter J. Pories, MD, of Greenville, took office as the Board's new vice president on November 1, replacing Dr Kanof in that post. A native of Germany, Dr Pories is professor of surgery and biochemistry at the

East Carolina University School of Medicine. He is also a clinical professor of surgery at the Uniformed Services University of Health Sciences. He received his BA at Wesleyan University, Middletown, Connecticut, and his MD with honors from the University of Rochester School of Medicine and Dentistry. His postgraduate study included an internship at Strong Memorial Hospital of the University of Rochester; a part-time fellowship at the Centre du Cancer of the Universite de Nancy, France; a graduate research fellowship in biochemistry at the University of Rochester; and a residency in general and thoracic surgery at Strong Memorial Hospital. He is certified by the American Board of Surgery and the American Board of Thoracic Surgery. He was appointed to the North Carolina Medical Board in 1997 and served as the Board's secretary-treasurer for the past year.

Frequently honored for his work as a surgeon and teacher, Dr Pories is a past governor of the American College of Surgeons and has served as president of the North Carolina Chapter of the American College of Surgeons, the North Carolina Surgical

Association, the Eastern Carolina Health Organization, Hospice of Greenville, and the Association of Program Directors in Surgery. Active on a large number of professional boards and committees, he is also the author/coauthor of 47 book chapters, 7 books, and over 250 medical articles dealing primarily with the metabolism of trace elements, diabetes, and surgical education. He has also been involved in the making of four educational films.

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

John T. Dees, MD, Secretary-Treasurer

John T. Dees, MD, of Cary, became the Board's secretary-treasurer on November 1,



Dr Dees

replacing Dr Pories in that position. A family physician, he practiced for many years in his native Burgaw, a rural area of the state. He received his undergraduate education at the University of North Carolina, Chapel Hill, and

his MD from Duke University School of Medicine. He did his internship at Durham's Watts Hospital and his residency at Duke Hospital. He is a charter diplomate of the American Board of Family Physicians.

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

While on the Board, Dr Dees has served, among other committees, on the Complaints Committee, the Physicians Health Program Committee, the

Investigative Committee, and the Clinical Pharmacist Practitioner Joint Subcommittee.

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

Aloysius P. Walsh, of Greensboro, and Robin N. Hunter-Buskey, PA-C, of Gastonia, Named to NCMB

Andrew W. Watry, executive director of the North Carolina Medical Board, has announced that Governor James B. Hunt, Jr, has reappointed Mr Aloysius P. Walsh, of Greensboro, as a public member of the North Carolina Medical Board. He has also named Robin N. Hunter-Buskey, PA-C, of Gastonia, to replace Wayne W. VonSeggen, PA-C, as the physician assistant member of the Board. Mr VonSeggen has completed his second three-year term on the Board.

Mr Walsh is a graduate of the University of Scranton and was a non-degree student at the Temple University School of Law. He pursued studies in business management at Mercer University and North Carolina State University. He is currently a consultant for the



Mr Walsh

Medical Management Institute. Mr Walsh and his wife moved to Greensboro in 1975 and are active members of their church and community.

For over 30 years, Mr Walsh worked in various capacities for the Prudential Insurance Company, focusing for much of that time on the Medicare program in several states, including New Jersey, Georgia, and North Carolina. During his time with Prudential Medicare, he was responsible for professional relations with the North Carolina Medical Society; and when Prudential left the Medicare program, he was commended by the Society for his efforts in developing effective interaction between the two organizations. He also worked closely with the North Carolina

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Society of Medical Assistants and holds an honorary membership in that group. From 1988 to 1990, he was Medicare consultant to EQUICOR (CIGNA).

In his current position, he conducts Medicare and related seminars nationwide for physicians and their staffs, covering topics such as coding, reimbursement, coverage, audits, appeals, hearings, and fraud and abuse.

Born in New York, Ms Hunter-Buskey took two BS degrees, one as a physical therapist and the other as a physician assistant, from the State University of New York at Stony Brook. She was certified in both fields. From 1981 to 1997, she worked in one or both of these capacities in several New York institutions, including the VA Medical Center, the Bronx, and Montefiore Hospital and



Ms Hunter-Buskey

Medical center, the Bronx. From 1989 to 1997, she was a member of the New York Board of Professional Medical Conduct. Since 1997, she has worked as a physician assistant at CaroMont Internal Medicine in Gastonia, North Carolina.

In 1994, she received the Outstanding Leadership Award from the New York Society of Physician Assistants, and in 1996, the Distinguished Alumnus Award from SUNY at Stony Brook School of Health Technology and Management. In the latter year, she was also given the Innovations in Health Care: Clinical Excellence Award from the American Academy of Physician Assistants and Pfizer Pharmaceuticals. In 1998, she received the "Women Who Dare to Be Different" Community Service Award from Congressman Edolphus Towns.

Ms Hunter-Buskey is a member of the American Academy of Physician Assistants, the North Carolina Academy of Physician Assistants, and the New York State Society of Physician Assistants. She has been deeply involved in the organizational and educational activities of each of these professional groups and is currently president of the Physician Assistant Foundation. She has also been a lecturer and clinical instructor in geriatrics at the Harlem Physician Assistant Program of the City University of New York, the SUNY Downstate-Brooklyn, the

SUNY at Stony Brook, and other institutions.

Mr Watry said, "The Board is pleased to have members as distinguished as Mr Walsh and Ms Hunter-Buskey. They bring out-

standing experience and background to the Board. They exemplify the continuing support we get from the Governor's Office in making excellent appointments to the medical board." ♦



LETTER TO THE EDITOR



Scope of Practice Issues: Optometry and Ophthalmology

To the Editor: As an ophthalmologist and past president of the North Carolina Society of Eye Physicians and Surgeons (NCSEPS), I would like to comment on some of the statements made by Mr VonSeggen in his recent President's Message in the Forum (No. 3, 2000). His message centered on the role of the North Carolina Medical Board in regulating the practice of medicine and surgery in North Carolina. Specifically, he described recent "differences of opinion about ophthalmology and optometry scopes of practice, primarily regarding whether an injection should or should not be considered surgery."

The events precipitating his comments were generated by the Medical Board's favorable consideration of a request from the North Carolina Optometry Board to perform procedures described by specific CPT codes, including: 11900 intralesional injection; 68200 subconjunctival injection; 92330 fluorescein angiography with interpretation; 9235 fluorescein angiography with interpretation; and 92240 ICG angiography with interpretation. Three of these procedures had already been determined to be outside the scope of optometric practice through a 1994 litigation Settlement Agreement. The NCSEPS and the North Carolina Medical Society raised concerns about the Medical Board's decision to reopen this issue. As Mr VonSeggen correctly states, the scope of practice is controlled by statute and the scope of practice statutes have not changed since 1994. When there is a question regarding interpretation of a law, the judicial process is available to resolve the question if necessary. On the other hand, the Medical Board is aware, as are we all, that some injections are routinely performed by non-physicians in complete safety.

Based on the law, current knowledge of optometric education, the risk/benefit ratios to patients, and optometric testimony presented to the Medical Board, organized oph-

thalmology, as well as the Medical Society, felt the procedures in question were the practice of medicine and surgery and did not fall within the optometric scope of practice. Despite our efforts to urge the Medical Board to use its subjective expertise in determining whether a procedure involves medical judgment requiring the training and clinical experience of a medical license, Mr VonSeggen requested ophthalmology and optometry to confine our arguments to the Medical Board to the technical and mechanical legal question of whether these, or any, injections are included within the statutory definition of surgery. This request implied that injections can never be considered surgery because they involve a "puncture," a term that is not specifically included in the definition of surgery as adopted by the Medical Board in November 1998.

Mr VonSeggen writes that the Medical Board "heard ophthalmologists state that there was no possible way that an injection in any form by an optometrist could be considered within the scope of practice of optometry. . . ." I would like to voice my objection to this statement by quoting modified excerpts of my letter to the Medical Board on this issue.

Injections are procedures in which a needle perforates (or punctures) tissue. As indicated by Mr VonSeggen, the Board's definition of surgery does not include the words "injection" or "puncture" and therefore this procedure can never be considered to be surgical in nature. If this concept is accepted at face value, without any further consideration of the intent of the puncture or the type of tissue involved, then the Board is on a slippery slope indeed. This leaves the Board with no ability to "interpret" which, if any, types of procedures that involve puncture of tissue

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comprise not only surgery, but also the practice of medicine.

Understandably, some injection procedures entail a low enough risk/benefit ratio that non-medical health care providers, even laypeople, can use them (eg, subcutaneous insulin injections, injections for anaphylaxis, etc). Does this mean that all injection procedures must be classified as non-surgical? What about a needle puncture of a tumor located on any part of the body for biopsy, including the eye? What about lumbar punctures? Pericardial taps (punctures)? What about intraocular injections?

The use of needles to puncture a body part simply cannot fit a single, hard fast definition that confines it to *always* being a form of surgery or never being a form of surgery. The Board must consider the intent of the needle, the tissue being punctured, the training necessary to competently perform the procedure, and the level of risk to either body part or life should the "puncture" or "injection" result in complications.

Finally, I must disagree with Mr VonSeggen's comments regarding the Settlement Agreement in which he questions "whether such an agreement is the right vehicle for the determination of the scope of practice, or whether it is time for the General Assembly to clarify its intent concerning the scope of practice of optometry." First, the litigation that generated the Settlement Agreement stemmed from a unilateral declaration by the Optometry Board stating that optometrists could perform, without physician supervision, all the procedures described in 150 new CPT codes. As a result of the litigation, 50 of these CPT codes were ruled to be the practice of medicine or surgery. The Medical Board was a necessary party to this litigation, being the guardian of the Medical Practice Act. The Settlement Agreement envisioned a process that would bring the boards and the disciplines, through their professional societies, together in an orderly fashion, to determine what the law does allow, in hopes of preventing future unilateral declarations or legislative battles. When used properly, the Settlement Agreement, or a similar collaborative process, provides for thoughtful, non-political discussion of scope of practice issues, specifically for optometry. Theoretically, it should be immune to the maneuverings of politics or legislative pres-

ures, and any modification should be based solely on serving the best interests of patients through dispassionate review of the law, including the interface of optometry and medicine where an invasive act is not classic surgery, yet requires complex medical judgments and techniques. I fail to see how our patients are better served by throwing such complex medical decisions into the legislative arena where politics, lobbying, and backroom deals can place public safety in the backseat. I would personally prefer that members of the Medical Board continue to courageously observe their charge under *North Carolina General Statute 90-2(a)* to "regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina."

Cynthia A. Hampton, MD
Henderson, NC

Response:

It is true that the North Carolina Medical Board is central to decisions relating to medical scope of practice questions. I like your description of the Board as "guardian of the Medical Practice Act."

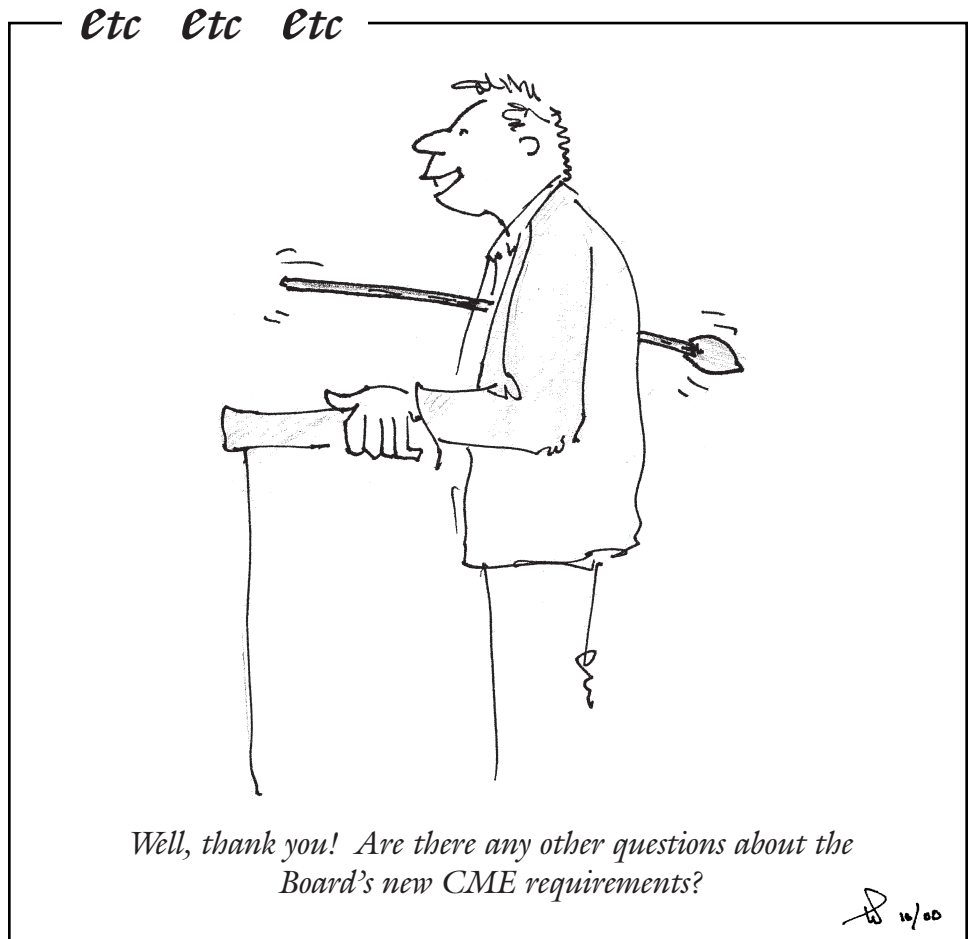
We've heard considerable open discourse with formal presentations to the Board by both optom-

etry and ophthalmology. Only during a particular session when the Board had other responsibilities waiting did I request, as President of the Board, that all parties limit their discussion at that meeting to the core of the issue. There has never been any "implied outcome" regarding injections being or not being surgery.

I look forward to hearing how this issue may be further resolved by the contributions of the Collaborative Committee of the North Carolina Medical Board, the North Carolina Board of Optometry, optometrists, and ophthalmologists. The members will be: Dr John Foust and Dr Elizabeth Kanof of the NCMB, Dr David Baxter and Dr Scott Edwards of the NCBOE, Dr Mike Clark and Dr William Rafferty representing optometry, and Dr W. Banks Anderson and Dr Cynthia Hampton representing ophthalmology.

The recommendations from this select committee will be presented to the Medical Board for additional consideration and its work product will reflect, I hope, the honest communication efforts of its members to form a year 2001 "NC Eye Team-Building Proposal." We need "the right words," sometime soon!

Wayne W. VonSeggen, PA-C
Immediate Past President, NCMB ♦



Position Statements of the North Carolina Medical Board

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

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

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

1. In its Position Statements, the Board attempts to articulate some of the standards it believes applicable to the medical profession and to the other health care professions it regulates. However, a Position Statement should not be seen as the promulgation of a new standard as of the date of issuance or amendment. Some Position Statements are reminders of traditional, even millennia old, professional standards, or show how the Board might apply such standards today.
2. The Position Statements are not intended to be comprehensive or to set out exhaustively every standard that might apply in every circumstance. Therefore, the absence of a Position Statement or a Position Statement's silence on certain matters should not be construed as the lack of an enforceable standard.
3. The existence of a Position Statement should not necessarily be taken as an indication of the Board's enforcement priorities.
4. A lack of disciplinary actions to enforce a particular standard mentioned in

a Position Statement should not be taken as an abandonment of the principles set forth therein.

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

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

[Adopted November 1999]

THE PHYSICIAN-PATIENT RELATIONSHIP

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

Elements of the Physician-Patient Relationship

The North Carolina Medical Board licenses physicians as a part of regulating the practice of medicine in this state. Receiving a license to practice medicine grants the physician privileges and imposes great responsibilities. The people of North Carolina expect a licensed physician to be competent and worthy of their trust. As patients, they come to the physician in a vulnerable condition, believing the physician has knowledge and skill that will be used for their benefit.

Patient trust is fundamental to the relationship thus established. It requires that

- there be adequate communication between the physician and the patient;
- there be no conflict of interest between the patient and the physician or third parties;
- intimate details of the patient's life shared with the physician be held in confidence;
- the physician maintain professional knowledge and skills;
- there be respect for the patient's autonomy;
- the physician be compassionate;
- the physician be an advocate for needed medical care, even at the expense of the physician's personal interests; and
- the physician provide neither more nor less than the medical problem requires.

The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on patient trust, is considered sacred, and when the elements crucial to that relationship and to that trust — communication, patient primacy, confidentiality, compe-

tence, patient autonomy, compassion, selflessness, appropriate care — are foremost in the hearts, minds, and actions of the physicians licensed by the Board.

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

Termination of the Physician-Patient Relationship

The Board recognizes the physician's right to choose patients and to terminate the professional relationship with them when he or she believes it is best to do so. That being understood, the Board maintains that termination of the physician-patient relationship must be done in compliance with the physician's obligation to support continuity of care for the patient. The decision to terminate the relationship must be made by the physician personally. Further, termination must be accompanied by appropriate written notice given by the physician to the patient, the relatives, or the legally responsible parties sufficiently far in advance (at least 30 days) to allow other medical care to be secured. Should the physician be a member of a group, the notice of termination must state clearly whether the termination involves only the individual physician or includes other members of the group. In the latter case, those members of the group joining in the termination must be designated.

(Adopted July 1995)

(Amended July 1998, January 2000)

DOCUMENTATION OF THE PHYSICIAN-PATIENT RELATIONSHIP*

It is the position of the North Carolina Medical Board that when a physician-patient relationship is established, it should be documented by medical records, which should contain, at a minimum, the following:

1. an appropriate history and physical and/or mental examination for the patient's chief complaint relevant to the physician's specialty;
2. results of diagnostic tests (when indicated);
3. a working diagnosis;
4. notes on treatment(s) undertaken;
5. a record by date of all prescriptions for drugs, with names of medications, strengths, dosages, quantity, and number of refills; and
6. a record of billings.

*See also position statement on Medical Record Documentation.

(Adopted May 1991)

(Amended May 1996)

MEDICAL RECORD DOCUMENTATION

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

- the purpose of the patient encounter;
- the assessment of patient condition;
- the services delivered — in full detail;
- the rationale for the requirement of any support services;
- the results of therapies or treatments;
- the plan for continued care;
- whether or not informed consent was obtained; and, finally,
- that the delivered services were appropriate for the condition of the patient.

- The record should be legible. When the care giver will not write legibly, notes should be dictated, transcribed, reviewed, and signed within reasonable time. Signature, date, and time should also be legible. All therapies should be documented as to indications, method of delivery, and response of the patient. Special instructions given to other care givers or the patient should be documented: Who received the instructions and did they appear to understand them?
- All drug therapies should be named, with dosage instructions and indication of refill limits. All medications a patient receives from all sources should be inventoried and listed to include the method by which the patient understands they are to be taken. Any refill prescription by phone should be recorded in full detail.
- The physician needs and the patient deserves clear and complete documentation.

(Adopted May 1994)

(Amended May 1996)

ACCESS TO PHYSICIAN RECORDS

■ A physician's policies and practices relating to medical records should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient's care when such a transfer is requested by the patient or anyone authorized by law to act on the patient's behalf.

It is the position of the North Carolina Medical Board that notes made by a physician in the course of diagnosing and treating patients are primarily for the physician's use and are therefore the property of that physician. Moreover, the resulting record is a confidential document and should only be released with proper written consent of the patient. Each physician has a duty on the request of a patient to release a copy or a summary of the record in a timely manner to the patient or anyone the patient designates. If a summary is provided, it should include all the information and data necessary to allow continuity of care by another physician.

The physician may charge a reasonable fee for the preparation and/or the photocopying of the materials. To assist in avoiding misunderstandings, and for a reasonable fee, the physician should be willing to review the materials with the patient at the patient's request. Materials should not be held because an account is overdue or a bill is owed.

Should it be the physician's policy not to include in either the copied or the summarized record those materials that were provided by other physicians regarding the patient's former or current care, he or she should advise the patient of that fact and of ways those materials might be obtained.

■ Should it be the physician's policy to complete insurance or other forms for established patients, it is the position of the Board that the physician should complete those forms in a timely manner. If a form is simple, the physician should perform this task for no fee. If a form is complex, the physician may charge a reasonable fee.

■ To prevent misunderstandings, the physician's policies about providing copies or summaries of patient records and about completing forms should be made available in writing to patients when the physician-patient relationship begins.

(Adopted November 1993)

(Amended May 1996, September 1997)

RETENTION OF MEDICAL RECORDS

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

7.05: Retention of Medical Records

Physicians have an obligation to retain patient records which may reason-

ably be of value to a patient. The following guidelines are offered to assist physicians in meeting their ethical and legal obligations:

- (1) Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.
- (2) If a particular record no longer needs to be kept for medical reasons, the physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.
- (3) In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information.
- (4) Whatever the statute of limitations, a physician should measure time from the last professional contact with the patient.
- (5) If a patient is a minor, the statute of limitations for medical malpractice claims may not apply until the patient reaches the age of majority.
- (6) Immunization records always must be kept.
- (7) The records of any patient covered by Medicare or Medicaid must be kept at least five years.
- (8) In order to preserve confidentiality when discarding old records, all documents should be destroyed.
- (9) Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.

.....
Please Note:

- a. North Carolina has no statute relating specifically to the retention of medical records.
- b. Several North Carolina statutes relate to time limitations for the filing of malpractice actions. Legal advice should be sought regarding such limitations.

(Adopted May 1998)

DEPARTURES FROM OR CLOSINGS OF MEDICAL PRACTICES

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

Permit Patient Choice

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

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

Provide Continuity of Care

Practitioners continue to have obligations toward patients during and after the departure from or closing of a medical practice. Except in case of the death or other incapacity of the practitioner, practitioners may not abandon a patient or abruptly withdraw from the care of a patient. Therefore, patients should be given reasonable advance notice to allow their securing other care. Good continuity of care includes preserving, keeping confidential, and providing appropriate access to medical records.* Also, good con-

tinuity of care may often include making appropriate referrals. The practitioner(s) and other parties that may be involved should ensure the requirements for continuity of care are effectively addressed.

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

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

(Adopted January 2000)

THE RETIRED PHYSICIAN

□ The retirement of a physician is defined by the North Carolina Medical Board as the total and complete cessation of the practice of medicine and/or surgery by the physician in any form or setting. According to the Board's definition, the retired physician is not required to maintain a currently registered license and SHALL NOT:

- provide patient services;
- order tests or therapies;
- prescribe, dispense, or administer drugs;
- perform any other medical and/or surgical acts; or
- receive income from the provision of medical and/or surgical services performed following retirement.

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

- practice within their areas of professional competence;
- prepare and keep medical records in accord with good professional practice; and
- maintain their competence through an active continuing medical education effort.

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

(Adopted January 1997)

ADVANCE DIRECTIVES AND PATIENT AUTONOMY

Advances in medical technology have given physicians the ability to prolong the mechanics of life almost indefinitely. Because of this, physicians must be aware that North Carolina law specifically recognizes the individual's right to a peaceful and natural death. NC Gen Stat §90-320 (a) (1993) reads:

The General Assembly recognizes as a matter of public policy that an individual's rights include the right to a peaceful and natural death and that a patient or his representative has the fundamental right to control the decisions relating to the rendering of his own medical care, including the decision to have extraordinary means withheld or withdrawn in instances of a terminal condition.

They must also be aware that North Carolina law empowers any adult individual with understanding and capacity to make a Health Care Power of Attorney [NC Gen Stat §32A-17 (1995)] and stipulates that, when a patient lacks understanding or capacity to make or communicate health care decisions, the instructions of a duly appointed health care agent are to be taken as those of the patient unless evidence to the contrary is available [NC Gen Stat §32A-24(b)(1995)].

□ It is the position of the North Carolina Medical Board that it is in the best interest of the patient and of the physician-patient relationship to encourage patients to complete documents that express their wishes for the kind of care they desire at the end of their lives. Physicians should encourage their patients to appoint a health care agent to act with the Health Care Power of Attorney and to provide documentation of the appointment to the responsible physician(s). Further, physicians should provide full information to their patients in order to enable those patients to make informed and intelligent decisions prior to a terminal illness.

□ It is also the position of the Board that physicians are ethically obligated to follow the wishes of the terminally ill or incurable patient as expressed by and properly documented in a declaration of a desire for a natural death.

□ It is also the position of the Board that when the wishes of a patient are contrary to what a physician believes in good conscience to be appropriate care, the physician may withdraw from the case once continuity of care is assured.

□ It is also the position of the Board that withdrawal of life prolonging technologies is in no manner to be construed as permitting diminution of nursing care, relief of pain, or any other care that may provide comfort for the patient.

(Adopted July 1993)
(Amended May 1996)

AVAILABILITY OF PHYSICIANS AFTER HOURS

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

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

(Adopted July 1993)
(Amended May 1996)

GUIDELINES FOR AVOIDING MISUNDERSTANDINGS DURING PHYSICAL EXAMINATIONS

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

1. Sensitivity to patient dignity should be considered by the physician when undertaking a physical examination. The patient should be assured of adequate auditory and visual privacy and should never be asked to disrobe in the presence of the physician. Examining rooms should be safe, clean, and well maintained, and should be equipped with appropriate furniture for examination and treatment. Gowns, sheets and/or other appropriate apparel should be made available to protect patient dignity and decrease embarrassment to the patient while a thorough and professional examination is conducted.
2. Whatever the sex of the patient, a third party should be readily available at all times during a physical examination, and it is advisable that a third party be present when the physician performs an examination of the breast(s), genitalia, or rectum. When appropriate or when requested by the patient, the physician should have a third party present throughout the examination or at any given point during the examination.
3. The physician should individualize the approach to physical examinations so that each patient's apprehension, fear, and embarrassment are diminished as much as possible. An explanation of the necessity of a complete physical examination, the components of that examination, and the purpose of disrobing may be necessary in order to minimize the patient's possible misunderstanding.

4. The physician and staff should exercise the same degree of professionalism and care when performing diagnostic procedures (eg, electro-cardiograms, electromyograms, endoscopic procedures, and radiological studies, etc), as well as during surgical procedures and postsurgical follow-up examinations when the patient is in varying stages of consciousness.
5. The physician should be on the alert for suggestive or flirtatious behavior or mannerisms on the part of the patient and should not permit a compromising situation to develop.

(Adopted May 1991)
(Amended May 1993, May 1996)

SEXUAL EXPLOITATION OF PATIENTS

□ It is the position of the North Carolina Medical Board that entering into a sexual relationship with a patient, consensual or otherwise, is unprofessional conduct and is grounds for the suspension or revocation of a physician's license. Such conduct is not tolerated.

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

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

(Adopted May 1991)
(Amended April 1996)

CONTACT WITH PATIENTS BEFORE PRESCRIBING

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

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

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

[Adopted November 1999]

WRITING OF PRESCRIPTIONS

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

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

□ No prescriptions, including those for controlled substances or mind-altering chemicals, should be issued for a patient in the absence of a documented physician-patient relationship.

- No prescription for controlled substances or mind-altering chemicals should be issued by a practitioner for his or her personal use.
- The practice of pre-signing prescriptions is unacceptable to the Board.

(Adopted May 1991, September 1992)
(Amended May 1996)

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 color judgment, will compromise the objectivity of the physician and make the delivery of sound medical care problematic in such situations, while real patient autonomy and informed consent may be sacrificed.
- When a minor illness or emergency requires self-treatment or treatment of a family member or other person with whom the physician has a significant emotional relationship, the physician must prepare and keep a proper written record of that treatment, including but not limited to prescriptions written for controlled substances and the medical indications for them. Record keeping is too frequently neglected when physicians manage such cases.
- The Board expects physicians to delegate the medical and surgical care of themselves, their families, and those with whom they have significant emotional relationships to one or more of their colleagues in order to ensure appropriate and objective care is provided and to avoid misunderstandings related to their prescribing practices.

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

(Adopted May 1991)
(Amended May 1996; May 2000)

THE USE OF ANORECTICS IN TREATMENT OF OBESITY

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

(Adopted October 1987)
(Amended March 1996)

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

General

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

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

The Board is not opposed to the use of innovative, creative therapeutics; however, treatments not having a scientifically valid basis for use should be

studied under investigational protocols so as to assist in the establishment of evidence-based, scientific validity for such treatments.

Substances/Preparations with Anabolic Properties

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

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

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

(Adopted May 1998)
(Amended July 1998)

MANAGEMENT OF CHRONIC NON-MALIGNANT PAIN

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

There are three general categories of pain.

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

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

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

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

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

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

- thorough documentation of all aspects of the patient's assessment and care;
- a thorough history and physical examination, including a drug and pain history;
- appropriate studies;
- a working diagnosis and treatment plan;
- a rationale for the treatment selected;

- education of the patient;
 - clear understanding by the patient and physician of methods and goals of treatment;
 - a specific follow-up protocol, which must be adhered to;
 - regular assessment of treatment efficacy;
 - consultation with specialists in pain medicine, when warranted; and
 - use of a multidisciplinary approach, when indicated.
- The Board expects physicians using controlled substances in the management of chronic pain to be familiar with conditions such as:
- physical dependence;
 - respiratory depression and other side effects;
 - tolerance;
 - addiction; and
 - pseudo addiction.

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

- No physician need fear reprisals from the Board for appropriately prescribing, as described above, even large amounts of controlled substances indefinitely for chronic non-malignant pain.
- Nothing in this statement should be construed as advocating the imprudent use of controlled substances.

(Adopted September 1996)

END-OF-LIFE RESPONSIBILITIES AND PALLIATIVE CARE

Assuring Patients

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

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

Palliative Care

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

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

Opioid Use

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

Selected Guides

To assist physicians in meeting these responsibilities, the Board recommends *Cancer Pain Relief: With a Guide to Opioid Availability*, 2nd ed (1996), *Cancer Pain Relief and Palliative Care* (1990), *Cancer Pain Relief and Palliative*

Care in Children (1999), and *Symptom Relief in Terminal Illness* (1998), (World Health Organization, Geneva); *Management of Cancer Pain* (1994), (Agency for Health Care Policy and Research, Rockville, MD); *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain*, 4th Edition (1999)(American Pain Society, Glenview, IL); *Hospice Care: A Physician's Guide* (1998) (Hospice for the Carolinas, Raleigh); and the *Oxford Textbook of Palliative Medicine* (1993) (Oxford Medical, Oxford).

*Steven A. Schroeder, MD, President, Robert Wood Johnson Foundation.

(Adopted October 1999)

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

□ Through dialogue with members of the healthcare community and consumers, a number of perceived regulatory barriers to adequate pain management in end-of-life care have been expressed to the Boards of Medicine, Nursing, and Pharmacy. The following statement attempts to address these misperceptions by outlining practice expectations for physicians and other health care professionals authorized to prescribe medications, as well as nurses and pharmacists involved in this aspect of end-of-life care. The statement is based on:

- the legal scope of practice for each of these licensed health professionals;
- professional collaboration and communication among health professionals providing palliative care; and
- a standard of care that assures on-going pain assessment, a therapeutic plan for pain management interventions; and evidence of adequate symptom management for the dying patient.

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

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

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

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

The nurse is often the health professional most involved in on-going pain assessment, implementing the prescribed pain management plan, evaluating the patient's response to such interventions and adjusting medication levels based on patient status. In order to achieve adequate pain management, the

prescription must provide dosage ranges and frequency parameters within which the nurse may adjust (titrate) medication in order to achieve adequate pain control. Consistent with the licensee's scope of practice, the RN or LPN is accountable for implementing the pain management plan utilizing his/her knowledge base and documented assessment of the patient's needs. *The nurse has the authority to adjust medication levels within the dosage and frequency ranges stipulated by the prescriber and according to the agency's established protocols.* However, the nurse does not have the authority to change the medical pain management plan. When adequate pain management is not achieved under the currently prescribed treatment plan, the nurse is responsible for reporting such findings to the prescriber and documenting this communication. Only the physician or other health professional with authority to prescribe may change the medical pain management plan.

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

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

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

(October 1999)

OFFICE-BASED SURGERY

Office-based surgery is surgery* performed outside a hospital or an outpatient facility accredited by the North Carolina Division of Facility Services. Although surgery is not a perfect science in any setting, office-based surgery is generally safe, effective, and efficient, provided proper measures are taken in the process. It is the position of the North Carolina Medical Board that the physician is responsible for providing a safe environment for office-based surgery.

The following general guidelines are recommended for office-based surgery.

- **Training:**
Any procedures, whether done in an office or a hospital, should be performed by physicians operating within their area of professional training. Appropriate training and continuing medical education should be documented and that documentation should be readily available to patients and the North Carolina Medical Board. Those who perform office-based surgery must have plans, such as prearranged hospital admission protocols, for managing emergency complications.
- **Patient Selection:**
Patients must be evaluated per procedure to determine if the office is an appropriate setting for the surgery.
- **Patient Evaluation:**
Patients undergoing office surgery must have an appropriately documented history and physical examination, and any other studies or consultations indicated.
- **Anesthesia:**
When general anesthesia or sedation is provided in the office setting, it must be administered by those qualified to do so. Anesthesia personnel should be familiar with variations in technique based on the specifics of the patient and the procedure, particularly those requiring large volumes of fluids or airway management. Patients must be properly monitored before, during, and after the procedure. Physicians are referred to the protocols of the American Society of Anesthesiologists** for guidance. ACLS certification of anesthesia personnel is an important consideration.

- **Office Setting:**
The office should be set up with patient safety as a primary consideration. Safety issues should include, but not be limited to, accessibility, sterilization and cleaning routines, storage of materials and supplies, supply inventory, and emergency equipment.
- **Emergency Planning:**
Planning should include, but not be limited to, emergency medicines, emergency equipment, and transfer protocols. Practitioners should be trained and capable of managing complications related to the procedures they perform.
- **Follow-Up Care:**
As with any surgical treatment or procedure, follow-up care by the responsible surgeon is requisite. Arrangements should be made for follow-up care and for treatment of problems or complications outside normal office hours.
- **Quality Improvement:**
Continuous quality improvement should be a goal.

*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 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."

**"Guidelines for Office-Based Anesthesia," "Guidelines for Ambulatory Anesthesia and Surgery," "Basic Standards for Preanesthesia Care," "Standards in Basic Anesthetic Monitoring," "Standards for Postanesthesia Care," "Guidelines for Nonoperating Room Anesthetizing Locations." All available from the American Society of Anesthesiologists

[Adopted September 2000]

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 practitioner 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.

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 a licensed practitioner with appropriate medical training functioning under the supervision, preferably on-site, of a physician who bears responsibility for those 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 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)

OPHTHALMOLOGISTS: CARE OF CATARACT PATIENTS

- The evaluation, diagnosis, and care of cataract surgical patients is primarily the responsibility of the operating surgeon. The operating surgeon may not delegate to optometrists, nurses, or anesthesiologists the responsibility of performing an adequate preoperative examination. The surgeon must thoroughly examine each patient on whom he performs surgery prior to time for that surgery. This thorough examination shall include a review of the patient's his-

tory and an independent diagnosis by the operating surgeon of cataracts requiring surgery. The operating surgeon shall have a detailed discussion with each patient regarding the diagnosis and the nature of the cataract surgery, advising the patient fully of the risks involved. All surgical decisions must be made by the operating surgeon.

■ Following surgery, the operating surgeon must perform the 24 hour postoperative examination on every patient on whom he performs surgery, including clear documentation of such examination in the patient record. In the case of an emergency, the operating surgeon shall ensure that another ophthalmologist performs the 24 hour postoperative examination. Following the 24 hour postoperative examination, the operating surgeon shall provide postoperative care for each patient on whom he performs surgery until the healing process is complete.

■ It is not improper to involve non-physicians in postoperative care so long as the operating surgeon maintains responsibility for the patient's postoperative care and examines the patient in the period following surgery to assess the healing process and the long-term results.

■ Even in the case of repetitive surgical procedures, a record should be kept including detailed surgical notes describing each patient, his or her condition, the procedures, methods, prostheses, results, prognosis, medication relative to the surgery, and significant variations in each surgical procedure.

■ The act of severing a suture following ophthalmologic surgery is a medical act that can only be performed by the operating surgeon or by those health care providers to whom this act may be legally delegated.

■ It is improper to permit non-physicians to prescribe medication except as provided by statute. In instances where the surgeon communicates and collaborates with an optometrist prescribing other than topical pharmaceutical agents not used for the purpose of examining the eye, that communication and collaboration must be contemporaneous with the issuance of any prescription and specific for each patient.

(Adopted September 1991)

HIV/HBV INFECTED HEALTH CARE WORKERS

The North Carolina Medical Board supports and adopts the North Carolina Department of Environment, Health and Natural Resources Division of Epidemiology's rule for HIV and HBV Infected Health Care Workers (T15A:19A.0207), and its rule for Infection Control in Health Care Settings (T15A:19A.0206). It is the Board's position that all licensees should be familiar with the current requirements of those rules.

(Adopted November 1992)
(Amended May 1996)

PROFESSIONAL OBLIGATION TO REPORT INCOMPETENCE, IMPAIRMENT, AND UNETHICAL CONDUCT

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

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

This duty is subordinate to the duty to maintain patient confidences. In other words, when the colleague is a patient or when matters concerning a colleague are brought to the physician's attention by a patient, the physician must

give appropriate consideration to preserving the patient's confidences in deciding whether to report the colleague.

(Adopted November 1998)

ADVERTISING AND PUBLICITY

It is the position of the North Carolina Medical Board that physician advertising or publicity that is deceptive, false, or misleading is unprofessional conduct. If patient photographs are used, they should be of the physician's own patients and demonstrate realistic outcomes. The key issue is whether advertising and publicity, regardless of format or content, are true and not materially misleading.

Information conveyed may include:

- a) the educational background of the physician;
- b) the basis on which fees are determined, including charges for specific services;
- c) methods of payment;
- d) any other non-deceptive information.

Advertising and publicity that create unjustified medical expectations, that are accompanied by deceptive claims, or that imply exclusive or unique skills or remedies must be avoided. Similarly, a statement that a physician has cured or successfully treated a large number of patients suffering a particular ailment is deceptive if it implies a certainty of results and/or creates unjustified or misleading expectations.

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

(Adopted November 1999)

FEE SPLITTING

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

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

(Adopted November 1993)
(Amended May 1996)

UNETHICAL AGREEMENTS IN COMPLAINT SETTLEMENTS

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

(Adopted November 1993)
(Amended May 1996)

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

August-September-October 2000

DEFINITIONS

Annulment:

Retrospective and prospective cancellation of the authorization to practice.

Conditions:

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

Consent Order:

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

Denial:

Final decision denying an application for practice

authorization or a motion/request for reconsideration/modification of a previous Board action.

NA:

Information not available.

NCPHP:

North Carolina Physicians Health Program.

RTL:

Resident Training License.

Revocation:

Cancellation of the authorization to practice.

Summary Suspension:

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

Suspension:

Temporary withdrawal of the authorization to practice.

Temporary/Dated License:

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

Voluntary Dismissal:

Board action dismissing a contested case.

Voluntary Surrender:

The practitioner's relinquishing of the authorization to practice pending an investigation or in lieu of disciplinary action.

ANNULMENTS

NONE

REVOCATIONS

FONDREN, Frank Burkett, III, MD

Location: Mobile, AL

DOB: 5/28/1945

License #: 0000-21034

Specialty: OSM (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1974)

Cause: Dr Fondren has been convicted of a felony in the U.S. District Court for the Southern District of Alabama. The Board informed him on June 27, 2000, that unless he requested a hearing on the matter within 60 days, his license would be automatically revoked.

Action: 10/09/2000. Entry of Revocation issued: The Board having received no request for a hearing on this matter, Dr Fondren's license was revoked by operation of law on September 5, 2000.

TEBRUGGE, Kevin Ray, DO

Location: North Wilkesboro, NC (Wilkes Co)

DOB: 10/22/1962

License #: 0096-01773

Specialty: FP (as reported by physician)

Medical Ed: University of Health Sciences, College of Osteopathy (1990)

Cause: A hearing was held on September 21, 2000, on the Notice of Charges and Allegations of 1/05/2000. Dr Tebrugge was found to have engaged in various boundary violations with a patient, including waiving his fees, permitting her to stay at his apartment rent-free, kissing, fondling, and having sex with her while she was his patient. He was also found to have prescribed controlled substances to four patients for the purpose of maintenance and/or detoxification treatment when he did not have a separate DEA registration for doing so.

Action: 10/03/2000. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Tebrugge's medical license will be revoked as of midnight, Tuesday, 10/31/2000; he shall wind down his practice so that continuity of patient care is maintained.

Appeal: 10/24/2000. Notice of Appeal to the Superior Court of Wake County filed 10/23/2000. On 10/24/2000, the Superior Court stayed enforcement of the Board's Order of Discipline pending the appeal.

SUSPENSIONS

FINCHER, Ronald Edwin, MD

Location: Atlanta, GA

DOB: 7/17/1933

License #: 0096-01118

Specialty: OBG (as reported by physician)

Medical Ed: Emory University (1965)

Cause: Hearing held July 20 on the Notice of Charges and Allegations dated March 15, 2000. The Virginia Board of Medicine reprimanded Dr Fincher for drinking wine at a wine festival while on call to a hospital and because, after arrival at the hospital, to which he was called to deliver a baby, he submitted to a blood alcohol test that revealed a blood alcohol level of .098. By his own admission, he had drunk about 180 milliliters of wine while on call.

Action: 9/22/2000. Findings of Fact, Conclusions of Law, and Order issued: Dr Fincher's North Carolina medical license is suspended indefinitely, effective 9/22/2000.

SUMMARY SUSPENSIONS

BRINTON, Lewis Floyd, MD

Location: Mooresville, NC (Iredell Co)

DOB: 11/27/1925

License #: 0000-13752

Specialty: GP/NTR (as reported by physician)

Medical Ed: New York Medical College (1958)

Cause: Dr Brinton may have committed acts of immoral or dishonorable conduct.

Action: 8/16/2000. Order of Summary Suspension of License issued, effective 8/17/2000. [Notice of Charges and Allegations issued on 8/16/2000 alleging sexual advances to a patient.]

LITTLE, Douglas Johnathan, MD

Location: Sanford, NC (Lee Co)

DOB: 4/22/1945

License #: 0000-17390

Specialty: IM/C (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1971)

Cause: Dr Little may be unable to practice medicine with reasonable skill and safety by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of a physical or mental abnormality.

Action: 10/03/2000. Order of Summary Suspension of License issued: Dr Little's North Carolina medical license is summarily suspended effective 10/11/2000. [A formal Notice of Charges and Allegations against Dr Little was filed by the Board on 10/03/2000 and is available on request.]

CONSENT ORDERS

BJORK, Paul Edward, Jr, MD

Location: Pinehurst, NC (Moore Co)

DOB: 3/06/1954

License #: 0000-36146

Specialty: OBG (as reported by physician)

Medical Ed: University of South Carolina (1983)

Cause: Regarding the application for reinstatement of Dr Bjork's license. Dr Bjork has a long history of polydrug dependency and alcohol abuse; in July 1999, he suffered a relapse and used opiates and alcohol; as a result of his relapse, he surrendered his license in September 1999; from September 1999 through February 2000, he sought and obtained continuing in-patient

treatment for his substance and alcohol abuse. Dr Bjork is a participant in the NCPHP and has a contract in which he commits not to drink alcohol or consume controlled substances except as prescribed by his physician and to follow the NCPHP treatment plan; he reports he has been sober since September 1999; he appears to be involved in an active recovery program with AA, NA, and Caduceus.

Action: 10/11/2000. Consent Order executed: Dr Bjork is issued a license to practice to expire on the date shown on the license [3/31/2001]; he shall work as a physician no more than 40 hours a week unless approved by the Board's president; he shall obtain psychotherapy and have his psychotherapist send quarterly reports to the Board about his progress; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use or possession of all mind or mood altering substances and all controlled substances, and he shall refrain from the use or possession of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall provide a copy of his Consent Order to his colleagues with whom he works or shares call and to all present and future employers for whom he practices medicine; he shall regularly attend AA, NA, and Caduceus meetings; must comply with other conditions.

CHUMAK, Bogdan Alberto, MD

Location: Hewitt, TX
DOB: 12/29/1950
License #: 0000-29540
Specialty: EM/FP (as reported by physician)
Medical Ed: Universidad Autonoma Guadalajara (1980)
Cause: On May 12, 1993, in the U.S. District Court for Colorado, Dr Chumak pled guilty and was convicted of a felony for aiding and abetting the use of a false document; in August 1998, he was involuntarily separated from the U.S. Army Reserve with an honorable discharge and the Army is now considering an appeal by Dr Chumak for reinstatement with his former rank of lieutenant colonel; he is now licensed to practice in six states; in August 1999, Virginia suspended his license due to his felony conviction; in October 1999, Virginia reinstated his license; in January 2000, the California Board reprimanded him due to the felony conviction. Dr Chumak has shown his actions in the matter did not involve a danger to his patients; the North Carolina Board has reviewed the records of the U.S. Court and the Virginia and California actions and has noted no action has been taken by Georgia, Texas, or Washington, other states in which Dr Chumak is licensed.

Action: 9/21/2000. Consent Order executed: Dr Chumak is reprimanded; must comply with other conditions.

CROMER, William Browning, MD

Location: Kinston, NC (Lenoir Co)
DOB: 11/16/1931
License #: 0000-10448
Specialty: GP/OS (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1956)
Cause: Application for reissuance of license. In the fall of 1999, Dr Cromer relapsed in his recovery from substance abuse, taking aspirin with codeine, diazepam, and meperidine HCl prescribed to him, at his request, by a colleague; he surrendered his license 4/17/2000. Dr Cromer has completed a 28 day inpatient program and a several-week-long aftercare program; he has a contract with the NCPHP and NCPHP drug screens of him have been negative; he reports six months of sobriety.

Action: 10/27/2000. Consent Order executed: the Board shall issue Dr Cromer a license to expire on the date shown on the license [5/03/2001]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within 10 days of the issuance of any prescription to him for any such substances; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

DIAMOND, Patrick Francis, MD

Location: Evergreen, NC (Columbus Co)
DOB: 5/15/1946
License #: 0098-00042
Specialty: FP (as reported by physician)
Medical Ed: Autonomous Universidad de Tamaulipas, Mexico (1987)
Cause: On application for reinstatement of his license, which was summarily suspended 6/28/1999. In early 1999, Dr Diamond wrote prescriptions for Nubain® for himself, had them filled, and administered them to himself; in May 1999, he signed a contract with the NCPHP but for the first few weeks of June the NCPHP lost touch with him; the Board Summarily Suspended his license on 6/28/1999; pursuant to a Consent Order, the Board issued Dr Diamond a temporary license in August 1999; he surrendered his temporary license on 11/18/1999 after he relapsed in his recovery from Nubain®. For six weeks in late 1999, Dr Diamond attended an in-patient treatment program; he reports he has not consumed any alcohol or drugs other than those lawfully prescribed for him since his relapse in November 1999; he has signed and is compliant with a contract with the NCPHP; he has been regularly screened for alcohol and drug use by the NCPHP, results being negative; he reports he has been actively involved in AA and Caduceus.

Action: 10/19/2000. Consent Order executed: Dr Diamond is issued a license to expire on the date shown on the license [11/30/2000]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall attend AA and/or Caduceus meetings as recommended by NCPHP; he may not work more than 30 hours per week; he must provide a copy of his Consent Order to all current and prospective employers; must comply with other conditions.

HOLTKAMP, John Harry, MD

Location: Raleigh, NC (Wake Co)
DOB: 11/20/1954
License #: 0000-28045
Specialty: CHN/PD (as reported by physician)
Medical Ed: New York University (1980)
Cause: To amend the Consent Order of 2/05/1998. Dr Holtkamp surrendered his license on 1/17/1997, acknowledging a relapse in his alcoholism. By a Consent Order of 7/23/1997, amended on 2/05/1998, he was issued a time-limited license to practice. Dr Holtkamp continues to abide by his contract with the NCPHP, attends AA meetings, and reports he continues clean and sober. He no longer needs to limit his working hours.

Action: 8/31/2000. Consent Order executed: the Board extends Dr Holtkamp's license to practice to expire on the date shown on the license [3/31/2001]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall continue attendance at AA meetings; he shall obtain and document 50 hours of CME relevant to his practice each year, at least 30 of which must be Category I; he shall cause his therapist to send a report to the Board of Dr Holtkamp's therapy when requested by the Board; must comply with other conditions. The numbered paragraphs of this Consent Order supersede those in the Consent Order of 2/05/1998, except those regarding the public nature of that consent order.

JACOBS, Kenneth Lee, MD

Location: North Wilkesboro, NC (Wilkes Co)
DOB: 7/26/1959
License #: 0096-00953
Specialty: OBG (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1992)
Cause: On Dr Jacobs application for reinstatement of his license, which he surrendered on 3/26/1999 following five screenings in February and March 1999 in which he tested positive for cocaine and after a four-day in-patient chemical dependency evaluation in mid-March 1999 that concluded he had abused cocaine. Dr

Jacobs has steadfastly denied that he ingested cocaine and has submitted to over 35 random drug screenings since April 1999, all of which have been negative. He signed a contract with the NCPHP on 2/05/1999, and, as of this date, has complied with the terms of that contract.

Action: 9/11/2000. Consent Order executed: Dr Jacobs is issued a license to expire on the date shown on the license [11/30/2000]; he shall practice only in a setting approved in writing by the Board's president; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall provide a copy of this Consent Order to all prospective employers; must comply with other conditions.

MARINO, Baptiste Steven, MD

Location: Lexington, NC (Davidson Co)

DOB: 2/10/1960

License #: 0000-34079

Specialty: AN (as reported by physician)

Medical Ed: Medical College of Ohio (1986)

Cause: In August 1990, following his residency, Dr Marino began work at Colleton Regional Hospital in South Carolina; he billed for his services apart from the hospital billing and paid support staff working for him at the hospital; he had no experience in billing and contracted with a billing company to administer billing and collection; in July 1992, he moved to Lexington, NC, and now practices at Lexington Memorial Hospital; in October 1996, he was indicted on 15 counts of mail fraud that arose from his billing practices at Colleton; in March 1997, following dismissal of all 15 original charges, he pled guilty to a superceding charge of one count of mail fraud, a felony; pursuant to his plea agreement, he admitted he had not properly supervised and had been willfully blind to some of the billing practices of his billing agency, which had submitted a bill to an insurer for reimbursement for services not properly identified or rendered as indicated. As part of his negotiated plea, he paid or arranged to pay full restitution so no person or entity suffered loss due to his conduct or that of his billing service; all parties and the hospital agreed he provided appropriate medical care and none of his conduct raised any issues as to the quality of care. In October 1997, a guilty verdict was entered against Dr Marino and he was sentenced to three years probation; he was permitted to continue his practice at Lexington Memorial. He successfully completed his probation and received early termination due to exemplary conduct; he has been forthcoming with the board and has become familiar with proper billing practices; he is now properly vigilant in monitoring billing matters.

Action: 9/22/2000. Consent Order executed: Dr Marino is reprimanded; must comply with other conditions.

MARTIN, Carol Ann, MD

Location: Raleigh, NC (Wake Co)

DOB: 10/14/1952

License #: 0099-01651

Specialty: P (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1978)

Cause: To amend the Consent Order of 12/17/1999. The Board has agreed to allow Dr Martin to work 40 hours per week rather than limit the time to 25 hours. It appears that Dr Martin has been complying with the terms and conditions of her Consent Order.

Action: 8/08/2000. Consent Order executed: Dr Martin is issued a license to expire on the date shown on the license (1/31/2001); her practice is limited to psychiatry and sleep disorders; she may not work more than 40 hours per week; she may work only in a setting first approved by the Board's president; she shall obtain a clinical supervisor to regularly review her cases and report to the Board regarding those cases; Dr Martin may not supervise PAs or NPs in any way; she shall continue her therapy and comply with all recommendations made by her therapist; she shall direct her therapist to send quarterly reports to the Board; she shall maintain and abide by a contract with the NCPHP; she shall obtain and document 50 hours of relevant Category I CME each year; must comply with other conditions. The numbered paragraphs of this Consent Order supersede those in any prior consent order except those regarding the public nature of such consent orders.

MITCHELL, John Bradley, PA-C

Location: Fayetteville, NC (Cumberland Co)

DOB: 9/21/1950

License #: 0001-02471

PA Education: Academy of Health Sciences (1977)

Cause: Appeal of license denial communicated to him May 17, 2000. Mr Mitchell previously held a temporary PA license; he may have had problems while working in Wilmington, NC, as reflected in the Board's letter of denial. He has provided the Board additional information about his ability to safely perform medical acts, tasks, and functions as a PA; he has worked as a PA in the VA Medical Center in Fayetteville, NC, since April 1997 with no complaints and the supervising staff there is supportive of his application.

Action: 10/24/2000. Consent Order executed: the Board shall issue Mr Mitchell a PA license; he shall notify the Board of any patient complaints concerning his practice promptly on learning of such complaints; he shall notify the Board in writing of any change in his residence, practice addresses, or primary supervising physician within 10 days; must comply with other conditions.

SHAFTNER, Kimberly K., MD

Location: Princeton, NC (Johnston Co)

DOB: 12/09/1954

License #: 0000-25426

Specialty: FP/AN (as reported by physician)

Medical Ed: Ohio State University (1980)

Cause: On the application of Dr Shaftner for reinstatement of his license. The Board entered into a Consent Order with Dr Shaftner in 1986 as a result of his substance abuse, including fentanyl and cocaine; from early 1999 until May 2000, Dr Shaftner diverted hydrocodone to his own use by means of prescriptions issued in the names of others; in May 2000, he surrendered his license. From May through August 2000, he sought and obtained continuing treatment for his substance abuse; he is a participant in the NCPHP; he reports he has been sober since May 5, 2000.

Action: 10/04/2000. Consent Order executed: Dr Shaftner is issued a license to expire on the date shown on the license [2/28/2001]; he shall limit his practice to general medicine and shall not practice anesthesia; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use or possession of all mind or mood altering substances and all controlled substances, and he shall refrain from the use or possession of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber, the pharmacy filling the prescription, and the indication for which it was prescribed; he shall not purchase or possess such substances for any other person, including family members; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain a log of all controlled substances he prescribes or orders and submit a copy to the Board's Investigative Department on a quarterly basis and as requested; the log shall list patient name, date of prescription, name of medication, strength, dosage, quantity, and other details; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

SHERMAN, Randall Lester, MD

Location: Elizabeth City, NC (Pasquotank Co)

DOB: 6/13/1949

License #: 0000-33891

Specialty: NS (as reported by physician)

Medical Ed: University of Oklahoma (1978)

Cause: On application for reinstatement his of license, which was surrendered 11/18/1999 after he relapsed in his recovery from alcohol abuse. After surrendering his license, Dr Sherman attended and successfully completed an alcohol treatment program from 12/1999 through 6/2000; he reports he has not consumed alcohol since 11/1999; the NCPHP reports he has signed and complied with an NCPHP contract; he has been regularly screened for alcohol use by the NCPHP and all tests have been negative; Dr Sherman reports he is active in AA and Caduceus; he also reports he has fully complied with the after-care requirements of his treatment program.

Action: 10/18/2000. Consent Order executed: Dr Sherman is issued a license to expire on the date shown on the license [1/31/2001]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the

pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall attend AA and/or Caduceus meetings as recommended by the NCPHP and shall abide by all after-care recommendations of his treatment program; must comply with other conditions.

TOLLESON, Thaddeus Rex, MD

Location: Durham, NC (Durham Co)

DOB: 11/10/1966

License #: 0097-01175

Specialty: IM/C (as reported by physician)

Medical Ed: University of Texas, Houston (1993)

Cause: On the application of Dr Tolleson for reinstatement of his license, which was surrendered May 23, 2000. Dr Tolleson has had a problem with substance abuse, which includes having obtained hydrocodone bitartrate through forging prescriptions in the names of non-existent patients; in April 2000, he was arrested and charged with obtaining a controlled substance by fraud (a charge later dropped) after he presented a forged prescription at a Durham pharmacy; following his arrest, he became a participant in the NCPHP. It appears Dr Tolleson has maintained sobriety since May 22, 2000, and is involved in an active recovery program with AA, Caduceus, and the NCPHP.

Action: 10/06/2000. Consent Order executed: Dr Tolleson is issued a license to expire on the date shown on the license [April 30, 2001]; he shall limit his practice to Duke University and its affiliated practices or such other sites as may be approved by the Board's president; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use or possession of all mind or mood altering substances and all controlled substances, and he shall refrain from the use or possession of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

VAUGHAN, Howell Anderson, Physician Assistant

Location: Durham, NC (Durham Co)

DOB: 3/31/1958

License #: 0001-01513

PA Education: Wake Forest University (1992)

Cause: On Mr Vaughan's application for reissuance of his license, previously surrendered. He surrendered his license in December 1993 due to a problem with substance abuse. Pursuant to a Consent Order of January 1995, modified by a Consent Order of May 1997, the Board issued Mr Vaughan a license on conditions related to his recovery from substance abuse. Having relapsed in his recovery, he surrendered his license again in October 1999 and sought treatment. In Catawba County District Court, he pled guilty to obtaining controlled substances by fraud, for which he was sentenced to 45 days in prison, the sentence being suspended for 36 months on supervised probation. Mr Vaughan has undergone a 28 day inpatient treatment related to his relapse and has reestablished a relationship with the NCPHP. The NCPHP reports he has been complying with their program, has been sober for nine months, and his urine screens have been negative.

Action: 8/16/2000. Consent Order executed: Mr Vaughan is issued a license to expire on the date shown on the license [11/30/2000]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall surrender any and all controlled substance registrations to the DEA and shall not reapply for such registrations; he shall not order, prescribe, administer, or dispense, and, except as noted above, shall not possess any controlled substances; he shall abide by all terms of his probation; must comply with other conditions.

WANGELIN, Robert Lester, MD

Location: Greensboro, NC (Guilford Co)

DOB: 5/21/1945

License #: 0000-28370

Specialty: P (as reported by physician)

Medical Ed: West Virginia University (1972)

Cause: To modify the Consent Order of 4/26/1999, which followed Consent Orders of 11/18/1996 and 11/07/1997 under which Dr Wangelin's license was suspended until 1/31/1999 and then restored with a number of conditions related to his improper relationships with female patients. One of the conditions of his current Consent Order (4/26/1999) is that he limit his practice to male patients. It is now agreed Dr Wangelin can safely consult with female patients over the telephone.

Action: 8/01/2000. Consent Order executed: the Board shall issue Dr Wangelin a license to expire on the date shown on the license [1/31/2001]; he shall limit his practice to male patients only, except that he may consult over the telephone with female patients; if any such female patients require examination or treatment more extensive than may be provided over the telephone, he shall make appropriate referrals or otherwise arrange for the care of those patients but shall not further examine or treat them himself; he shall continue treatment and supervision by his psychiatrist or such other psychiatrist approved by the president of the Board and shall have that psychiatrist submit monthly reports to the Board; must comply with other conditions. The terms of this Consent Order supersede those imposing any continuing obligation in the prior Consent Orders, except those terms regarding the public nature of those Consent Orders. This Consent Order does not change any aspect of Dr Wangelin's license status during any prior period.

WORLAX, Eric, Physician Assistant

Location: Efland, NC (Orange Co)

DOB: 8/25/1960

License #: 0001-01585

PA Education: Duke University (1992)

Cause: On Mr Worlax's petition to lift the August 3, 1999, summary suspension of his license. On August 3, 1999, the Board issued charges against Mr Worlax alleging he engaged in inappropriate sexual conduct before a patient; on August 12, 1999, he denied, and continues to deny, the allegations except as follows: between 1992 and 1995, on 15 to 30 occasions, for purposes of gratifying himself, he examined female patients while having an erection under his clothes, and on many of those occasions he hoped they would notice his erection and comment about it. Mr Worlax has entered and maintains a contract with the NCPHP; he has been assessed by Dr Abel at the Behavioral Medicine Institute of Atlanta, he has attended and successfully completed eight weeks of cognitive-behavioral treatment at BMI and has continued such treatment under Dr Norris; Dr Abel believes that if Mr Worlax complies with the program established by Dr Abel, he can return to practice as a PA without posing a threat to patients.

Action: 10/06/2000. Consent Order executed: Mr Worlax shall surrender his license and the Board shall then issue him a temporary license to expire on the date shown on the license [11/30/2000]; Mr Worlax shall ensure that a female chaperone, who has read his Consent Order, is present when he is in an examination room with a female patient and documents she was there and that no boundary violations or other misconduct occurred; he shall post a copy of the "Principles of Medicine" on his office wall and any other places it can be easily read by patients; each month, he shall ask three staff members with whom he works to complete the "Staff Surveillance Form," which shall be sent to Dr Norris or his successor so they can be incorporated in a quarterly report; during one week each quarter, Mr Worlax or a staff member will ask all patients to complete a "Patient Satisfaction Survey," which shall be sent to Dr Norris or his successor so they can be incorporated in a quarterly report to the Board; every six months, Mr Worlax will undergo a polygraph examination to determine if he has been involved in sexual misconduct with patients or staff, and the results will be sent to Dr Norris or his successor to be incorporated in a quarterly report to the Board; Mr Worlax will continue his relapse prevention therapy with Dr Norris, or such other person as may be approved by the Board's president, and shall comply with all recommendations made by Dr Norris or his successor regarding his medical practice; Mr Worlax shall direct Dr Norris or his successor to provide quarterly reports of Mr Worlax's progress to the director of the Board's Investigations Department; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

YOUNG, Richard Lane, MD

Location: Sunset Beach, NC (Brunswick Co)
 DOB: 8/12/1951
 License #: 0000-31090
 Specialty: ORS (as reported by physician)
 Medical Ed: Medical University of South Carolina (1979)
 Cause: On Dr Young's application for reinstatement of his license. Dr Young has had a problem with alcohol and substance abuse, which led to surrender of his license in February 2000. Following surrender of his license, he sought and obtained treatment for his alcohol and substance abuse. He has an active contract with the NCPHP and is committed to follow the treatment recommended by NCPHP; he has been sober since February. It appears Dr Young is involved in an active recovery program that includes attending aftercare and Caduceus meetings.

Action: 8/16/2000. Consent Order executed: Dr Young is issued a license to expire on the date shown on the license [11/30/2000]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind or mood altering substances and all controlled substances, and he shall refrain from the use of alcohol; he shall notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall provide a copy of this Consent Order to colleagues with whom he practices or takes call and to all future employers and the chief of staff of each hospital where he obtains privileges; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL

NONE

SURRENDERS**BANIEWICZ, Frank John, MD**

Location: Laurinburg, NC (Scotland Co)
 DOB: 2/01/1959
 License #: 0097-01693
 Specialty: OM/IM (as reported by physician)
 Medical Ed: Northeastern Ohio University (1987)
 Action: 10/05/2000. Voluntary surrender of his North Carolina medical license.

CONNINE, Tad Robert, MD

Location: Elizabeth City, NC (Pasquotank Co)
 DOB: 1/19/1964
 License #: 0099-00193
 Specialty: RO (as reported by physician)
 Medical Ed: University of South Florida (1992)
 Action: 8/16/2000. Voluntary surrender of North Carolina medical license.

McCONVILLE, Robert N., Physician Assistant

Location: Shallote/Carolina Beach, NC (Brunswick Co)
 DOB: 12/23/1968
 License #: 0001-02280
 PA Education: Gannon University (1993)
 Action: 8/16/2000. Voluntary surrender of North Carolina physician assistant's license.

SHUMWAY, David Lucius, MD

Location: Knoxville, TN
 DOB: 1/26/1949
 License #: 0000-21310
 Specialty: EM (as reported by physician)
 Medical Ed: University of Illinois (1975)
 Action: 9/05/2000. Voluntary surrender of North Carolina medical license.

See Consent Orders:

WORJAX, Eric, Physician AssistantCONSENT ORDERS LIFTED**AUSLEY, Mett Bagley, Jr, MD**

Location: Warsaw, NC (Duplin Co)
 DOB: 8/06/1957
 License #: 0000-38004
 Specialty: PTH (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1984)
 Action: 7/10/2000. Order issued lifting Consent Order of 8/10/1997.

BENTLEY, Steven Edmunds, MD

Location: Raleigh, NC (Wake Co)
 Oxford, NC (Granville Co)
 DOB: 9/01/1953
 License #: 0000-23676
 Specialty: EM (as reported by physician)
 Medical Ed: Medical College of Georgia (1978)
 Action: 9/27/2000. Order issued lifting Consent Order of 12/16/1998.

BURSON, Jana Kaye, MD

Location: Mooresville, NC (Iredell Co)
 DOB: 5/14/1961
 License #: 0000-39164
 Specialty: IM (as reported by physician)
 Medical Ed: Ohio State University (1987)
 Action: 8/04/2000. Order issued lifting Consent Orders of 1/23/1999 and 4/14/1999.

CROLAND, David Alan, DO

Location: Little River, SC
 DOB: 11/27/1962
 License #: 0097-01729
 Specialty: FP (as reported by physician)
 Medical Ed: Southeastern College of Osteopathic Medicine (1989)
 Action: 8/31/2000. Order issued lifting Consent Orders of 12/18/1997, 5/11/1999, and 1/04/2000.

HARRIS, Donald Philip, MD

Location: Greensboro, NC (Guilford Co)
 DOB: 4/09/1934
 License #: 0000-13127
 Specialty: IM (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1961)
 Action: 8/04/2000. Order issued lifting Consent Orders of 7/27/1988, 2/08/1996, and 4/30/1996.

KHOT, Prakash Nilkath, MD

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 5/10/1944
 License #: 0000-19016
 Specialty: FP/EM (as reported by physician)
 Medical Ed: Nagpur Medical College, India (1967)
 Action: 7/10/2000. Order issued lifting Consent Order of 2/19/1999.

WEST, Harold Kenneth, Jr, MD

Location: Maitland, FL
 DOB: 4/21/1954
 License #: 0098-00437
 Specialty: FP/EM (as reported by physician)
 Medical Ed: Loma Linda University (1979)
 Action: 8/04/2000. Order issued lifting Consent Order of 3/18/1998.

TEMPORARY/DATED LICENSES:ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES**BENTLEY, Steven Edmunds, MD**

Location: Raleigh, NC (Wake Co)
 Oxford, NC (Granville Co)
 DOB: 9/01/1953
 License #: 0000-23676
 Specialty: EM (as reported by physician)
 Medical Ed: Medical College of Georgia (1978)
 Action: 9/22/2000. Full and unrestricted license reinstated.

CHEEK, John Christopher, MD

Location: Smithfield, NC (Johnston Co)
 DOB: 3/03/1957
 License #: 0097-01906
 Specialty: GP/CN (as reported by physician)
 Medical Ed: University of North Carolina Medical School (1984)
 Action: 9/22/2000. Temporary/dated license extended to expire 3/31/2001.

CHANGE OF ADDRESS FORM

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

Please print or type.

Date: _____

Full Legal Name of Licensee: _____

Social Security #: _____ License/Approval #: _____

(Check preferred mailing address)

Business: _____

Phone:(_____) _____ Fax:(_____) _____

Home: _____

Phone:(_____) _____ Fax:(_____) _____

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

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Raleigh, NC

ELECTRONIC REGISTRATION: IT'S HERE!!!!!!

Physicians, physician assistants, and nurse practitioners who are within 60 days of their birthdays now have the opportunity to handle their annual registration with the North Carolina Medical Board via the Internet, using a valid Mastercard® or Visa® credit card. Instructions for doing this will be included on the postcard registration notice mailed to them prior to their birthdays. (The postcard will also tell them how to obtain a paper registration form if they prefer to continue registering by mail.) The Board's new electronic registration system is not only easy and simple, it offers an immediate receipt and proof of registration using a secure Internet site. Go to <http://renewal.ncmedboard.org>.

As a physician, physician assistant, or nurse practitioner, you should make note of this new registration system and ensure the Board's postcard registration notice is not misplaced when it arrives at your designated address. If others handle your mail before it reaches you, be sure they know the importance of the postcard registration notice. And remember, register only once, either via the Internet OR by mail – not both.

North Carolina Medical Board
P.O. Box 20007
Raleigh, NC 27619