Primum Non Nocere

No. 4, 2003

forum
NC MEDICAL BOARD

The Ethical Medical Expert Witness
Page 7

The Triangle Reading Service: Breathing Words into Many Lives

Linda Ornt, Director
Triangle Reading Service

Ms Ornt

The Triangle Reading Service (TRS) went on the air 20 years ago to bring local news and information from the print media to blind, elderly, and disabled people living in Raleigh. The TRS was the brainchild of two very different people. Ben Eason, a blind man living in Raleigh, visited friends in Tidewater Virginia and heard the reading service there. He brought the word back to his Lions Club and enlisted its members to become the first Board of Directors and chief funders of the organization. Ed Funkhouser, a volunteer who was recording magazines for the North Carolina Library for the Blind and Physically Handicapped, felt blind people in the area needed to have access to local news. Between them, these men raised the money, interest, and technical expertise necessary to begin the Radio Reading Service, Incorporated (doing business as the Triangle Reading Service), in 1982. It took a year to get all the various parts working, but in March 1983 the Triangle Reading Service began broadcasting the reading of the Raleigh *Sun* over a special radio frequency donated by WKNC, the student radio station at North Carolina State University. At that time, the service could *almost* cover all of Raleigh's city limits.

Over Two Decades of Service

Since that humble beginning, the organization has undergone significant changes, but it still serves the same purpose, bringing local news and information to more than 4,000 listeners throughout the greater Triangle area of North Carolina and living up to its motto: "We breathe words into your life." Today, 21 years after it all began, Ben Eason and Ed Funkhouser continue their involvement with the service as emeritus members of the Board of Directors.

In 1989, the studio facilities on Capital Boulevard burned to the ground. This disaster brought a lot of publicity and public attention to the group and the service it was providing to the blind in the area. The final result was a bigger, better facility, but only after some time was spent broadcasting from one of the study carrels at D.H. Hill Library on the North Carolina State University campus while the search went on for a home, which was found on Brooklyn Street. A number of corporations donated equipment, office supplies, and time to refurbish the TRS and bring it back to life.

For the past decade, the TRS has leased studio facilities on Six Forks Road in Raleigh. The radio frequency is donated by WUNC-FM. This means that the TRS can reach 16 counties in north central North Carolina. Two paid staff members, myself and May Tran, support about 150 volunteers who read local newspapers, various magazines, and novels. Listeners fill out an application and are loaned a specially tuned radio receiver, which is very easy to operate. TRS broadcasts are also available over community access TV in Raleigh, Cary, Apex, and Garner. The five major hospitals in the area have made the TRS available at every patient's bed through their in-house cable systems, and, in Durham, Croasdaile Village has put the TRS on its in-house cable system for every resident.

The majority of TRS listeners are people who have lost their sight as they have aged. Most were avid current events readers and want to "stay in the loop." Listeners say the TRS keeps them company, gives them confidence and awareness, and helps them cope with their disability. TRS programs also help relieve the isolation that the elderly blind frequently face. Reading services also

In This Issue of the FORUM

Primum Non Nocere

forum

NC MEDICAL BOARD

Raleigh, NC **Vol. VIII, No. 4, 2003**

North Carolina Medical Board

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

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

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

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

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

Robin N. Hunter-Buskey, PA-C
Raleigh
Term expires
October 31, 2006

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

Janelle A. Rhyne, MD
Wilmington
Term expires
October 31, 2006

George L. Saunders, III, MD
Shallotte
Term expires
October 31, 2006

Shikha Sinha
Morrisville
Term expires
October 31, 2004

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

Aloysius P. Walsh
Greensboro
Term expires
October 31, 2006

R. David Henderson, JD
Executive Director

Bryant D. Paris, Jr
Executive Director Emeritus

Publisher
NC Medical Board

Editor
Dale G Breaden

Assistant Editor
Dena M. Marshall

Street Address
1203 Front Street
Raleigh, NC 27609

Mailing Address
PO Box 20007
Raleigh, NC 27619

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

Fax
(919) 326-0036

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

keep the working blind aware of community news and events, which makes them better employees.

The TRS is a nonprofit, funded in part by local governments and United Way. The majority of the TRS budget comes from donations by individuals, corporations, and foundations.

Volunteers are the backbone of the service. Their contribution of time spent reading on the air totaled 6,858 hours last year. The majority of volunteers read local newspapers for the same shift weekly. Some of them read twice a month in the evening, and others read one weekend shift a month. Volunteers also provide governance on the Board of Directors, assist with planning and staffing special events, raise funds, and represent the TRS at charity fairs and other informational venues throughout the area.

Tim Mannix on reading duty.

Statewide Effort

The Triangle Reading Service is a founding member of the North Carolina Association of Reading Services. This group of all eight reading and information services in the state works to pool funding resources, mentor new services, and support the continuing efforts of older services. Currently, there are reading and information services reaching 80 percent of the state's 87,000 visually impaired citizens: the Cape Fear EARRS serves Wilmington, and includes Bladen, Duplin, and Brunswick Counties; the Charlotte/Mecklenburg Public Access Corporation serves the city of Charlotte; the Eastern NCRRS is based in Greenville but serves New Bern and Jacksonville as well; the RAISE serves 23 counties in southwest North Carolina and has its studios in Asheville; the Southeastern NCRRS is located on the Fayetteville State University campus and serves south central North Carolina; the Triad Information Reading Service has studios at Wake Forest University and reaches 20 counties in the surrounding area; the Triangle Reading Service, located in Raleigh, serves 16 counties in north central North Carolina; and the newly formed Down East Radio Reading Service in Rocky Mount/Wilson went on the air for the first time in October 2003. All of the North Carolina services offer 24-hour-a-day programming.

Radio reading services use the sub-channel of an existing radio station to reach listeners. As I mentioned previously, the listeners fill out an application for a specially tuned radio receiver that allows them to hear the programs. Each service determines what newspapers it can receive in a timely manner to share with listeners. In Raleigh, the TRS reads the Raleigh *News & Observer*, the Durham *Herald-Sun*, the Chapel Hill *Herald*, and a number of other weekly and bi-weekly newspapers at regularly scheduled times, seven days a week. Most of the North Carolina services also use another reading source as a "network" to round out the program day. In Raleigh, the New York City reading service, the In Touch Network, is received via satellite, allowing TRS listeners to hear the *New York Times, Wall Street Journal*, and magazines such as the *New Yorker* and *Reader's Digest*. Currently, three "national" services are available on the National Public Radio satellite. Each allows other, smaller services to use their transmissions as needed.

Frank Holman listening in.

Most listeners to reading services are blind or visually impaired, but some have other disabilities. Some listeners may have had a stroke that left them unable to comprehend print, others may have Parkinson's or palsy that keeps them from holding print material, some are illiterate and need to have material read to them. Surveys of listeners show that 60 percent are women over the age of 60 who have lost their sight later in life. They were avid readers prior to this event and find they miss the news they have read in the newspapers most of all. The volunteers also read drug and department store ads, grocery ads, feature magazines, and listings of upcoming events in order to keep listeners up to date and in the mainstream of the community. Reading services provide companionship to people. During training, volunteers are reminded that the listeners have invited the readers into their homes to sit beside them like a friend and simply read what was written in the newspaper today.

There is no charge for the programs. Each reading service purchases the receivers, which cost about $100 each, and loans them to those who request the service. It is expected that the receivers, which remain property of the respective service, will be returned when the listener dies, moves from the area, or no longer wishes to listen.

A Note on Funding

As different as the various reading services are, their funding is just as diverse. Some are completely run by volunteers with no paid staff. Others have one or two paid staff members. Funding in all instances is cobbled together from a variety of sources that may include local governments, United Ways, Lions Clubs, grants, foundations, and, primarily, individual contributors who feel that reading services are something to get behind and assist. (No reading service in North Carolina receives state or federal funding.) All eight North Carolina services are registered nonprofit organizations and all donations are tax deductible to the extent of the law.

The headquarters of the North Carolina Association of Reading Services is in Raleigh at the office of the Triangle Reading Service. Donations may be made to any individual service, or to all eight, through NCARS, 211 East Six Forks Road, Suite 103, Raleigh, NC 27609.

"The Triangle Reading Service is a founding member of the North Carolina Association of Reading Services"

North Carolina's Eight Reading Services

Cape Fear EARRS, PO Box 144, Wilmington NC 28402, (910) 362-0903

Charlotte/Mecklenburg Public Access Corp., 613 Calvert St., Charlotte NC 28208, (704) 377-8988

Eastern NCRRS, PO Box 20555 Greenville NC 27858, (252) 758-4683

DownEast Radio Reading Service, PO Box 763, Rocky Mount NC 27802, (252) 443-7551

RAISE, 75 Haywood St., Suite G-5, Asheville NC 28801, (828) 251-2166

Southeastern NCRRS, PO Box 35029, Fayetteville NC 28303, (910) 486-7007

Triad Information Reading Service, 512 Timberline Ridge Ln., Winston-Salem NC 27106, (336) 758-6011

Triangle Reading Service, 211 E. Six Forks Rd., Suite 103, Raleigh NC 27609, (919) 832-5138

.....

The Triangle Reading Service's Web site is: *www.triangleread-ingservice.org*. Its e-mail address is: *trserv@btitelecom.net*.

Physician Assistants and Nurse Practitioners in NC

Over the past decade, the growth rate of nurse practitioners and physician assistants in North Carolina's workforce outstripped the growth of physicians, says a report released by the Cecil G. Sheps Center for Health Services Research in August 2003.

Between 1990 and 2001, nurse practitioners increased their supply relative to the population at a rate seven times faster than physicians (183% compared to 24%), while physician assistants increased at quadruple the physician growth rate (104%). The report, Trends in the Supply of Nurse Practitioners and Physician Assistants in North Carolina, 1990-2001, tracks the state's supply of nurse practitioners and physician assistants relative to physicians in North

Carolina's rural and underserved areas.

The fastest growth in nurse practitioners and physician assistants has been in the state's 50 counties designated as underserved areas. "This may be a sign that an increasing amount of care in North Carolina's rural areas is being provided to patients by a nurse practitioner or a physician assistant," said Erin Fraher, assistant director of the Sheps Center and author of the report.

In counties which have a persistent shortage of physicians, the number of nurse practitioners has increased exponentially: while only 7 nurse practitioners worked per 100 physicians in these underserved counties in 1990, 18 nurse practitioners practiced per 100 physicians in 2001. Similarly, the number of physician assistants rose from 14 for every 100 physicians in 1990 to 21 in 2001.

"One of the contributing factors to the rising supply of nurse practitioners and physician assistants is that North Carolina has been a leader in the education and training of both physician assistants and nurse practitioners," said Fraher. The very first physician assistant program in the United States was developed at Duke University Medical Center, and the University of North Carolina at Chapel Hill established one of the first three family nurse practitioner programs in the country. Today, four institutions in North Carolina offer physician assistant education programs: Duke University, Wake Forest University, Methodist College, and East Carolina University. Nurse practitioner programs are available at seven schools around the state.

The fact sheet was produced by the NC Health Professions Data and Analysis System at the Cecil G. Sheps Center for Health Services at the University of North Carolina at Chapel Hill. Data for the fact sheet were obtained from the North Carolina Medical Board and the North Carolina Board of Nursing. In addition to Fraher, John Shadle and Laura Smith served as co-authors. An electronic copy of the fact sheet is available on line at *www.shepscenter.unc.edu/hp*. Sheps Center Contact: Erin Fraher, MPP: (919) 966-5012.

Cecil G. Sheps Center for Health Services Research
University of North Carolina at Chapel Hill

Janelle A. Rhyne, MD, of Wilmington, Appointed to the North Carolina Medical Board

Dr Rhyne

In late November 2003, Governor Easley appointed Janelle A. Rhyne, MD, of Wilmington, to the North Carolina Medical Board to replace Walter J. Pories, MD, who completed two terms on the Board. The Board's executive director, R. David Henderson, said: "The Board and its staff are delighted to welcome Dr Rhyne to the Board. She is a distinguished, experienced, and dedicated member of this state's medical community and will make a significant contribution to the vital work of this Board."

Dr Rhyne earned a BA degree in anthropology from the University of North Carolina at Chapel Hill and continued her education at Arizona State University, where she took an MA degree in physical anthropology. Following graduation, she returned to UNC Chapel Hill where she completed additional studies and worked in neuropathology research. She earned her MD at Wake Forest University School of Medicine. She did her internship in internal medicine, her residency training, and a fellowship in infectious diseases at Wake Forest University Baptist Medical Center.

Dr Rhyne currently serves as clinical associate professor in the Department of Medicine at the University of North Carolina School of Medicine and has served Wilmington's New Hanover Regional Medical Center in many capacities, including chair of numerous medical staff committees, chief of staff, and member of the Board of Trustees. She also practices at Wilmington Health Associates, PLLC, and is medical consultant for the New Hanover County Health Department.

Following the completion of her medical education, Dr Rhyne began teaching responsibilities, some of which she still performs today, including giving conferences and being a preceptor for medical students and residents. She is certified by the American Board of Internal Medicine in the specialty of internal medicine and subspecialty of infectious diseases.

Dr Rhyne is a member of numerous professional societies, including, among others, the American College of Physicians, of which she is a fellow, the Infectious Disease Society of America, the New Hanover-Pender County Medical Society, and the North Carolina Medical Society, where she chairs the Ethical and Judicial Affairs Committee and is a New Hanover-Pender County Delegate. She has been the recipient of numerous honors and awards; most recently, in 1998, she was named Physician Scholar for the North Carolina Medical Society Foundation Leadership Symposium. In 1995, she was Professor of the Year at New Hanover Regional Medical Center,

and in 1994, Physician of the Year at Wilmington Health Associates.

In the past, Dr Rhyne has served as president of the North Carolina Chapter of the American College of Physicians, president of the North Carolina Society of Internal Medicine, chief of staff at New Hanover Regional Medical Center, president of the New Hanover-Pender County Medical Society, and governor of the North Carolina Chapter for the American College of Physicians. She has also coauthored scientific publications and given scientific presentations.

Gov Easley Reappoints Ms Hunter-Buskey, Dr Saunders, and Mr Walsh to the North Carolina Medical Board

R. David Henderson, executive director of the North Carolina Medical Board, recently announced that Governor Easley has reappointed Robin N. Hunter-Buskey, PA-C, of Raleigh; George L. Saunders, III, MD, of Shallotte; and Aloysius P. Walsh, of Greensboro, to the North Carolina Medical Board. Mr Henderson said: "The members and staff of the Board are deeply pleased that these three outstanding individuals are to continue their service to the Board. They are committed to the work of the Board and to the health and safety of the people of North Carolina."

Robin N. Hunter-Buskey, PA-C, Raleigh

Ms Hunter-Buskey

Born in New York, Robin N. Hunter-Buskey, PA-C, a member of the North Carolina Medical Board since November 2000, 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 Medical Center, the Bronx. From 1989 to 1997, she was a member of the New York Board of Professional Medical Conduct. From 1997 to August 2003, she worked as a physician assistant at CaroMont Internal Medicine in Gastonia, NC. In 2002, she earned a master's degree (MPAS) from the University of Nebraska Medical Center. She is presently on active duty as a United States Public Health Service Officer-Rank 04. She is serving with the Department of Justice, Bureau of Prisons, at the Federal Medical Center, Butner, NC.

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 an active member of several professional organizations and was president of the Physician Assistant Foundation from 1999 to 2001. 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. She is currently a member of and consultant to the National Advisory Boards for primary care issues (diabetes, depression).

As a member of the North Carolina Medical Board since 2000, Ms Hunter-Buskey has served as chair of the Board's PA Advisory Council and its Allied Health Committee. She has also been a member of the Board's Licensing, Compliance, Investigative, and Midwifery Committees, and its Joint Subcommittee on Nurse Practitioners.

George L. Saunders, III, MD, of Shallotte

Dr Saunders

George L. Saunders, III, MD, of Shallotte, graduated from Loyola University of Los Angeles and earned his MD from the University of California at San Diego School of Medicine. He completed his residency training in family practice at St Joseph's Medical Center in Yonkers, NY, where he then served as a preceptor. He also served on the faculty at New York Medical College as a clinical instructor in the Department of Medicine.

Following the completion of his medical education,

Dr Saunders became the first medical director of the Urgent Care Network at Jackson Memorial-University of Miami Medical Center, and later was appointed associate clinical professor in the Department of Family and Community Medicine. He joined Landmark Learning Center, in Miami, where he served as medical executive director and quality assurance officer at the 360-bed facility for the developmentally disabled. During his tenure at the Learning Center, Dr Saunders received a state award for quality and efficiency of service.

Since 1992, Dr Saunders has been in private practice in Brunswick County, where he has been a trustee for Brunswick Community College. At Brunswick Hospital, Dr Saunders has served as chief of the medical staff and is currently a hospital trustee.

In the past, Dr Saunders has held numerous appointments, including president, vice president, and recording secretary of the Dade County, Florida, Chapter of the National Medical Association. He also served as president of the Brunswick County Medical Society and as second vice president and convention chair of the Old North State Medical Society, by which group he was named Physician of the Year in 1998 and 1999.

He is currently an adjunct clinical instructor at the University of North Carolina School of Medicine and a preceptor for medical students, nurse practitioner students, and family practice residents.

Dr Saunders is a member of the American Geriatrics Society, the American Academy of Family Physicians, the National Medical Association, and other professional organizations. He is certified by the American Board of Family Practice and the American Board of Geriatric Medicine. Dr Saunders is the medical director of Autumn Care Shallotte and conducts lectures on dementia.

First appointed in 2003 to complete the term of the Board's late president, John T. Dees, MD, Dr Saunders serves on the Board's Policy and Licensing Committees.

Aloysius P. Walsh, of Greensboro

Mr Walsh

Mr Aloysius P. Walsh, of Greensboro, NC, 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. Mr Walsh and his wife and eight children 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 Society of Medical Assistants and holds an honorary membership in that group. From 1988 to 1990, he was a Medicare hearing officer and consultant to CIGNA Healthcare Medicare Administration.

From 1990 to 2000, Mr Walsh was a consultant for the Medical Management Institute. In that position, he conducted Medicare and related seminars nationwide for physicians and their staffs, covering topics such as coding, reimbursement, coverage, audits, appeals, hearings, and fraud and abuse.

He was first named to the North Carolina Medical Board in April 2000. During his first term, he served on the Physicians Health Program Board of Directors and its Compliance Committee, the PA/NP Allied Health Committee, the Midwifery Committee, the Policy Committee, and the Task Force on Office Based Surgery. He was recently elected to the Board's Executive Committee and chairs the Board's Complaints Committee. To stay abreast of developments in the field of medical licensure, he has regularly attended meetings of the Federation of State Medical Boards of the United States.

North Carolina Medical Board

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

In the Next *Forum*: The NCMB Annual Report of Board Actions for 2003

The Ethical Medical Expert Witness

Louise B. Andrew, MD, JD, President,
Coalition and Center for Ethical Medical Testimony

Dr Andrew

Serving as an expert witness in a court of law carries a number of ethical obligations that are rarely delineated by those who seek or provide such service. Since expert witness testimony can and often does directly affect the standard of care that will be applied to future medical practice, providing such testimony can be considered to come within the realm of the practice of medicine. For this reason, giving expert testimony should be undertaken with the same degree of integrity as the practice of medicine, and may be subject to the same scrutiny and regulation.

Because lay juries are generally not knowledgeable about medicine or other highly technical fields, the courts in most states depend on expert witnesses to help them understand and decide complex cases. To protect patients and physicians, and to uphold applicable standards of medical care, it is both morally and legally appropriate for physicians with sufficient expertise to testify in medical malpractice claims. Legal requirements for qualification as a medical expert witness vary significantly from state to state. The American Medical Association and many specialty societies have established policies regarding expert witness testimony to guide their members in providing such service. Many of these policies, though not all, state that to act as an expert witness, at a minimum, a physician should be familiar with the applicable standard of care and be in the active practice of medicine as of the date of the incident. Some require that the member be board certified or prepared in the specialty area involved in the claim. Some require that the member be willing to submit testimony to review by a committee of peers.

As an expert witness, a physician has a clear ethical responsibility to be objective, truthful, and impartial when evaluating a case on the basis of generally accepted standards of practice. It is unethical for an expert to overstate his/her opinions or credentials, to misrepresent mal-occurrence as malpractice, to offer false testimony, or to testify on any sort of contingency basis.

Qualification as an Expert Witness

When state law does not otherwise specify, the qualification of a witness as an expert is determined by the judge on a case-by-case basis. Judges have broad discretion in making such determinations. Although generally conscientious, judges in our judicial system are as a rule limited to hearing the testimony of those potential "experts" brought to them and to the jury by the parties to the case. Furthermore, the questions that are posed to the expert must, for the most part, come from the attorneys representing the parties rather than directly from the judge. (In some countries, France for example, judges can appoint their own experts and question them directly. There is some movement toward court appointed experts in our system, but not much thus far in the medical arena). Occasionally, a judge may disqualify an expert, but this does not yet happen often because of the potential for provoking a mistrial or appeal.

Expertise in the specialty in which the defendant is practicing should be the *sine qua non* of an ethical expert witness. Yet most juries and some judges do not know what constitutes expertise in a medical specialty. Expertise is appropriately established on the basis of (1) *knowledge of the field* and (2) *relevant experience*. Board preparation and current certification are the gold-standard (though not the only) indicators of knowledge of the specialty. For several legitimate reasons (such as grandfathering into a new specialty), some experts are unable to certify in the specialty they practice, but could still be qualified to serve as experts by virtue of continuing medical education and study of the literature in addition to extensive practice. Rural areas may not have the luxury of board certified physicians in certain specialties, and therefore experts from the same pool would in all likelihood also not be board certified. Relevant experience is established by a period of active clinical practice beyond training, and particularly by practice during the time frame of the incident giving rise to the case. An ethical expert witness should be actively practicing within her or his field at the time of the incident involved in a claim in order to be aware of the actual applicable standard of care in effect as of that date. This is because the prevailing standard reflects what is actually being done in clinical practice by the preponderance of practitioners at a given time.

"An ethical expert witness should be actively practicing within her or his field at the time of the incident involved in a claim"

The American Medical Association's *Code of Medical Ethics* (Section 9.07) states:

> Medical experts should have recent and substantive experience in the area in which they testify and should limit testimony to their sphere of medical expertise. Medical witnesses should be adequately prepared and should testify honestly and truthfully to the best of their medical knowledge.

While it might seem reasonable that an expert who testifies against a physician in a case should be knowledgeable, experienced, and trained or certified in the specialty that is the basis for the claim, there are, in point of fact, very few states whose laws require this degree of qualification. This creates a significant vulnerability for certain specialties such as emergency medicine and family practice. Because emergency medicine and family practice are so-called "horizontal" specialties that encompass clinical problems and procedures that cross traditional specialty lines, specialists from a variety of fields have been allowed to testify as experts in EM and FP cases in countless

courts, despite the fact that they have no recent practice experience in an emergency department except as a consultant. By the same token, some emergency physicians and family practitioners have testified as experts in cases involving other specialties, despite limited familiarity with the actual applicable standard of care in that specialty. Many physician expert witnesses have even testified as to the standard of care of other health care providers, such as nurses, technicians, and therapists, based on their observation of the practice of these providers rather than any specific knowledge, training, or experience.

"There is very rarely a clear-cut standard of care for any condition"

As a general rule, an expert witness should be a member of the same profession and specialty as the defendant in the case unless the defendant was clearly practicing outside the confines of his or her specialty. This is the law in North Carolina and California, as well as some other states. If state law allows for another type of specialist to act as an expert witness in evaluation of specific practices or procedures that are performed by a defendant, it is appropriate that such procedures, when performed by the testifying expert, must, at least some of the time, take place in the same or a similar clinical setting as when performed by the defendant in the present claim. This is because an operating room, for example, can not be compared to the facilities available in a typical emergency department or medical office, so standards can differ significantly depending on where a procedure is performed.

Objectivity

The expert witness' primary responsibility must always be to the truth.[1] Full discernment of the truth means that, before forming any opinion, the physician must be thoroughly knowledgeable about all aspects of the case. Ideally, before undertaking review of the records, the prospective witness should know nothing about the case except the broad subject matter and filing deadlines. The expert should request additional records, original documents (such as X rays), and any other possibly relevant information even if the attorney does not volunteer to provide them.

Analysis and testimony should reflect knowledge of, and comparison with, applicable and generally accepted standards of care. Importantly, the medical expert must be aware of and apply the standard of care that existed *at the time of the incident* giving rise to the claim, as well as to regional variations in practice and alternative treatments. The location and capabilities of the facility in which the incident giving rise to the case occurred must also be taken into account.

The standard of care is frequently defined as "that degree of care that would be rendered by a reasonably competent physician practicing under the same or similar circumstances." This standard is not well understood by many expert witnesses, and, unfortunately, whether because they do not themselves understand it or because it does not suit their purpose, some attorneys do not define this concept clearly for their experts. A reader-response series in a popular monthly emergency medicine publication continuously illustrates that there is incredibly wide divergence of opinion in what practicing emergency physicians believe to be the standard of care applicable to any given case scenario.[2] One expert who is unusually candid admitted privately that, although informed by a number of sources, the standard of care that she applies in any given case is essentially "made up," since nowhere is it cast in stone.

An expert must also be aware of the prevailing legal standards in the community where a case is being tried. If the locality rule applies, rather than a national standard, in a given jurisdiction, the expert has an ethical obligation to be familiar with the local standards that are applicable and to explain how she or he has gained this knowledge.

Clinical policies and guidelines have been developed by specialties to address many medical conditions, but most have been very intentionally worded so as to make clear that they are indeed "guidelines" and not standards of care. While this nomenclature may appear to the legally trained practitioner to be designed to avoid liability, medically trained practitioners know that there is very rarely a clear-cut standard of care for any condition, given the variability of human clinical presentation and response. It is often said in jest in the medical community, but often borne out in fact, that "the standard of care is established the first time someone is successfully sued for not doing something." The textbook example of this type of setting is *Helling v Carey* (83Wn.2d 514,519 P.2d 981), a 1974 Washington Supreme Court case in which, based on their understanding and balancing of the risks and benefits, testing for glaucoma in patients less than 40 years of age was established by the *judges* to be the appropriate standard of care, even though it was not the prevailing practice in the community.

An ethical witness must be careful in differentiating for the benefit of a jury between a widely accepted standard of care on the one hand and ideal care that might be provided by the most astute clinician practicing under optimum circumstances on the other. This is a particular hazard for clinicians, such as medical school faculty, whose only practice experience has been in a tertiary care facility but who are testifying in cases involving community facilities with typical practicing clinicians who have limited backup and equipment. An expert must also be able to help the jury understand the difference between the type of evaluation or care that is most commonly rendered for a particular condition, and an equally acceptable method that is not often rendered but is also medically valid or theoretically sound. The expert must also be able clearly to understand and to delineate the difference between reasonably competent care and care that would be considered substandard by an average practitioner under any circumstances.

An ethical expert must be careful to evaluate each case as if the end result is not known. Everyone knows that "hindsight is 20/20," yet some attorneys and their witnesses cannot seem to resist applying the taint of an untoward outcome to their analysis of the case. Representation of one's personal opinion as an absolute truth is misleading to a lay jury, and thus is unethical. Personal opinion, belief, and preference may be offered during expert testimony, but should be

clearly designated as such. The ethical witness will recognize that in most instances differences of opinion between competent medical practitioners will exist in the management of any case, and acknowledge that the ideal course of events is almost always clearer when viewed retrospectively in light of a less than optimal outcome.

An additional responsibility of the expert witness is to differentiate for the jury between malpractice and mal-occurrence. Many lay people do not understand that when an untoward outcome occurs, this does not necessarily indicate that malpractice has intervened. Plaintiff's bar has done nothing to dispel this misconception. Typically, defense counsel will attempt to make this point during cross examination, but the ethical expert witness will volunteer this truth even when it may detract from their theory of liability in the case. This is because the expert's principal obligation is to educate the finder of fact (judge or jury), not to advocate for a given side by revealing only those points that support a given conclusion. All experts have an ethical obligation to educate the public about the reality of the practice of medicine.

Financial Influences

Ethical expert testimony should not be provided for financial gain. Reasonable compensation for a physician's time used in analysis or testimony in a case is ethically acceptable, but financial remuneration must not be the key motivation behind expert witness work. Compensation for time expended acting as an expert witness should be commensurate with compensation that would be earned during the same amount of time devoted to medical practice, and not indexed to the "market rate" for expert testimony. For a physician to earn more through work as an expert witness than as a practicing physician is morally questionable if not unethical, yet many do. Expert testimony by physicians can be useful to juries, the profession, and society, but exorbitant fees charged for such review and testimony will predictably increase the cost of malpractice defense, and therefore threaten liability insurance premiums and availability, and ultimately the availability and affordability of health care. Under no circumstances is it appropriate for an expert's professional remuneration to be contingent on the outcome of a case. Such an arrangement immediately casts doubt on the objectivity of an expert witness. In fact, an ethical expert will establish a fee schedule at the beginning of any case, so as to avoid even the appearance of contingency billing and attendant bias.

Unethical Expert Witness Practices

Acting as an expert witness has become a profession for some individuals. The medical-legal annals are replete with testimony by "hired guns" who earn a significant portion or even the majority of their professional income from testifying in malpractice cases. Some have not practiced for years, falsify their current level of practice or past experience, or practice just enough to keep their medical licenses or be qualified in their states as expert witnesses. Some have been barred from acting as expert witnesses on this or other grounds in certain states, yet continue to testify in others. Some use past or lapsed credentials as evidence of current expertise. Some witnesses typically testify almost exclusively for either the defense or the plaintiff. Accurate records should be kept by medical experts of the number of cases they have reviewed and in which they have given depositions and testimony, the nature of the cases, and the side for whom they testified. This is a requirement for testifying in federal court. If there is a significant imbalance, then the expert is either selectively choosing cases or the bar is selectively choosing experts. Either practice casts doubt on the objectivity of the witness, since a skilled and objective witness should be sought out equally by all members of the bar who participate in medical malpractice litigation.

One particularly egregious statement is often made by those acting as expert witnesses on behalf of plaintiffs. Any physician who states, "if it wasn't documented, it wasn't done," is either lying or has never practiced medicine of any kind. Yet there is probably no more common mantra to be heard among the expert witnesses serving the plaintiff's bar. This *concept* may be a useful teaching tool for risk managers, but it flies in the face of the reality of practicing medicine, and has no place in a deposition or courtroom in our universe. Even the most compulsive video docu-dramatist could not possibly document every aspect and element of any one clinical encounter. An ethical expert could not make this utterance under any circumstances, let alone under oath.

"For a physician to earn more through work as an expert witness than as a practicing physician is morally questionable, if not unethical"

Recourse for Unethical Expert Testimony

The basic flaw in the judicial system's dependence on expert witness testimony is that there is no accountability for statements made by experts under oath. Even if the testimony is successfully impeached (shown to be false) during trial by the opposing side, very little if anything will happen to the expert. Rarely, an expert may be disqualified by a judge for behaving unethically on the witness stand (as for example, exchanging signals with clients or attorneys during testimony), or on the basis of some obvious falsification of qualifications uncovered through cross-examination during the course of a trial. Some courts have disqualified individual experts as not being sufficiently expert in a given field, which has some precedential value in other courts.

Counterclaims or other means of legal recourse against expert witnesses who testify falsely is extremely difficult to mount, both because of the financial and time commitment involved, and because of the legal presumption that testimony provided under oath and not impeached at trial is truthful, or at least honest, opinion testimony that has been provided in the public interest. To be actionable in a civil suit, actual malice must be shown on the part of the expert witness in providing false testimony that is damaging to the defendant physician, and this, for all intents and purposes, has been found to be a nearly insurmountable standard.

Peer Review of Expert Testimony

Ideally, medical expert testimony would be routinely peer reviewed to ensure it meets the ethical standards of the AMA and other medical professional societies. In some states, expert testimony has been included in the definition of medical practice and can be subject to peer review and disciplinary action by the state medical board. A few states are moving toward requiring a limited state license in order to testify in the state. But this is by no means standard practice. Although several states have disciplined health professionals for perjury, only one state to date (North Carolina) has revoked the license of a professional expert witness on the basis that unsupportable expert witness testimony constituted unprofessional conduct.[3] The revocation was subsequently reduced by the Board to a one year suspension because, on appeal, the Wake County Superior Court ruled that the North Carolina Medical Practice Act is unconstitutionally vague and would not put a reasonably intelligent member of the medical profession on notice that repeatedly misstating the standard of care constitutes unprofessional conduct. However, the Court held that repeatedly testifying without an evidentiary or good faith basis that another physician falsified medical records constitutes unprofessional conduct for which a physician would be put on notice under the act. This ruling is likely to be appealed, and presumably other states are waiting for the outcome before deciding whether to proceed on any complaints pending in their own states regarding similar issues. In most cases, a state's medical practice act will determine whether disciplinary action against a physician's medical license is allowable based on issues relating to expert witness testimony.

"The U.S. Supreme Court recently upheld the right of a professional society to discipline a member for inappropriate expert testimony"

Some professional societies (such as the American Association of Neurological Surgeons,[4] the American College of Emergency Physicians, the American College of Obstetricians and Gynecologists, the American College of Surgeons, and the American Society of Plastic Surgeons) will review the testimony of a member acting as an expert witness upon complaint by another member, and others are investigating the possibility of instituting similar procedures.[5] But sanctions in the event of proven false or unethical testimony are generally limited to those affecting the membership of the expert witness in the society.

The U.S. Supreme Court recently upheld the right of a professional society to discipline a member for inappropriate expert testimony (the Supreme Court refused to hear the appeal, thereby allowing the lower court decision to stand).[6] The American Association of Neurological Surgeons suspended a neurosurgeon for giving improper expert witness testimony at a medical malpractice trial. This precedent represents an important victory for those professional societies that include expert witness testimony of their members in their ethical guidelines and disciplinary procedures. Those members who believe an expert has not acted in an ethical manner giving testimony have the recourse of requesting a review of the testimony by their specialty society (if the witness is a member). Not all societies, however, have a mechanism in place to perform this function, and it is not without cost and liability. And not all "experts" belong to medical societies. Further, if the expert is from a different specialty than the defendant, which is often the case, that specialty society typically has no obligation to a non-member complainant from another specialty, or to a member of the public. Although ethics review policies are equally applicable to plaintiff and defense testimony, a limitation of this method is that society members would be more inclined to lodge ethical complaints against unethical experts for the plaintiff.

Current AMA policy limits disciplinary proceedings against unethical experts to those who have been convicted of perjury or who have experienced adverse licensure actions. Like the specialty societies, this method of peer review is also flawed in that sanctions are limited and only affect members or those who apply to become members.

Certifying Experts

Another type of expert witness is emerging in those states whose professional liability statutes require some form of pre-certification of the likelihood of professional negligence prior to the initiation of a suit. A physician will be asked to review the records of the case and submit an affidavit to be submitted with the case filings. Often a single specialist will be asked to opine about the liability of every health care worker whose name appears in the record, including physicians of other specialties and even non-physicians. The affidavit will sometimes be prepared by the law firm and submitted to the expert along with the records for initial review. A "certifying" expert in some states, notably Illinois, must sign the affidavit, but his or her identity need not be revealed to the parties named in the case. Therefore, there is no possibility of any kind of peer review of this type of expert "testimony," since it cannot even be determined by a defendant that the affiant is a physician, unless that expert also serves as a testifying expert witness in the case.[7]

Certifying "experts" may feel that they need not conform to the same standards as an expert who is actually testifying in a case, since the risk of a given named defendant making a settlement of the claim is less predictable at this stage of the case. Yet, physicians named as possibly negligent by a certifying expert are forced to defend themselves and will have the claim on their records with credentialing agencies and institutions forever, regardless of the outcome. Therefore, the exact same standards of ethicality should apply in acting as a certifying expert as apply to "testifying" experts.

An ethical physician who is asked as an expert to certify a claim for potential negligence would carefully consider whether or not she or he would qualify to serve as an expert witness who is testifying in the case. Such a physician should, at a minimum, be familiar with the standard of care for each potential defendant whose care she or he intends to consider, using the criteria outlined above for "testifying" experts: current knowledge and relevant experience in the field of the potential defendant. A physician who makes a certifi-

cation against a health provider, without such qualification as an expert, should be subject to peer review in the same manner as any other expert witness.

Conclusions

It is ethical and appropriate for physicians to serve as expert witnesses. But serving in this way carries certain moral and ethical obligations. A physician who takes part in medical-legal case evaluation or expert medical testimony should first have knowledge and relevant experience in the specialty and/or the procedure involved in the case. Ethical experts must make every attempt to educate themselves in a blinded fashion about every aspect of the case, to analyze all available information carefully informed by the appropriate standard of care, and give informed, truthful, non-biased opinion about the care that the patients received. The expert's legal duty is to educate and serve the judge and jury, not the parties to the case or legal counsel. Ethical expert medical opinion should never be influenced by what the witness believes the attorney desires or by the remuneration that is offered. Certifying experts are, in effect, offering preliminary expert testimony and should be identified and held to the same standards as testifying experts. All expert testimony should follow ethical guidelines established by the AMA and other medical societies, and should be able to withstand peer review, and, where available, disciplinary scrutiny. A peer review and disciplinary mechanism that is available to members of the public and can be applied to all physician expert witnesses, such as state licensing board review, should be developed and standardized. The last concept is the simplest, yet most profound. The hallmark of the ethical expert witness must always be unswerving dedication to truth and, therefore, to the integrity of the process.

"The expert's legal duty is to educate and serve the judge and jury, not the parties to the case or legal counsel"

1. Bucy PC: The Medical Expert Witness in Malpractice Suits. *JAMA*, 1975; 232:1352-1353
2. [Standard of Care Project, *EM Monthly*, ongoing]
3. *www.ama-assn.org/amednews/2002/08/19/prsc0819.htm*
4. *www.aans.org/bulletin/pdfs/spring02.pdf* [see pages 10 and following] and *www.aans.org/bulletin/pdfs/summer02.pdf* [see pages 29 and following]
5. Personal communication, Rick Peterson, General Counsel, American Academy of Orthopaedic Surgeons
6. Adams D: High Court Denies Appeal of Physician Discipline Case. *AMNews*, Feb 4, 2002, 17
7. *www.ama-assn.org/amednews/2003/07/28/prsb0728.htm*

Parts of this article were adapted from an article titled Expert Witness Testimony: Pitfalls and Dilemmas, written jointly with Robin Hemphill, MD, and Catherine Marco, MD, for the American College of Emergency Physicians *ACEP News*, July 2002. Dr Andrew may be contacted at *landrew@ccemt.org*.
For further information, see the Web site of the Coalition and Center for Ethical Medical Testimony: *www.ccemt.org*.

President's Message

A Tribute to Staff

Stephen M. Herring, MD

The North Carolina Medical Board has undergone considerable change over the past year under the outstanding leadership of Dr Charles L. Garrett. His experience and wisdom have guided the Board through this transition period in a seamless fashion, all for the betterment of the Board. The transition involved two components: the physical move of all the offices, equipment, and records, and the structural and functional reorganization of all departments and committees. At the same time, the work of the Board has continued, with the staff having the equivalent of three jobs: reorganization, relocation, and routine Board work.

By design, most medical boards, including the North Carolina Medical Board, have staggered and defined terms for Board members. The advantage of this is assuring the appointment of new Board members with fresh ideas on a regular basis. A potential disadvantage, however, is the risk of loss of continuity in the regulatory process. The North Carolina Medical Board has been blessed with an excellent staff that ensures continuity in process as Board members come and go. The process of professional regulation is complex, demanding, and not innate to the professional and public members who serve on the Board.

During an average month, the Board staff performs many tasks, including preparation of over a thousand pages of material for Board members, fielding thousands of telephone and written inquiries, issuing hundreds of new professional licenses, reregistering thousands of current licenses, and staffing the monthly Board meetings that can run up to three days of up to twelve hours each. Despite the enormous workload and responsibility, the work product remains excellent.

The current state of the North Carolina Medical Board is the result of a building process started in 1859, with continuous attention to improvement. The cement that secures that building process is our excellent Board staff. The national recognition the North Carolina Medical Board enjoys is in large part due to the outstanding work product of the Board.

On behalf of all the members of the Board, I offer deepest thanks to the Board's staff for its hard work, loyalty, innovation, dependability, and dedication. Great job!

Position Statements of the North Carolina Medical Board

Table of Contents

[The principles of professionalism and performance expressed in the position statements of the North Carolina Medical Board 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 of the North Carolina Medical Board refer to persons who are MDs or DOs licensed by the Board to practice medicine and surgery in North Carolina.]

Disclaimer

The North Carolina Medical Board makes the information in this publication available as a public service. We attempt to update this printed material as often as possible and to ensure its accuracy. However, because the Board's position statements may be revised at any time and because errors can occur, the information presented here should not be considered an official or complete record. Under no circumstances shall the Board, its members, officers, agents, or employees be liable for any actions taken or omissions made in reliance on information in this publication or for any consequences of such reliance.

A more current version of the Board's position statements will be found on the Board's Web site: www.ncmedboard.org, which is usually updated shortly after revisions are made. In no case, however, should this publication or the material found on the Board's Web site substitute for the official records of the Board.

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 relationship 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;
- the physician report all significant findings to the patient or the patient's legally designated surrogate/guardian/personal representative;
- there be no conflict of interest between the patient and the physician or third parties;
- personal 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 respect the patient's right to request further restrictions on medical information disclosure and to request alternative communications;
- 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, competence, 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 or the patient's representative 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. It is advisable that the notice of termination also include instructions for transfer of or access to the patient's medical records.

(Adopted July 1995)
(Amended July 1998, January 2000; March 2002, August 2003)

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 caregiver 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 caregivers 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 MEDICAL RECORDS

A physician's policies and practices relating to medical records under their control 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. Such policies and practices should conform to applicable federal and state laws governing health information.

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 to promote continuity of care. Patients, however, have a substantial right of access to their medical records and a qualified right to amend their records pursuant to the HIPAA privacy regulations.

Medical records are confidential documents and should only be released when permitted by law or with proper written authorization of the patient. Physicians are responsible for safeguarding and protecting the medical record and for providing adequate security measures.

Each physician has a duty on the request of a patient or the patient's representative to release a copy of the record in a timely manner to the patient or the patient's representative, unless the physician believes that such release would endanger the patient's life or cause harm to another person. This includes medical records received from other physician offices or health care facilities. A summary may be provided in lieu of providing access to or copies of medical records only if the patient agrees in advance to such a summary and to any fees imposed for its production.

Physicians may charge a reasonable fee for the preparation and/or the photocopying of medical and other records. To assist in avoiding misunderstandings, and for a reasonable fee, the physician should be willing to review the medical records with the patient at the patient's request. Medical records should not be withheld because an account is overdue or a bill is owed (including charges for copies or summaries of medical records).

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 medical records and about completing forms should be made available in writing to patients when the physician-patient relationship begins.

Physicians should not relinquish control over their patients' medical records to third parties unless there is an enforceable agreement that includes adequate provisions to protect patient confidentiality and to ensure access to those records. 1

When responding to subpoenas for medical records, unless there is a court or administrative order, physicians should follow the applicable federal regulations.

---

1 See also Position Statement on Departures from or Closings of Medical Practices.

(Adopted November 1993)
(Amended May 1996, September 1997, March 2002, August 2003)

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 reasonably 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, sufficiently far in advance (at least 30 days) to allow other medical care to be secured, which is often done by newspaper advertisement and by letters to patients currently under care;
- ✔ patients clearly understand that the choice of a health care provider is the patients';
- ✔ patients are told how to reach any practitioner(s) remaining in practice, and when specifically requested, are told how to contact departing practitioners; and
- ✔ patients are told how to obtain copies of or transfer their medical records.

■ **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, sufficiently far in advance (at least 30 days) to

allow other medical care to be secured. Good continuity of care includes preserving, keeping confidential, and providing appropriate access to medical records. * Also, good continuity 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.

* NOTE: 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)
(Amended August 2003)

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
- meet the Board's continuing medical education requirement.

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)
(Amended January 2001)

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 TO THEIR PATIENTS

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.

The surgeon is responsible for postoperative care of the patient, including complications. This responsibility extends through the period of convalescence until the residual effects of the surgical procedure are minimal, and the risk of complications of the operation is predictably small.

(Adopted July 1993)
(Amended May 1996, January 2001, October 2003)

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, a staff member, should be readily available at all times during a physical examination, and it is strongly advised that a third party be present when the physician performs an examination of the breast(s), genitalia, or rectum. It is the physician's responsibility to have a staff member available at any 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, January 2001, February 2001, October 2002)

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 a guide in defining sexual exploitation of a patient by a licensee, the Board will use the language of the North Carolina General Statutes, Chapter 90, Article 1F (Psychotherapy Patient/Client Sexual Exploitation Act), §90-21.41.

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, January 2001)

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 inappropriate except as noted in the paragraph below. 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]
[Amended February 2001]

WRITING OF PRESCRIPTIONS

It is the position of the North Carolina Medical Board that prescriptions should be written in ink or indelible pencil or typewritten or electronically printed and should be signed by the practitioner at the time of issuance. Quantities should be indicated in both numbers AND words, 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 should be issued for a patient in the absence of a documented physician-patient relationship.

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

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

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

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

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 and the medical indications for them. Record keeping is too frequently neglected when physicians manage such cases.

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

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

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

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 VALIDATED 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 validated 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 validated 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, January 2001)

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 AHCPR 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 judgment and legal responsibilities of each licensed health professional as to what is in the patient's best interest.

(October 1999)

OFFICE-BASED PROCEDURES

Preface

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

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

General Guidelines

The Physician's Professional and Legal Obligation

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

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

Exemptions

These guidelines do not apply to Level I procedures.

Written Policies and Procedures

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

Emergency Procedure and Transfer Protocol

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

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

Infection Control

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

Performance Improvement

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

Performance improvement activities should include, but are not limited to,

review of mortalities; the appropriateness and necessity of procedures performed; emergency transfers; reportable complications, and resultant outcomes (including all postoperative infections); analysis of patient satisfaction surveys and complaints; and identification of undesirable trends (such as diagnostic errors, unacceptable results, follow-up of abnormal test results, medication errors, and system problems). Findings of the performance improvement program should be incorporated into the practice's educational activity.

Medical Records and Informed Consent

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

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

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

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

Credentialing of Physicians

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

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

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

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

Accreditation

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

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

Patient Selection

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

ASA Physical Status Classifications

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

Candidates for Level II Procedures

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

Candidates for Level III Procedures

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

Surgical or Special Procedure Guidelines

Patient Preparation

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

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

The physician performing the surgical or special procedure also should:

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

Discharge Criteria

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

1. confirmation of stable vital signs;

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

Information to the Patient

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

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

Reportable Complications

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

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

Equipment Maintenance

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

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

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

Compliance with Relevant Health Laws

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

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

Patient Rights

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

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

Enforcement

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

Level II Guidelines

Personnel

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

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

Surgical or Special Procedure Guidelines

Intraoperative Care and Monitoring

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

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

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

Postoperative Care and Monitoring

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

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

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

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

Equipment and Supplies

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

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

Level III Guidelines

Personnel

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

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

Surgical or Special Procedure Guidelines

Intraoperative Monitoring

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

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

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

Postoperative Care and Monitoring

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

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

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

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

Equipment and Supplies

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

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

Definitions

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

AAAHC - the Accreditation Association for Ambulatory Health Care

ABMS - the American Board of Medical Specialties

ACGME - the Accreditation Council for Graduate Medical Education

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

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

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

Anesthesia provider - an anesthesiologist or CRNA.

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

AOA - the American Osteopathic Association

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

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

ASA - the American Society of Anesthesiologists

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

Board - the North Carolina Medical Board.

Conscious sedation - the administration of a drug or drugs in order to induce that state of consciousness in a patient which allows the patient to tolerate unpleasant medical procedures without losing defensive reflexes, adequate cardio-respiratory function and the ability to respond purposefully to verbal command or to tactile stimulation if verbal response is not possible as, for example, in the case of a small child or deaf person. Conscious sedation does not include an oral dose of pain medication or minimal pre-procedure tranquilization such as the administration of a pre-procedure oral dose of a benzodiazepine designed to calm the patient. "Conscious sedation" should be synonymous with the term "sedation/analgesia" as used by the American Society of Anesthesiologists.
Credentialed - a physician that has been granted, and continues to maintain, the privilege by a hospital or ambulatory surgical facility licensed in the jurisdiction in which it is located to provide specified services, such as surgical or special procedures or the administration of one or more types of anesthetic agents or procedures, or can show documentation of adequate training and experience.

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

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

FDA - the Food and Drug Administration.

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

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

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

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

Immediately available - within the office.

JCAHO - the Joint Commission for the Accreditation of Health Organizations

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

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

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

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

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

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

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

Monitoring - continuous, visual observation of a patient and regular observation of the patient as deemed appropriate by the level of sedation or recovery

using instruments to measure, display, and record physiologic values such as heart rate, blood pressure, respiration and oxygen saturation.

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

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

OSHA - the Occupational Safety and Health Administration.

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

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

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

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

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

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

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

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

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

LASER SURGERY

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

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

Laser Hair Removal

Lasers are employed in certain hair-removal procedures, as are various devices that (1) manipulate and/or pulse light causing it to penetrate human tissue and (2) are classified as "prescription" by the U.S. Food and Drug Administration. Hair-removal procedures using such technologies should be performed only by a physician or by an individual designated as having adequate training and experience by a physician who bears full responsibility for the procedure. The responsible supervising physician should be on site or readily available to the person actually performing the procedure.

---

*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; March 2002, August 2002)

CARE OF SURGICAL PATIENTS*

The evaluation, diagnosis, and care of the surgical patient is primarily the responsibility of the surgeon. He or she alone bears responsibility for ensuring the patient undergoes a preoperative assessment appropriate to the procedure. The assessment shall include a review of the patient's data and an independent diagnosis by the operating surgeon of the condition requiring surgery. The operating surgeon shall have a detailed discussion with each patient regarding the diagnosis and the nature of the surgery, advising the patient fully of the risks involved. It is also the responsibility of the operating surgeon to reevaluate the patient immediately prior to the procedure.

It is the responsibility of the operating surgeon to assure safe and readily available postoperative care for each patient on whom he or she performs surgery. It is not improper to involve other licensed health care practitioners in postoperative care so long as the operating surgeon maintains responsibility for such care. The postoperative note must reflect the findings encountered in the individual patient and the procedure performed.

When identical procedures are done on a number of patients, individual notes should be done for each patient that reflect the specific findings and procedures of that operation.

---

*This position statement was formerly titled, "Ophthalmologists: Care of Cataract Patients."

(Adopted September 1991)
(Amended March 2001)

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 famil-

iar 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. 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 basis on which fees are determined, including charges for specific services;
b. b) methods of payment;
c. c) 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. If patient photographs are used, they should be of the physician's own patients and demonstrate realistic outcomes.

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.

**Business letterheads, envelopes, cards, and similar materials are understood to be forms of advertising and publicity for the purpose of this Position Statement.*

(Adopted November 1999)
(Amended March 2001)

SALE OF GOODS FROM PHYSICIAN OFFICES

The physician-patient relationship constitutes a fiduciary relationship between the physician and the patient in the strictest sense of the word "fiduciary." In this fiduciary capacity, physicians have a duty to place the interests of their patients above their own financial or other interests. Inherent in the in-office sale of products is a perceived conflict of interest with regard to physicians' fiduciary duty. Further, the for-profit sale of goods by physicians to patients raises ethical questions that should not intrude on the physician-patient relationship, as does the sale of products that can easily be purchased by patients locally.

On this issue, it is the position of the North Carolina Medical Board that the following guidelines should inform the conduct of physicians.

- Practice related items (such as ointments, creams, and lotions by dermatologists; splints and appliances by orthopedists; eye glasses by ophthalmologists; etc) may be dispensed only after the patient has been told if those items, or generically similar items, can be obtained locally from another source. Any charge made should be reasonable.
- Due to the potential for patient exploitation, physicians are encouraged not to engage in exclusive distributorship and/or personal branding.

Physicians should not sell any non-health related goods from their offices or other treatment settings. (This does not preclude the selling of low-cost, non-health related items for the benefit of charitable or community organizations, provided the physician receives no share of the proceeds, that such sales are conducted only on an occasional basis, and that patients are not pressured into making purchases.)

(Adopted March 2001)

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 paraprofessional 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 2003

DEFINITIONS

Annulment:
Retrospective and prospective cancellation of the authorization to practice.

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

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 or during an investigation. Surrender does not preclude the Board bringing charges against the practitioner.

ANNULMENTS

NONE

REVOCATIONS

KNISELY, Samuel Scott, MD
Location: Greensboro, NC (Guilford Co)
DOB: 7/12/1959
License #: 0093-00190
Specialty: N (as reported by physician)
Medical Ed: Georgetown University (1987)
Cause: By failing to submit himself to a complete physical and psychiatric assessment as directed by the Board, Dr Knisely failed to respond in a reasonable time and manner to a request of the Board. By writing a note on another physician's letterhead without permission so as to create the impression he was that physician's patient when he was not, he attempted to mislead the Board into believing he was trying to comply with the Board's order.
Action: 10/13/2003. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Knisely's medical license is revoked.

NABORS, Dennis Ray, Physician Assistant
Location: Greensboro, NC (Guilford Co)
DOB: 7/26/1950
License #: 0001-02153
PA Education: University of Washington (1976)
Cause: Mr Nabors was convicted of felonies in Guilford County in the three cases of State v. Dennis Ray Nabors. He did not request a hearing within 60 days of receiving the resulting Notice of Revocation from the Board that was served on 5/30/2003.
Action: 9/10/2003. Entry of Revocation issued: Mr Nabors' license was revoked by operation of law on July 30, 2003.

SUSPENSIONS

MAHONY, Cheryl, MD
Location: Kelly, WY
DOB: 7/14/1952
License #: 0000-26563
Specialty: CD/IM (as reported by physician)
Medical Ed: Duke University School of Medicine (1976)
Cause: The Wyoming Board of Medicine summarily suspended Dr Mahony's license based on evidence she had demonstrated a manifest incapacity or incompetence to practice medicine. In December 2002, she entered into a Consent Order with the Wyoming Board, agreeing, among other things, to undergo evaluation by a Board approved psychiatrist, which would involve a diagnosis and treatment plan, possible monitoring by the Wyoming Professional Assistance Program, and evaluation by the Colorado Personalized Education for Physicians program within nine months of her license reinstatement.
Action: 9/17/2003. As a result of a hearing held 8/21/2003, Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Mahony's North Carolina medical license is suspended indefinitely on service of this order. She may petition for reinstatement no sooner than 18 months from the date of service of this order.

See Consent Orders:
BRADEN, Gregory Alan, MD
FRUCHTMAN, Marc Sol, MD
MASSENBURG, O'Laf Sorento, Physician Assistant
MASSLOFSKY, Anthony Paul, Physician Assistant
RIDDLE, William Mark, MD
SELLERS, Marc T., Physician Assistant
SOLAN, Gwen Emily, MD

SUMMARY SUSPENSIONS

LUTZ, Robert Paul, MD
Location: Chapel Hill, NC (Orange Co)
DOB: 5/05/1948
License #: 0000-27387
Specialty: FP (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1982)
Cause: Dr Lutz may be unable to practice medicine with reasonable skill and safety to patients. See Notice of Charges and Allegations dated 10/24/2003.
Action: 10/24/2003. Order of Summary Suspension of License issued.

CONSENT ORDERS

BHIRO, Thakurdeo Michael, Physician Assistant
Location: Laurel Hill, NC (Scotland Co)
DOB: 10/29/1948
License #: 0001-01561
PA Education: U.S. Army Academy (1989)

Cause: In 1997 and 1998, Mr Bhiro saw several patients for chronic pain management but in many cases failed to adequately work up the chronic pain syndromes in a systematic fashion. He often billed for an extended office visit that required a level of complexity not recorded in office notes.
Action: 10/21/2003. Consent Order executed: Mr Bhiro is reprimanded; within one year, he must attend CME courses in pain management and in record keeping approved in writing by the president of the Board.

BRADEN, Gregory Alan, MD
Location: Winston-Salem, NC (Forsyth Co)
DOB: 10/09/1956
License #: 0000-39240
Specialty: CD/IM (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1982)
Cause: Beginning in 2002 and continuing through much of 2003, Dr Braden failed to respond in a reasonable time to the Board's inquiries and requests for information regarding a complaint filed with the Board. He also failed to appear for an informal inquiry at the Board as requested by the Board and, later, failed to appear before the Board when ordered to do so. Dr Braden acknowledges his failure to respond as required is grounds for action by the Board.
Action: 10/17/2003. Consent Order executed: Dr Braden's license is suspended for 45 days effective 12/17/2003; must comply with other conditions.

BREWER, Thomas Edmund, Jr, MD
Location: High Point, NC (Guilford Co)
DOB: 11/04/1956
License #: 0000-28141
Specialty: EM/OM (as reported by physician)
Medical Ed: Wake Forest University School of Medicine (1983)
Cause: Dr Brewer has a history of abuse and use of cocaine, details of which are set forth in a Consent Order issued in 1999. A urine sample Dr Brewer supplied the Board in May 2002 tested positive for cocaine use, which violated the 1999 Consent Order. He voluntarily surrendered his license in June 2002 and signed a contract with the NCPHP. He has complied with his NCPHP contract. He entered into a Consent Order with the Board in December 2002, indefinitely suspending his license but allowing him to reapply after June 18, 2003, which he has done.
Action: 10/30/2003. Consent Order executed: The Board shall reissue Dr Brewer's license to expire on the date shown on the license [2/29/2004]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind- or mood-altering substances; he shall notify the Board within ten days 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 not practice more than 32 hours and no more than four days a week; he may practice only in a setting approved by the president of the Board; must comply with other conditions.

BUZZANELL, Charles Anton, MD
Location: Asheville, NC (Buncombe Co)
DOB: 9/23/1956
License #: 0098-00481
Specialty: AN/APM (as reported by physician)
Medical Ed: Georgetown University School of Medicine (1984)
Cause: On Dr Buzzanell's application for reissuance of his medical license, which he surrendered on 11/01/2002. In September 2002, Patient A, who has a physician-patient relationship with Dr Buzzanell presented to the ER at Pardee Hospital in Hendersonville with suicidal ideations. Dr Buzzanell authorized the ER physician to admit Patient A, but later failed to remember, and denied, he had authorized admission of Patient A. He prescribed his memory loss to his failure to take his prescribed medication. Patient B, who had a patient-physician relationship with Dr Buzzanell, had a history of lung cancer and, in September 2002, Dr Buzzanell performed an intrathecal pump revision on Patient B at Pardee Hospital. Patient B died the following day, leading to a conversation between Dr Buzzanell and the medical examiner, Dr Rholl. Dr Rholl believed Dr Buzzanell was less than forthcoming in discussing Patient B's surgery and said she would have ordered an autopsy had she obtained information she now believes she has regarding the surgery. Dr Buzzanell surrendered his license on 11/01/2002. He has now successfully completed evaluation and treatment at Ridgeview Institute for attention-deficit/hyperactivity disorder NOS and has continued his treatment on an outpatient basis. He has a contract with the NCPHP and the NCPHP reports he is compliant.
Action: 9/16/2003. Consent Order executed: Dr Buzzanell's license is reissued to expire on the date shown on the license [1/31/2004]; he shall limit his practice to no more than 30 hours a week; he shall restrict privileges to one local hospital; he shall not implant intrathecal pumps or spinal column stimulators and tunneled catheter systems; he shall continue his treatment with his health care providers, therapists, and support groups; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

CILIBERTO, Samuel David, MD
Location: Sanford, NC (Lee Co)
DOB: 1/02/1942
License #: 0000-19980
Specialty: ORS (as reported by physician)
Medical Ed: State University of New York, Downstate (1967)
Cause: From July through September 2002, Dr Ciliberto prescribed Valium®, Stadol®, and Phenergan® to Patient A, who was also a physician, without thorough documentation of, among other things, the patient's history and physical examination, appropriate laboratory studies, a working diagnosis and treatment plan, and a rationale for prescribing medications.
Action: 10/27/2003. Consent Order executed: Dr Ciliberto is reprimanded; in future he shall strictly comply with the Board's Position Statement on Contact with Patients Before Prescribing.

COCHRAN, Teresa Jean, Physician Assistant
Location: Goldsboro, NC (Wayne Co)
DOB: 7/15/1961
License #: 0001-01516
PA Education: Alderson-Broaddus (1991)
Cause: From 3/10/2003 through 4/01/2003, Ms Cochran practiced as a PA prior to submitting the required Notice of Intent to Practice form. On 4/02/2003, she submitted the proper form.
Action: 9/18/2003. Consent Order executed: Ms Cochran is reprimanded; must comply with other conditions.

DELLACONA, Salvatore John, MD
Location: Macon, GA
DOB: 10/27/1949
License #: 0000-29102
Specialty: ESM/IM (as reported by physician)
Medical Ed: University Autonoma Guadalajara (1979)
Cause: Dr Dellacona was disciplined by the Georgia Board in June 2001. He was reprimanded and fined, and was required to complete CME having to do with his treatment of a particular patient the Georgia Board found was not treated in conformity with minimal standards. He has complied with the Public Consent Order of the Georgia Board.
Action: 10/16/2003. Consent Order executed: Dr Dellacona is reprimanded.

DYLIK, Jason, MD
Location: Durham, NC (Durham Co)
DOB: 8/07/1970
License #: Resident Training License
Specialty: EM (as reported by physician)
Medical Ed: St George's University School of Medicine, Grenada (2002)
Cause: Relating to Dr Dylik's application for an RTL. Dr Dylik admits he provided false and misleading information to members of the Board in August 2003 when discussing discrepancies that appear on his application for a resident training license. He has taken steps and has agreed to take further steps to ensure he can safely practice medicine.
Action: 9/03/2003. Consent Order executed: Dr Dylik is issued an RTL to expire on the date shown on the license; 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 current and prospective employers, including his residency program director and the graduate education office at Duke University; he shall begin psychiatric treatment with a psychiatrist approved by the NCPHP and shall comply with recommendations made by the psychiatrist; he shall direct the psychiatrist to send quarterly reports to the Board; must comply with other conditions.

FRUCHTMAN, Marc Sol, MD
Location: Salisbury, NC (Rowan Co)
DOB: 3/07/1967
License #: 0097-00248
Specialty: FPG (as reported by physician)
Medical Ed: Medical University of South Carolina (1994)
Cause: Dr Fruchtman began treating Patient A at Rowan Primary Care in the fall of 1997. He last treated Patient A in June 1998. Following that, Dr Fruchtman's wife began treating Patient A. In November 1998, Patient A began working as a secretary at Rowan Primary Care. Beginning in January 1999, Dr Fruchtman engaged in a consensual sexual relationship with Patient A that lasted about three years. Patient A remained a patient of Dr Fruchtman's wife until about September 1999. Dr Fruchtman began treating Patient B, Patient A's husband, in October 1997. In January 2001, Patient B discovered the relationship between his wife, Patient A, and Dr Fruchtman when he found them kissing in the home of Patients A and B. Shortly afterwards, Dr Fruchtman disclosed the affair to his wife and later moved into the home of Patients A and B with their approval. He lived with Patients A and B until about July 2001. Dr Fruchtman continued treating Patient B as his family physician until about August 2001. On February 27, 2002, Patient A called Patient B and asked him to pick her up at Dr Fruchtman's house. When Patient B arrived, an altercation between Patient B and Dr Fruchtman ensued.
Action: 8/21/2003. Consent Order executed: Dr Fruchtman's license is suspended indefinitely. He may petition for reinstatement no sooner than 12 months from the date of the Consent Order.

HEGE, Keith Jerome, Physician Assistant
Location: Winston-Salem, NC (Forsyth Co)
DOB: 1/23/1956
License #: 0001-00981
PA Education: Bowman Gray (1986)
Cause: In August, 2001, while working as a PA in Yadkinville, Mr Hege met with the NCPHP and admitted he had a history of opiate dependency but was clean and sober from 1986 until his relapse in 2001. During that meeting, he signed a contract with the NCPHP, agreeing to abstain from mood changing chemicals, including alcohol, unless prescribed by a physician and approved by the NCPHP. He also entered an inpatient treatment program. In November 2002, he lost his job because he authorized refills of patient prescriptions early without proper chart documentation or approval. He underwent further assessment in 2002 at the Ridgeview Institute in Georgia, where he was diagnosed with opiate dependency, sedative-hypnotic drug abuse, and ADD. In 2003, he completed a 14 week inpatient treatment program. He was cleared by the NCPHP to return to work. In July 2003, Mr Hege was contacted by Patient A, who had been treated by him before, and asked to provide care for her again. Although Patient A missed her appointment with Mr Hege's supervising physician, Mr Hege wrote her a prescription without examining her. In August 2003, a Winston-Salem pharmacist told the Board Patient A was frequently re-filling the prescription written for her by Mr Hege. On several occasions, Mr Hege picked up medications and other items and personally delivered them to Patient A. Later in August 2003, a Board investigator conducted a site check at Hoots Memorial Hospital and found Mr Hege was not in compliance with the Board's rules for PAs in that he did not have in place a required Statement of Supervisory Arrangements. At the same time, the investigator collected a urine sample from Mr Hege that showed the presence of alcohol in Mr Hege's system. In September 2003, the NCPHP conducted a saliva screen on Mr Hege that revealed low levels of methadone hydrochloride in Mr Hege's system. In October 2003, Mr Hege met with members of the Board and, later, provided the Board copies of his Statement of Supervisory Arrangements. On October 28, he surrendered his PA license.
Action: 10/28/2003. Consent Order executed: Mr Hege is reprimanded and is issued a temporary license to expire on the date shown on the license [2/28/2004]; he shall immediately surrender his DEA registration; he shall complete a CME course on professional boundaries; he shall be subject to and comply with random drug screens; he shall maintain and abide by his contract with the NCPHP; must comply with other conditions.

HORTON, Tiffany, Physician Assistant
Location: Snow Hill, NC (Greene Co)
DOB: 2/10/1970
License #: 0001-03683
PA Education: University of Utah (2002)
Cause: Ms Horton admits and the Board finds that Ms Horton practiced as a PA under supervision of Michael Lawrence, MD, from December 2002 through January 2003, prior to submitting the required Notice of Intent to Practice form to the Board. She was informed by the Board that she must submit the required form and get an acknowledgement from the Board that the form was received before practicing. Ms Horton continued to practice prior to receiving Board approval and submitted the required form on February 27, 2003.
Action: 8/21/2003. Consent Order executed: Ms Horton is reprimanded.

LOVETTE, Kenneth Maurice, MD
Location: Tarboro, NC (Edgecombe Co)
DOB: 12/27/1949
License #: 0000-24606
Specialty: GYN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1979)
Cause: Relating to Dr Lovette's request that his Consent Order of 10/30/2002 be amended. In that Consent Order, he admitted to professional sexual misconduct and he was, among other things, prohibited from supervising physician extenders. He asks the restriction prohibiting him from supervising physician extenders now be eliminated. It appears Dr Lovette is complying with his 10/30/2002 Consent Order, including the requirement he maintain and abide by a contract with the NCPHP. Therefore, the Board has agreed with his request.
Action: 8/07/2003. Consent Order executed: Dr Lovette's license is reissued to expire on the date shown thereon [10/21/2003]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind- or mood-altering substances, and he shall refrain from the use of alcohol; he shall notify the Board within 10 days 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.

MASSENBURG, O'Laf Sorento, Physician Assistant
Location: Winston-Salem, NC (Forsyth Co)
DOB: 2/10/1960
License #: 0001-01117
PA Education: Bowman Gray (1988)
Cause: Relating to reissuance of Mr Massenburg's PA license. In 2000, Mr Massenburg was indicted in the U.S. District Court for the Middle District of North Carolina for multiple counts of conspiracy to submit false claims and making false entries. In May 2001, he pled guilty to one count of conspiracy to submit false claims and two counts of submitting false claims involving Medicare. He was sentenced to six months imprisonment in a community corrections center facility. He was also fined $6,000 and held jointly and severally responsible for $200,000 in restitution. In April 2002, he surrendered his PA license. He has now completed his term of imprisonment and paid all fines and restitution.
Action: 8/01/2003. Consent Order executed: Mr Massenburg's PA license was suspended from 4/19/2002 to the date shown on the license issued pursuant to this Consent Order; the Board

reissues Mr Massenburg's PA license to expire on the date shown on the license [1/31/2004]; he shall practice only in a setting approved by the president of the Board in writing; he agrees to provide truthful information about any and all criminal activity or unprofessional conduct within his knowledge to the Board and to testify truthfully in any hearings or other proceedings of the Board; must comply with other conditions.

MASSLOFSKY, Anthony Paul, Physician Assistant
Location: Semora, NC (Caswell Co)
DOB: 7/31/1944
License #: 0001-02338
PA Education: University of Medicine and Dentistry of New Jersey (1997)
Cause: While practicing in Yanceyville in late 1998, Mr Masslofsky's supervising physicians became concerned he was asking patients about their sexuality in ways that made some patients uncomfortable and were inappropriate. At the request of his supervising physicians, he resigned from the practice. On his 1999 North Carolina annual registration form, he answered "no" to a question asking if he had had any such disciplinary action taken against him since he last registered. In 2002, asked a similar question on his application for a PA license in Alaska, he answered "yes" and referred to his departure from the Caswell Family Medical Center. Mr Masslofsky contends he did not intend to mislead the North Carolina Medical Board on his 1999 registration form, believing the question did not relate to departure from employment, but he admits his response could reasonably be seen as misleading. When asked about his questioning of patients about their sexuality and about his response on his registration form, he was fully cooperative. On his own initiative, he submitted himself to the NCPHP and, at its recommendation, to an evaluation by psychologist Christopher Norris, PhD. The NCPHP and Dr Norris concluded Mr Masslofsky does not and never did pose a danger to patients.
Action: 9/18/2003. Consent Order executed: Mr Masslofsky's PA license in suspended for 12 months. Said suspension is stayed on condition that he maintain and abide by a contract with the NCPHP, that he follow the recommendations of the NCPHP, and that during the 12 months of stayed suspension he obtain approval of his practice site from the president of the Board.

McKINNON, Steven Malone, MD
Location: Statesville, NC (Iredell Co)
DOB: 2/07/1952
License #: 0000-27825
Specialty: OPH (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1979)
Cause: In the U.S. District Court for the Western District of North Carolina, Dr McKinnon pled guilty to misdemeanor Willful Failure to File a Tax Return.
Action: 8/20/2003. Consent Order executed: Dr McKinnon is reprimanded.

MELONE, George Anthony, Jr, MD
Location: Chapel Hill, NC (Orange Co)
DOB: 7/09/1960
License #: 0000-32793
Specialty: EM (as reported by physician)
Medical Ed: Pritzker School of Medicine, University, Chicago (1986)
Cause: In 2002, Dr Melone pled guilty in Wake County District Court to three counts of Willful Failure to File Individual Income Tax for years 1998, 1999, 2000. He was sentenced to 45 days in jail, the sentence being suspended for 24 months. He was placed on supervised probation, supervision to be lifted when he filed past due returns and paid all due taxes.
Action: 8/21/2003. Consent Order executed: Dr Melone is reprimanded.

RIDDLE, William Mark, MD
Location: Faison, NC (Duplin Co)
DOB: 3/20/1956
License #: 0000-39871
Specialty: FP/ADDM (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1985)
Cause: Dr Riddle surrendered his license in September 1997 after being confronted about his diversion and abuse of hydrocodone. Pursuant to a Consent Order in October 1998, Dr Riddle was issued a temporary license with conditions related to substance abuse. The Consent Order was amended in September 1999. In November 1999, Dr Riddle surrendered his license after he violated his Consent Order by self-prescribing tramadol hydrochloride and by working more than 40 hours per week. Pursuant to a Consent Order of June 2000, Dr Riddle was issued a temporary license with conditions related to substance abuse. The Consent Order was amended in March 2001. It was amended again in November 2001 to allow him to obtain DEA registration to prescribe controlled substances. Dr Riddle complied with the conditions of his Consent Order and the Board terminated the Consent Order in November 2002, issuing Dr Riddle a full and unrestricted license. In February 2003, Dr Riddle surrendered his license after being confronted by a staff member of the NCPHP about his diversion and abuse of a controlled substance and his attempt to substitute someone else's urine for his own when producing a urine sample for a drug screen.
Action: 8/22/2003. Consent Order executed: Dr Riddle's license is suspended indefinitely. He shall not reapply for a license for a minimum of one year.

SELLERS, Marc T., Physician Assistant
Location: Andrews, NC (Cherokee Co)
DOB: 6/15/1963
License #: 0001-01580
PA Education: Bowman Gray School of Medicine (1992)
Cause: Mr Sellers admits he improperly obtained a prescription for hydrocodone cough syrup in November 2001. He voluntarily received substance abuse treatment from January 2002 through April 14, 2002. He signed a contract with the NCPHP in December 2001 and has been compliant with that contract.
Action: 8/26/2003. Consent Order executed: Mr Seller's license is suspended for 30 days, which suspension is stayed on execution of this Consent Order; 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; he shall notify the Board within 10 days 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.

SMITH, Laurie, Physician Assistant
Location: Waynesville, NC (Haywood Co)
DOB: 3/12/1955
License #: 0001-00947
PA Education: Emory School of Medicine (1986)
Cause: Ms Smith admits and the Board finds that Ms Smith began practicing with John Paul Martin, MD, her new primary supervising physician, in June 2000 even though she had not received from the Board an acknowledgment that it had gotten the required Notice of Intent to Practice form from her. The Board became aware of this matter when Ms Smith asked the Board in April 2001 for a copy of her Notice of Intent to Practice with Dr Martin. She was told the Board had no such Notice of Intent to Practice and she promptly submitted the required paperwork. In May 2001, a Board investigator visited Ms Smith's practice and found all the other required paperwork was in order.
Action: 9/24/2003. Consent Order executed: Ms Smith is reprimanded.

SOLAN, Gwen Emily, MD
Location: Holly Ridge, NC (Onslow Co)
DOB: 6/25/1958
License #: 0094-00399
Specialty: GP/FP (as reported by physician)
Medical Ed: George Washington University (1985)
Cause: Between June and November 2000, Dr Solan diverted Lortab® and Percocet® for her personal use. In doing so, she issued prescriptions in the names of one or two employees, giving them money to pick up the prescriptions for her. From December 2000 to April 2001, she diverted those same drugs to her own use by issuing a prescription in the name of a patient, again providing money for the patient to pick up the drugs for her. On at least two occasions, she attempted to document the reason for the prescriptions by creating a false office

chart indicating she had seen the patient when she had not done so. She also diverted Percocet® for her own use in early 2001 by issuing prescriptions to another patient, who subsequently gave Dr Solan the drug. She again created a fictitious record to document the prescriptions. In 2000, a representative of the NCPHP, acting under the contract between the NCPHP and Dr Solan, requested a urine sample from Dr Solan for drug screening. Knowing she would test positive, Dr Solan asked an employee to go to the bathroom to provide a sample for her. In March 2003, Dr Solan pled guilty in Onslow County Superior Court to distributing controlled substances in violation of NCGS ß90-108 (a) (2). She was sentenced to 45 days, which sentence was suspended. She was placed on 18 months probation on condition she continue psychiatric treatment, be subject to searches and random drug screens, and not possess any controlled substance without a valid prescription. She was also fined $150 and assessed $200 in court costs.

Action: 10/16/2003. Consent Order executed: Dr Solan's North Carolina medical license is suspended indefinitely effective 10/16/2003. She may petition for reinstatement of her license no sooner than 15 months from the date of this action.

MISCELLANEOUS ACTIONS

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL

GARTRELL, Douglas Mervyn, MD
Location: Lake Oswego, OR
DOB: 6/17/1959
License #: 0093-00471 [surrendered 4/19/1999]
Specialty: P/CHP (as reported by physician)
Medical Ed: Duke University School of Medicine (1987)
Cause: The Board received information that in December 2002 Dr Gartrell was arrested in Jacksonville, NC, and charged with felonious possession of cocaine and other offenses.
Action: 4/08/2003. Application for medical license denied.

SURRENDERS

HARRIS, John Joel, Jr, MD
Location: Lumberton, NC (Robeson Co)
DOB: 6/30/1958
License #: 0000-32114
Specialty: AN (as reported by physician)
Medical Ed: University of Tennessee (1984)
Action: 9/02/2003. Voluntary surrender of medical license.

HEGE, Keith Jerome, Physician Assistant
Location: Winston-Salem, NC (Forsyth Co)
DOB: 1/23/1956
License #: 0001-00981
PA Education: Bowman Gray (1986)
Action: 10/28/2003. Voluntary surrender of PA license.

MURTUZA, Sarwar, MD
Location: North Wilkesboro, NC (Wilkes Co)
DOB: 1/07/1951
License #: 0000-33721
Specialty: IM/FP (as reported by physician)
Medical Ed: Osmania Medical College, India (1976)
Action: 9/30/2003. Voluntary surrender of medical license.

COURT APPEALS/STAYS

NONE

CONSENT ORDERS LIFTED

CARBALLO, Frank Edward, MD
Location: Lumberton, NC (Robeson Co)
DOB: 4/30/1963
License #: 0000-35291
Specialty: IM (as reported by physician)
Medical Ed: University of South Florida (1989)
Action: 10/01/2003. Order issued lifting Consent Order of 10/04/2002.

DeVANE, Evelyn Johnson, Nurse Practitioner
Location: Hampstead, NC (Pender Co)
DOB: 10/01/1953
Approval #: 0002-00298
NP Education: NA
Action: 10/01/2003. Order issued lifting Consent Order of 4/13/2002.

GOUBRAN, Michel Zaki, MD
Location: Dunn, NC (Harnett Co)
DOB: 2/15/1935
License #: 0000-21039
Specialty: OBG/REN (as reported by physician)
Medical Ed: University Ein Shams, Egypt (1962)
Action: 9/05/2003. Order issued lifting Consent Orders of 8/29/2002 and 4/30/2003.

TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES

CARBALLO, Frank Edward, MD
Location: Lumberton, NC (Robeson Co)
DOB: 4/30/1963
License #: 0000-35291
Specialty: IM (as reported by physician)
Medical Ed: University of South Florida (1989)
Action: 8/21/2003. Full and unrestricted license issued.

CARLSON, James Lennart
Location: Cerro Gordo, NC (Columbus Co)
DOB: 11/20/1959
License #: 2002-00010
Specialty: FP (as reported by physician)
Medical Ed: Medical College of Wisconsin (1991)
Action: 10/16/2003. Temporary/dated license extended to expire 2/29/2004.

EURE, Luther Haywood, Jr, MD
Location: Reidsville, NC (Rockingham Co)
DOB: 9/11/1963
License #: 0093-00102
Specialty: OBG (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1989)
Action: 9/18/2003. Temporary/dated license extended to expire 3/31/2004.

GOUBRAN, Michel Zaki, MD
Location: Dunn, NC (Harnett Co)
DOB: 2/15/1935
License #: 0000-21039
Specialty: OBG (as reported by physician)
Medical Ed: University Ein Shams, Egypt (1962)
Action: 8/21/2003. Full and unrestricted license issued.

LOVETTE, Kenneth Maurice, MD
Location: Tarboro, NC (Edgecombe Co)
DOB: 12/27/1949
License #: 0000-24606
Specialty: GN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1979)
Action: 10/16/2003. Temporary/dated license extended to expire 7/31/2004.

McCLELLAND, Scott Richard, DO
Location: Wilmington, NC (New Hanover Co)
DOB: 7/19/1948
License #: 0000-29064
Specialty: P (as reported by physician)
Medical Ed: Kirksville College of Osteopathic Medicine (1980)
Action: 8/21/2003. Temporary/dated license extended to expire 2/28/2004.

NEWTON, Jimmie Isaac, MD
Location: Winston-Salem, NC (Forsyth Co)
DOB: 11/29/1938

License #: 0000-14269
Specialty: OBG (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1964)
Action: 10/16/2003. Full and unrestricted license issued.

SHIVE, Robert MacGregor, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 11/02/1933
License #: 0000-13226
Specialty: P (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1961)
Action: 8/21/2003. Temporary/dated license extended to expire 9/30/2003.

SHIVE, Robert Macgregor, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 11/02/1933
License #: 0000-13226
Specialty: P (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1961)
Action: 9/18/2003. Full restricted license issued.

THOMPSON, Robert Bruce, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 2/29/1956
License #: 0000-40006
Specialty: N/EM (as reported by physician)
Medical Ed: University of Miami School of Medicine (1987)
Action: 10/16/2003. Temporary/dated license extended to expire 2/29/2004.

VAUGHAN, Howell Anderson, Physician Assistant
Location: Fuquay-Varina, NC (Wake Co)
DOB: 3/31/1958
License #: 0001-01513
PA Education: Wake Forest University (1992)
Action: 9/18/2003. Temporary/dated license extended to expire 3/31/2004.

See Consent Orders:
BREWER, Thomas Edmund, Jr, MD
BUZZANELL, Charles Anton, MD
HEGE, Keith Jerome, Physician Assistant
MASSENBURG, O'Laf Sorento, Physician Assistant

DISMISSALS

GEORGE, Pazhayidathe K., MD
Location: Zebulon, NC (Wake Co)
DOB: 5/16/1939
License #: 0000-27457
Specialty: IM/GE (as reported by physician)
Medical Ed: Trivandrum, India (1964)
Action: 10/22/2003. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Notice of Charges and Allegations of 10/18/2002 is dismissed following a hearing before the Board on 9/19/2003. The Board found no evidence that Dr George touched the breasts of Patients A, B, and C for his own sexual gratification.

GIRGIS, Sobhi Anis, MD
Location: Cordova, SC
DOB: 7/24/1938
License #: 0000-25913
Specialty: GER (as reported by physician)
Medical Ed: Alexandria University, Egypt (1964)
Action: 9/08/2003. Notice of Dismissal issued: the Notice of Charges and Allegations of 3/13/2001 is dismissed without prejudice.

HINES, Robert Lee, MD
Location: Fayetteville, NC (Cumberland Co)
DOB: 5/05/1949
License #: 0000-24831
Specialty: U (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1978)
Action: 9/17/2003. Order Allowing Motion to Dismiss Without Prejudice and Order to Appear for Informal Interview issued: it appearing Dr Hines has complied with the Board's Order for Examination, that he has been determined to be fit for practice by a psychiatrist chosen by the Board, and that he has no prior record with the Board, the Notice of Charges and Allegations of 2/20/2003 is dismissed without prejudice, in accord with the motion by Dr Hines, and he is ordered to appear for an informal interview before a panel of the Board in October 2003.

SMITH, Laurie, Physician Assistant
Location: Waynesville, NC (Haywood Co)
DOB: 3/12/1955
License #: 0001-00947
PA Education: Emory School of Medicine (1986)
Action: 9/24/2003. Notice of Dismissal with Prejudice issued in the matter of the North Carolina Medical Board versus Laurie Smith, PA. The matter has been resolved through a Consent Order.

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.

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

North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: February 18-19, 2004; March 17-19, 2004; April 21-22, 2004
May 19-21, 2004; June 16-17, 2004

Residents Please Note USMLE Information

United States Medical Licensing Examination Information (USMLE Step 3)

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

Special Purpose Examination (SPEX)

The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at PO Box 619850, Dallas, TX 75261-9850, or telephone (817) 868-4000.

North Carolina Medical Board
1203 Front Street
Raleigh, NC 27609