

forum

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

Meeting the Challenge
of Change
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From the Executive Director

Billing for Certain Anatomic Pathology Services¹



R. David Henderson

On December 1, 2005, a new law went into effect changing the way some entities, including physicians, must bill for anatomic pathology services (Session Law 2005-415, s. 1). This article provides notice of the new law to Medical Board licensees.²

Disclosure Part 1: Amount charged, Name of Licensed Practitioner

Session Law 2005-415 requires Medical Board licensees³ who bill for anatomic pathology services performed by an outside lab, *and* add a “mark-up” to the lab’s charge, to disclose the following items conspicuously on the itemized bill, statement, or in a separate itemized disclosure statement:

1. the amount charged by the laboratory for the anatomic pathology service;
2. any other charge that has been included in the bill; and
3. the name of the licensed practitioner performing or supervising the anatomic pathology service.

There are exceptions to this portion of the disclosure requirement. This portion of the new law’s disclosure requirements does not apply to:

1. a licensed practitioner performing or supervising anatomic pathology services; or
2. a hospital or physician group practice where a physician employee or physician under contract to a hospital or a

- physician group practice is providing or supervising anatomic pathology services and is compensated by the hospital or physician group practice for the services; or
3. a referring laboratory providing anatomic pathology services, for services performed by that laboratory, in instances where one or more samples must be sent for a second medical opinion on a specimen.

Disclosure Part 2: Name and Address of Laboratory

Session Law 2005-415 requires that physicians who bill for anatomic pathology services performed by an outside lab, even if they do not add anything to the amount charged by the laboratory, disclose the name and address of the laboratory performing the professional component of the service. This requirement complements another provision of the new law that makes it a Class I felony for an out-of-state person to practice medicine without a North Carolina medical license.⁴

Clarifying Provisions

The General Assembly included provisions to preempt two possible interpretations of the statute. First, it has precluded any interpretation of the new law to require the disclosure of the terms or conditions of a contract for the provision of anatomic pathology services between a managed care organization and physician’s practice. Second, it has precluded any interpretation that a physician is prohibited from requesting the anatomic pathology services of more than one clinical laboratory for a second medical opinion on a specimen.

Enforcement and Penalties

Each intentional failure to disclose is a separate Class 3 mis-

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Primum Non Nocere

forum

NC MEDICAL BOARD

Raleigh, NC

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The *Forum* of the North Carolina Medical Board is published four times a year. Articles appearing in the *Forum*, including letters and reviews, represent the opinions of the authors and do not necessarily reflect the views of the North Carolina Medical Board, its members or staff, or the institutions or organizations with which the authors are affiliated. Official statements, policies, positions, or reports of the Board are clearly identified.

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

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demeanor offense punishable by a fine of \$250.00. The Board may take disciplinary action against a licensee if it finds an intentional violation or an ongoing pattern of violations in the absence of a misdemeanor conviction.

Conclusion

Session Law 2005-415 can be viewed by going to the Medical Board's Web site: www.ncmedboard.org. Please familiarize yourself with this new law to avoid disciplinary action by the Medical Board or criminal prosecution. If you have any questions, please contact a health care attorney or contact me at david.henderson@ncmedboard.org or PO Box 20007, Raleigh, NC 27619.

¹This article is based on the Notice for Physicians that appears on the Board's Web site: www.ncmedboard.org.

²Physicians who do not bill anyone for anatomic pathology services, as defined in G.S. § 90-701(e), are not affected by the new law. N.C. Gen. Stat. § 90-701(e) states:

As used in this section, the term "anatomic pathology services" means:

1. Histopathology or surgical pathology meaning the gross and microscopic examination and histologic processing of organ tissue performed by a physician or under the supervision of a physician;
2. Cytopathology meaning the examination of cells from fluids, aspirates, washings, brushings, or smears, including the Pap test examination performed by a physician or under the supervision of a physician;
3. Hematology meaning the microscopic evaluation of bone marrow aspirates and biopsies performed by a physician or under the supervision of a physician, and peripheral blood smears when the attending or treating physician or technologist requests that a blood smear be reviewed by a pathologist;
4. Subcellular pathology and molecular pathology; and
5. Blood banking services performed by pathologists.

³Other groups not licensed by the Medical Board are also affected by the bill, including podiatrists, dentists, and hospitals.

⁴Session Law 2005-415, s. 2

NCMB Policy Committee Continues Review of Position Statements, Offers Results of Recent Review for Comment

The Policy Committee of the North Carolina Medical Board is continuing its review of the Board's various position statements. The Board's licensees and others interested in the subjects dealt with by the statements are invited to offer comments in writing to the Board, by e-mail or post, for consideration as part of the review process. Comments should be addressed to the Policy Committee of the North Carolina Medical Board and posted to PO Box 20007, Raleigh, NC 27619, or e-mailed to info@ncmedboard.org.

The Policy Committee will discuss the statements scheduled for consideration in public sessions during regularly scheduled meetings of the Board. Interested parties are invited to attend those sessions as observers. The results of each review will be published on the Board's Web site and in the *Forum*, and further written comments will be invited to assist the Policy Committee in preparing a final version of the statement for Board action.

The schedule currently set for statement review is noted below, though changes to the review schedule will occur from time to time. Those wishing to attend should check dates and times on the Board's agenda, which is posted on the Board's Web site several days before each meeting. They may also telephone the Board's office for information concerning meeting times.

March 15, 2006

- "Sexual Exploitation of Patients"
- "The Physician-Patient Relationship"
- "Care of Surgical Patients"

May 17, 2006

- "Retention of Medical Records"
- "Medical Record Documentation"
- "The Retired Physician"

Results of November 16 Review

The Policy Committee of the North Carolina Medical Board met on November 16, 2005, and completed initial review of two position statements. It made the following recommendations on the statements. Those interested in offering the Committee comments on its recommendations may do so as noted in the first paragraph above.

1. The Committee recommended that no change be made to the Position Statement titled "Prescribing Legend or Controlled Substances for Other Than Valid Medical or Therapeutic Purposes, with Particular Reference to Substances or Preparations with Anabolic Properties." The current text may be found in the full list of Position Statements published in this *Forum*.
2. The Committee recommended that the Position Statement titled "Sale of Goods from Physician Offices" be amended. The proposed change appears below, with deletions and additions indicated.

SALE OF GOODS FROM PHYSICIAN OFFICES

~~The Physician-Licensee-patient relationship constitutes a fiduciary relationship with the patient. In this capacity, there is a duty to place the financial or other interest of the patients above their own.~~

Inherent in the in-office sale of products is a perceived conflict of interest. On this issue, it is the position of the North Carolina Medical Board that the following instructions should guide the conduct of physicians or licensees.

Sale of practice-related items such as ointments, creams and lotions by Dermatologists, splints and appliances by Orthopedists, spectacles by Ophthalmologists, etc., may be acceptable only after the patient has been told those or similar items can be obtained locally from other sources. Any charge made should be reasonable.

Due to the potential for patient exploitation, the Medical Board opposes licensees participating in exclusive distributorships and/or personal branding, or persuading patients to become dealers or distributors of profit making goods or services.

Licensees should not sell any non health-related goods from their offices or other treatment settings. (This does not preclude selling of such low cost items on an occasional basis for the benefit of charitable or community organizations, provided the licensee receives no share of the proceeds, and patients are not pressured to purchase.)

All decisions regarding sales of items by the physician or his/her staff from the physician's office or other place where health care services are provided, must always be guided by what is in the patient's best interest.

(Adopted March 2001)

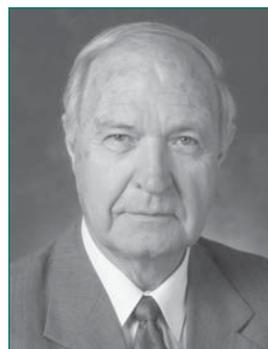
(Amendment Proposed November 2005)

NCMB Installs Officers: Robert C. Moffatt, MD, President; H. Arthur McCulloch, MD, President Elect; Janelle A. Rhyne, MD, Secretary; Aloysius P. Walsh, Treasurer

On November 1, 2005, Robert C. Moffatt, MD, of Asheville, took office as president of the North Carolina Medical Board and H. Arthur McCulloch, MD, of Charlotte, became president elect. Janelle A. Rhyne, MD, of Wilmington, assumed the office of secretary, and Aloysius P. Walsh, of Greensboro, became treasurer. Their terms will run until October 31, 2006.

Robert C. Moffatt, MD, President

Dr Robert C. Moffatt, president of the Board, is a native of Tennessee and took his BA degree from East Tennessee State University. He earned his MD degree at the University of Tennessee Center for Health Sciences, Memphis, and did his internship at Memorial Mission Hospital in Asheville. He completed his resi-



Dr Moffatt

dency training in surgery at the University of Georgia College of Medicine and did a surgical oncology fellowship at Memorial Sloan Kettering Cancer Center. He holds certification from the American Board of Surgery, is a fellow of the American College of Surgeons, and is licensed in North Carolina, Georgia, and Mississippi. He was appointed to the Board in 2001 and has served on several committees, including the Executive, Investigative, Licensing,

and Physicians Health Program Committees. He was elected secretary of the Board in February 2003 and took office as president elect in November 2004.

Dr Moffatt holds appointments at Memorial Mission Hospital and St Joseph's Hospital in Asheville. His practice is focused on surgical oncology. He has served as president of the Buncombe County Medical Society and is a member of the North Carolina Medical Society, the American Medical Association, and numerous other professional organizations. He was also Buncombe County medical examiner for seven years. Active in community affairs, over the years he has been on the Asheville Symphony Society Board, the King College (Bristol, TN) Board of Visitors and Board of Trustees, and the Mountain Ramparts Health Planning Council. He has also served as president of the Asheville Lyric Opera. Among other honors, he was made a member of the Governor's Order of the Long Leaf Pine by Governor James B. Hunt, Jr.

H. Arthur McCulloch, MD, President Elect



Dr McCulloch

A native of Ohio, Dr H. Arthur McCulloch, the Board's president elect, received a BA from Ohio State University and took his MD from the Medical College of Ohio. He did his internship at St Thomas Hospital Medical Center in Akron, Ohio, and his residency in anesthesiology at North Carolina Memorial Hospital.

Following his residency, he was a staff anesthesiologist at Wilford Hall USAF Medical Center. He is a diplomate of the American Board of Anesthesiology and is a clinical assistant professor of anesthesiology at the University of North Carolina. He practices with Southeast Anesthesiology Consultants, in Charlotte, and is vice chief of the Department of Anesthesiology at Carolinas Medical Center.

Dr McCulloch is an active member of the North Carolina Medical Society and, among other things, has served on its MedPAC Board and its Task Force on Office-Based Surgery. He is also a member of the North Carolina Society of Anesthesiologists, serving on that organization's Executive Committee and as its current president. He is a member of the House of Delegates of the American Society of Anesthesiologists. He was appointed to the Board in 2002 and has served as the Board's treasurer and secretary. He has served on several Board committees and is chair of its Policy Committee.

Dr McCulloch is co-author of three journal articles.

Janelle A. Rhyne, MD, Secretary

Dr Janelle A. Rhyne, of Wilmington, the Board's

new secretary, 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 precepting 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

Dr Rhyne is a member of numerous professional societies, including, among others, the American College of Physicians, of which she is a fellow, 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. 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 2004, she was presented the Ralph E. Snyder, MD, Award of Excellence in Healthcare Quality Improvement from Medical Review of North Carolina, Inc.

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. She was appointed to the Board in 2003, has served on several Board committees and chairs the Investigative Committee. She served as the Board's treasurer over the past year.

Aloysius P. Walsh, Treasurer



Mr Walsh

Mr Aloysius P. Walsh, of Greensboro, NC, the Board's new treasurer, is a graduate of the University of Scranton. He pursued studies in law at Temple University School of Law and 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. He has 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, the Task Force on Office Based Surgery, and the Board's Executive Committee. He chairs the Board's Complaints and Malpractice Committees. 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.

A Personal Reflection

My Odyssey Towards Peace

Dr L

A North Carolina Physician

In addition to referrals for substance abuse, the North Carolina Physicians Health Program is frequently called upon to assist in cases of "disruptive behavior." While it is not clear that disruptive behavior by physicians or physician assistants is any more prevalent today than in years past, it is certainly true that such behaviors are receiving increasing attention from practices and hospitals. Because the individual in question may not understand his or her impact on others, these behavioral cases can be difficult to address and resolve. Therefore, an important factor in a successful outcome is the individual's ability to accept his own role as part of the problem.

The following memoir was written by a physician who was initially quite reluctant to work with the NCPHP. He shares his personal journey to greater understanding and personal satisfaction in an effort to help others via his experience.

What can I say? From the age of five, I somehow knew I wanted to become a doctor. At that time, my idea of "doctor" most likely came from interacting with my pediatrician and television. I would be the first in my family to enter the medical profession. Little did I

know what the future held for me.

Studies came easy, even through medical school. I devoted far less time to studying than my friends seemed to need. Despite this, I graduated with honors at the top of my medical school class. I hadn't been pushed to my limits yet—or so I thought.

As I look back, I did have some interpersonal conflicts in medical school. Some classmates, and some residents who were my supervisors, found out what kind of a temper I had. I was critical and judgmental, and I was quick to let others know when they were not achieving the standards of care I expected. My attendings just thought that I was a "natural," and did not reprimand me for the rare occasion when I lost my temper. They simply thought I was exercising my individual judgment because I was an advanced student. I didn't critically examine what this behavior represented, nor did I care where it came from. Righteous indignation: I was right, they were wrong. They deserved to be chewed out, right?

I left medical school on Cloud Nine. With nothing but success in the rearview mirror, I marched into my internal medicine residency at a Top 5 institution with a reputation for being a "malignant" program. Yeah,

"Some classmates, and some residents who were my supervisors, found out what kind of a temper I had"

sure, “malignant.” That’s the sort of thing a “soft” person says about an appropriately tough program. With an arrogant series of assumptions, I figured I would breeze through just like I had every stage of my education to date.

Then came the wake-up call: after only two months of internship, I experienced my first episode of clinical depression, suicidal thoughts and all. I couldn’t sleep! I was wrought with anxiety during the first few months of internship. I somehow convinced myself that I needed to know *everything*. I would become frustrated if I couldn’t “fix” every patient I saw. I would perseverate about missing some yet undetected cancer in my clinic patients because I didn’t perform a thorough enough history and physical. In essence, I was overwhelmed by my own standards.

After about a month’s leave to start anti-depressants—which I never wanted to admit I needed—I returned to work. I was unsure of whether I wanted to finish my planned internal medicine residency, if I wanted to switch specialties, or maybe just scrap the idea of practicing medicine altogether. After getting back in the saddle, and experiencing the mood-boosting benefits of my SSRI, I began to receive the same kind of praise for outstanding clinical performance that I had become used to in school. This became my drug. Praise from superiors took the place of any need for self-esteem, or any consideration of what I might enjoy. I worked for praise, and I was damn good at it.

As you can imagine, to consistently elicit praise in a Top 5 program, you need to work hard. When my colleagues were sleeping, I was rounding. When friends went home, I was reading or teaching. I didn’t need any notes—I knew every lab value for every patient. Some of my superiors claimed I was “chief resident material.”

Well, I quickly found out that foregoing sleep, food, exercise, or any personal reflection leads to a quick demise. As I got more fatigued, I became progressively harsher towards my colleagues. My tirades were legendary. Chiefs of the ER, radiology department, nursing supervisors, and anyone else who witnessed one of my furious outbursts, felt strongly enough about my actions to write formal letters of complaint to my residency director. Several times a week, I was called into the director’s office to be reprimanded for my behavior. Still, I felt that my behavior was justified—I was fighting for better patient care, right?

In spite of warnings, probationary periods, and even the decision of my residency director that I would not be allowed to apply for cardiology fellowships, I could not control this explosive temper in times of high pressure and extreme fatigue. Then came the hammer: I was terminated from my Top 5 residency, despite being considered “chief resident material.”

To make a painfully long story short, through an appeal, I was reinstated with the agreement that I would complete whatever treatment the North Carolina Physicians Health Program (NCPHP) chose. Meeting

with Dr Wilkerson (NCPHP Medical Director at the time) was frightening. I was fighting (still) for a career that I had worked so hard to achieve. I had to wrestle with a mix of feelings—guilt for the problems I had caused and people I had hurt, and some residual feelings that it was unjust that I was being put through this! After all, I could name about a dozen attendings at my institution who had a reputation for chewing out interns and nurses mercilessly! Why me?

Dr Wilkerson did not recommend the 30-minute anger management course I had hoped he would. He told me to enter a day treatment program for 4-6 weeks! In the Midwest! Away from my wife and home! Are you kidding?! I am a “disruptive” physician—not an alcoholic!?! I yell at people who don’t do their job right! (Oh, and struggle with feelings of worthlessness, depression, anxiety, and a failing marriage that is only two-years old). Hindsight is 20/20!

So, reluctantly, I left my life behind to explore the issues that fueled my disruptive behavior. What I found was painful, frustrating, and overwhelming. It was a total psychic overhaul. And it was the greatest blessing I could ever hope for.

I learned what dark parts of my past influenced present day feelings. I learned about who I was and who I wanted to be. I had the opportunity to figure out what I wanted out of life and my career (in that order). I learned the importance of self-care, because if I am ill I am of no use to my patients or colleagues.

I am now a marathoner, a meditation instructor (something I picked up in the odyssey), an avid reader, and a contributor to a training program to help lost residents, like me, find their peace. I also reconnected with my faith, which fell by the wayside sometime during medical school. I am very excited about giving my first Sunday sermon for my church this summer!

Despite these past several years being the most painful and trying of my entire life, I couldn’t have hoped for a better outcome. I look at the world with fresh eyes. I stop and smell the flowers. I take better care of my patients, my staff, and, most importantly, myself. Thanks, NCPHP.

Reprinted with permission from the North Carolina Physicians Health Program publication *Metamorphosis*, Summer 2005.

Special Notice About Guidelines for CA-MRSA

Available in the next *Forum*: “The North Carolina Consensus Guidelines for Management of Suspected Community-Acquired Staphylococcus Aureus (CA-MRSA) Skin and Soft Tissue Infections.” The “Guidelines” are also now available on the NCMB Web site at www.ncmedboard.org. Click on the “Guidelines” menu item on home page.

“I learned the importance of self-care, because if I am ill I am of no use to my patients or colleagues”

SANTIAGO ATITLAN

The Call of Something Different—Part 3: October 5 and the Aftermath

Jack Page, MD*

Hundreds or even thousands of thousands of years ago, there was not as much land mass between North and South America as there is today. But because of the constant grinding of tectonic plates, one against the other, the molten rock in the earth's core finds it easier to exploit cracks or create cracks, allowing it to periodically and very dramatically explode into the atmosphere through what are called volcanoes. The hot lava weeps down the sides of the growing mountain and continues to run off or flow out until the viscosity of the mixture overwhelms the effects of gravity. Hence, recent volcanoes have steep and ragged sides where competing forces of physics meet in a very tenuous relationship.

Over unimaginable eons of time, the volcanic rock is worked on by the sun, the rains, and vegetation, first grasses, then vines and bushes, and ultimately trees, to break the rock down from huge, immovable slabs into much more fertile grains of sand and soil. And the process has gone on for further eons, leaving the tree, grass, and crop covered volcanic mountains surrounding Santiago Atitlan today. Beautiful, virginal, rugged creations of whatever deity we acknowledge. But within them lurks a danger, unknown to generations who live on their slopes, less dramatic than the volcano within, but just as deadly and even more silent.



Source of the mudslide.

Rains

The rainy season in Santiago goes from May to the end of October, and that means that it rains almost every afternoon and occasionally in the morning, too. Moist, warm air from the Pacific is forced up the mountains to the north, and when it cools, it can no longer support the moisture it holds, so it changes to clouds and then to rain. It rained every day, sometimes very hard, for the last couple of weeks of September and the first few days of October. A few

rocks on the sides of the hills lost their foundation, rolled down, many coming to rest on or next to the roads. But then Hurricane Stan, a nothing storm by U.S. standards, came to visit, bringing with it lots of additional rain and a fair amount of wind. It scored a direct hit on Santiago Atitlan and the 50,000 people living in and around the pueblo.

Mark Lepore is a family practice physician from the training program Leah Abraham, one of the full time docs at Hospitalito Atitlan, graduated from. That program specializes in training family practitioners for work in less developed countries and extremely rural locations in the U.S. So they get more complicated OB training, more hands on surgical training, all based on the assumption that referrals and help will be long distances and/or long travel times away. He had come to cover a time when Jack Page, another of the full time physicians at the *hospitalito*, was away in the U.S. thanking donors, seeking more help, and visiting with family. Mark's reservations for returning home were for 2:02 PM on Wednesday, October 5. Jack was flying back from the States on the same plane and would be arriving in Guatemala City at 12:30 PM. Bernadette, Jack's wife, another full time doc at the *hospitalito*, was supposed to be on call for emergencies the night of October 4, but since she would then be driving Mark to the airport while going to pick up Jack, Mark covered her shift from 10:00 PM on so she would be fresh for the six hour round-trip in the Page's Toyota pickup truck. He may never offer to cover for someone else again.

Mark went to bed about 11:00 PM. Not many Tz'utujils go to the *hospitalito* at night unless they are really sick or about to have a baby. But between recently born babies, families with inpatients, dogs, roosters, and trucks without mufflers, being in bed doesn't equate to sound sleep. Beginning about 2:00 AM, several families had come to the *hospitalito* seeking shelter from rising water. The *hospitalito* is surrounded by poverty and the people who live it daily. Most homes are dirt floors, corn stalk walls, and corrugated sheet metal roofs. Half have electricity and fewer have their own water. In their one or two room homes live the mother and father and an average of some four or five children. About 4:15 AM, Mark was awakened by the feeling and sound of a shaking rumble, like a large dump truck, freight train, or low flying jet just off the ground. "Doctor, doctor," cried the nurse on duty, knocking at his door. "All right, all right, keep your pants on, I'm coming." Out in the hall he was greeted by emergency power lights, a group of five or six peo-

"About 4:15 AM, Mark was awakened by the feeling and sound of a shaking rumble"

ple moving towards him, and a few feet of mud in the central corridor of the *hospitalito*. “¿Esta embarazada?” he asked. Near the doctors’ sleep room is the labor and delivery room, so he thought they were headed for there. But no, it was not a family for delivery; it was a group of people fleeing for their lives.

Mud

The wave of mud hit the *hospitalito* and broke open the double steel doors into the waiting room. The half-dozen Tz’utujil sitting there fled into the corridor, led by the nurse and guardian on duty, toward the doctors’ sleep room, the OR, and the labor and delivery room. One elderly woman fell to her knees, praying loudly mostly in Tz’utujil but with enough Spanish mixed in to recognize she was praying the Our Father. Another woman was simply sobbing and crying without solace. It was an hour and a half before dawn, only the emergency lights were on, people were screaming and crying, the mud was moving slowly down the hallway of the building, the wind was blowing strongly, and the rain was pouring down. Mark thought they were all going to die.

“It was an hour and a half before dawn, only the emergency lights were on, people were screaming and crying”

But the mud flow seemed to be stopping. Mark worked with the nurse and guardian to collect the people in the surgical supply room, farthest from where the mud was entering, and brought in the available oxygen tanks and drinkable water. There was food at the other end of the *hospitalito*, but that was where the mud was coming from, and in the dark and the noise and the terror, no one was willing to try to get the food to safety. Mark called on his cell phone for Leah. No answer. Bernie called to say she was thinking they shouldn’t try for the city and learned of the disaster from Mark. Mark welcomed the contact with the outside world, shared their predicament with Bernie, and asked her to call his parents and let them know he was safe but wouldn’t be making any flights soon.

A very watery sun began to lighten up those windows of the *hospitalito* that were not mostly covered by the mud. The slide had essentially stopped at the *hospitalito*, with one corner in seven feet of mud and the opposite corner mud free. Using a side door of the *hospitalito*, Mark and the staff, with some of the sheltering Mayans, explored briefly outside. The two-

story stone doctors’ house, across the street and built in the 1960s with the initial *hospitalito*, was gone. Later, they would learn the judge and the anthropologist living there were among the dead, swept away by the wall of mud that literally disintegrated the building. Dozens of “houses” were gone, either swept away by the wall of mud or simply inundated by it. Concrete block walls were partially demolished in places and, in others, the wave of mud had simply roared in through the windows to destroy all inside.

Evacuation

Mark then correctly thought: “What if more mud comes to follow the initial slide?” The *hospitalito* is one of three significant structures in a row along the dirt road in this area of Panabaj, a neighborhood of Santiago: first a school; then the *hospitalito*; and finally the Justice Center with courtrooms, a jail, police station, and many judicial offices. The Justice Center has two stories, so Mark coordinated the evacuation of the one *hospitalito* inpatient and her family into a second-story courtroom of the Justice Center. As they were doing so, Leah arrived, having walked from town through areas of flowing mud with Francisco Sojuel, the president of the *hospitalito* board and a *bombero*. Francisco coordinated other *bomberos* and volunteers at finding and evacuating to the Justice Center the injured in the immediate area. Leah and Mark took from the *hospitalito* basic supplies for rendering to the injured what care they could. Ultimately, the school next to the *hospitalito* was to learn that 70 of its 300 pupils had “disappeared.”

Like most disasters, there were few seriously injured. Ultimately, the death toll was fixed at around 700; records and statistics are not the highest priority in rural Guatemala. Mark and Leah cared for the half-dozen brought to them with serious injuries, including a young man with a tension pneumothorax and suspected intra-abdominal injuries, a young boy with a fractured femur and a dirty, huge scalp laceration, and a woman with an avulsion type injury of most of her lower lip exposing the mandible and teeth. All were cared for as best as possible by Leah and Mark with what basic supplies they were able to cobble together from repeated trips to bring needed items over



Painting hospitalito sign in September 2005.



Hospitalito sign after mudslide in October 2005.

from the abandoned *hospitalito*. At the same time, the six-month-old baby who had been admitted to the *hospitalito* with respiratory distress was again breathing at 100 times a minute and needed ongoing attention and care of his own. Volunteers from town began to arrive and assist with interpretation, obtaining supplies, and looking for food and water for the folks unable to evacuate from the site. Although about 100 people initially came to the Center looking for shelter, as soon as the word spread that it was possible to leave and get into town, every single one did. So as the sun set on the day of the disaster, an exhausted Leah and Mark settled down for the night with their patients, few supplies, and even less food.

Morning, October 6, brought more *bomberos* and the word that the patients could be evacuated to the National Hospital in Solola. This trip usually takes about an hour and a half from Santiago, but at this time it took five hours. Evacuation began with a one-hour or more walk to where the boats were able to pull to the shore in Santiago. All the docks had been destroyed by the storm. Then a one-hour boat ride across the lake, followed mostly by carrying stretchers up the side of the mountain on the other side of the lake to Solola and the National Hospital. The road from Solola to the lake shore was impassable to any vehicles at some 21 different locations due to the mud and rock slides and to washed out or unsafe bridges. But finally, after some 32 hours of service in the Justice Center, Mark and Leah got to leave and get some rest. Jack was still stranded in Guatemala City, furiously forwarding to the outside world the story of the disaster, the first pictures, and the need for medical supplies. Bernie and Ken, a retired family practitioner who had just arrived for a one-year stint, along with local doctors, provided around-the-clock coverage for the community for the next 24 hours at a not-for-profit clinic in town.

The Health Center

By the next day, October 7, the physician in charge of the Health Center in Santiago coordinated the available physician and other professional resources and more permanently established 24-hour-a-day access to care in the Health Center itself. This 20-by-30-foot building, meant for giving out well-baby vaccines and prenatal vitamins, provided care to over 200 patients a day for the first week, hundreds being seen for injuries to their lower extremities, anxiety and fear, and the usual number of colds, back pains, and headaches, along with the occasional delivery. An assessment of the resources available was not encouraging. No roads were open anywhere around the lake. Bridges were gone or so damaged that vehicles could not cross. The roads were blocked in hundreds of locations by rock and mud slides. There is no airport near Santiago and the lake so only helicopters could be considered, but for several days after the disaster it continued to rain every day, with heavy overcast im-

peding all but very few helicopters. Santiago had no electricity, little fuel, little potable water, and no sanitation. Calls went out for water, fuel, food, and porta-potties; hundreds of heroes came through for Santiago and other hard-hit areas of Guatemala.

On October 9, an exhausted Mark met Jack at the airport in Guatemala City, just before Mark's flight back to the States. That same day, helicopters brought in Doctors Without Borders and the Red Cross. Twenty Cuban doctors arrived to offer their services. Mark prudently saw his chance to get out by returning on one of them. For the first four days after the slide, all the help was local, with neighbor helping neighbor. A hundred of the dead were found and buried. A hundred more survivors were found and evacuated to safety. Many were reunited with their loved ones. Sadly, many more found out how many of their family they had lost. On one of Bernie's first shifts after the mudslide, a woman brought in a six-month-old baby to be examined. When asked the baby's name, she responded she didn't know. She had "found" the baby in the mud; she had lost all her own family and



Temporary hospital

was committed to making this baby part of her new family.

Some 2,500 residents were evacuated from areas of Santiago Atitlan, the overwhelming majority from Panabaj, the neighborhood of the *hospitalito*. Either their homes had been destroyed or their homes were still an "at risk" area for health or geological reasons. They were taken in by the dozens of churches in Santiago; some took 25, some took hundreds, but all were sheltered. But just like going away to college or entering the military in the U.S., putting all these folks in a common area with shared eating and sanitation facilities meant they also shared all their germs and viruses. Contagious diseases, most not serious, climbed through the roof. After the injuries of the slide were taken care of, colds, flu, sore throat, coughs, and diarrhea began to take their toll. The usual cases of hepatitis A became all the more problematic when the infected child was sleeping in the same room with another 50 people, including a dozen other children under the age of five who were all sharing a common kitchen and using the same bathroom facilities. Stores

"Hundreds of heroes came through for Santiago and other hard-hit areas of Guatemala"

of tetanus vaccine had long been exhausted and, initially, there was no hepatitis A vaccine, but cooperative efforts of volunteers in the U.S., the U.S. Embassy and the U.S. military, with the welcoming cooperation of the Guatemalan authorities, resulted in these vaccines beginning to arrive in quantities in Santiago on October 10. Hundreds would wait in lines for hours, finally under the hot sun, for their tetanus booster. Hundreds of children, focusing on those churches where active hepatitis had been found, were vaccinated for hepatitis A.

The people of the Health Center are some of the heroes Santiago provided for itself. But the building is and was a disaster of its own. Electricity and water in Santiago are always an iffy proposition. After the mudslides, electricity was out for almost 48 hours and water was out for over a week to most areas of the city. Most homes and businesses in Santiago have their own water tank on the roof that they keep filled from the city supply. When the city water stops flowing, you use the water from your tank. The tank at the Health Center was broken before the disaster and no money had been available to fix it. So the hundreds of people who came there for care shared one toilet with the staff; it did not flush. It was not a pretty sight or a pleasant smell. Local volunteers paid to fix the tank and then the *bomberos* could come each day and fill it with water drawn by the fire truck directly from the lake. Not safe to drink, but thank God the toilets flushed! The Health Center is a building of about 600 square feet, so seeing 200 patients a day was a real achievement. Combine that with the Tz'utijil practice of the whole family going with the patient, and all crowding into the same room with the doctor, and you can visualize some of the traffic flow problems experienced. Fortunately, two fourth-year medical students from the University of Pennsylvania were there to help with the crushing patient load and they shone like the troopers they were.

Back in Business

While all the current care was being provided, several members of the *Comite*, Jack, Bernie, or Leah, were furiously looking for any building in Santiago that might be adequate for the temporary *hospitalito*. All were inadequate, especially when plumbing and electrical service were considered. But the best just happened to be in a very picturesque spot on the shores of the lake. It was a deal. A horde of workers descended on the three-unit rental property, new walls, windows, electric circuits, and plumbing all going in like mad. And a 5,000-liter water tank, donated by Oxfam, became the hospital's back up water supply and was matched with a water pump/presurization system donated by the Posada de Santiago Hotel. On the morning of October 19, two weeks to the day after the mudslide, the temporary *hospitalito* opened for emergencies and deliveries. It admitted

its first two patients that night, both with gastrointestinal problems. The following Monday, the *consulta externo* (read "walk in clinics") were opened; and the following Friday, October the 28, the first C section for failure of labor to progress was performed in a converted living room with an almost all glass wall facing the lake. The *hospitalito* was back in business!

So what has been learned? It was learned that in 1949 a mudslide, not as severe as this one, came off the mountain in the same place and killed 10 to 15 people living in the area. It was also learned that Hurricane Mitch, the most renowned recent hurricane in Central America, caused a slide in the same area. So why did the sponsoring church build the hospital and doctors' house 16 years after the 1949 mudslide right in the old path? Why didn't anyone remember Mitch? No one seems to know, which contributes to the quandary about what to do now.

The community and the individual residents are waiting for a decision by the government about whether or not all will be allowed back into Panabaj to rebuild and, for the people, to retake possession of their land and, for some, their homes. The government is balancing their perception of the health hazard caused by the entombed dead, the cultural fear among the Mayans of the spirits of those unexpectedly killed, and the risk of future mudslides in the same area. Geologists who have come on behalf of the government have shared unofficially that they would never live in the area where the original *hospitalito* is. What their official report will say has yet to be seen. If the *hospitalito* cannot return, all of those involved in the *hospitalito* are committed to building anew to serve this community. But the poor lived where the original *hospitalito* was and, no matter what the government says, the poor will return. All worry that a new site will impair the ease and affordability of access for the very people who need the *hospitalito* the most. *Vamos a ver*. We will see.

Life goes on in Santiago Atitlan like it must after any disaster the world around. The injured cry, heal, and resume their lives. The care givers cry, sleep the sleep of the exhausted, and go on. Life has always been and remains difficult for the Tz'utujil.

.....

Jack extends his apologies to those who know so much more about the geology of the volcanoes in Central America. Like most humans, when confronted with something they don't fully understand, he has created a story/history to make him more comfortable.

*This is the third in a series of articles about Drs Jack and Bernadette Page and their work as they continue their planned two-year stay in Santiago Atitlan, Guatemala. The previous number of the *Forum* presented Part 2 of the series and a special report on the day of the mudslide. If you would like to contact the Pages, they can be reached at brpage@yahoo.com or jackpage45@yahoo.com. If you would like to give of your time or resources to support the *hospitalito* and their efforts, please visit the Web site of Pueblo a Pueblo at www.puebloapueblo.org.

"The injured cry, heal, and resume their lives"

Meeting the Challenge of Change: A Response to Dr Hill

L. Gail Clary, MD, Program Director
Pardee ICU Caring Connection

I was saddened to read Dr "Pete" Hill's article in the NCMB *Forum* ("Changing Ourselves Is the Key," No. 2, 2005). It is an unfortunate reality that physicians often fail to adequately communicate information and compassion to patients and their families. The August 22 *Newsweek* article, "I Shouldn't Have Had to Beg For a Prognosis," was a further indictment of our profession's failure to communicate.

This scenario is especially problematic in intensive care units (ICUs), where the pace is hectic, the acuity is high, and everyone is stressed by the cacophony of noise (alarms, phones, conversations, etc) and the reality that life and death are being "juggled" moment by moment, from patient to patient.

The good news, however, is that professional associations of ICU specialists are recognizing and addressing the need to bridge the gap between technology and "tender loving care." Both the Society of Critical Care Medicine and the American College of Chest Physicians (ACCP), the organizations to which I belong as a pulmonary/critical care specialist, have focused initiatives in this area. Professional nursing organizations such as the American Association of Critical Care Nurses are also addressing these issues of communication and compassion. Change is occurring, but it is slow.

It has been my great privilege to be involved with the ACCP's initiative, the Critical Care Family Assistance Program (CCFAP). Developed by the CHEST Foundation, the ACCP's benevolent arm, the CCFAP aims to foster a more family-focused environment for ICU patients and their loved ones, and to meet the needs of these highly stressed families. Launched in 2002, there are now eight CCFAP hospital sites across the country. Pardee Hospital in Hendersonville was selected in 2004 to study the development and implementation of the program in a rural community hospital setting.

Our local program, the Pardee ICU Caring Connection, is a multidisciplinary-team program whose goals mirror those of the national CCFAP:

- 1) to identify and meet the needs of families of ICU patients;
- 2) to increase the families' physical comfort through renovated, privatized waiting rooms and family retreat/sleep quarters;
- 3) to improve the dissemination and comprehension of medical information;
- 4) to train medical professionals to more effectively communicate compassionate care;
- 5) to improve patient and family satisfaction with their ICU experience; and
- 6) to improve job satisfaction and retention of ICU staff.



ICU Caring Connection Core Team, from left, Craig Franks (Engineering, Facilities Renovation), Keith Ford (Social Services Director; Program Co-Coordinator), Alexis Versalle (Chaplain), Lucy Bloomingdale, RN III (Program Co-Coordinator), and Gail Clary, MD (Program Director).

Web site, www.chestfoundation.org/ccfap. It is the hope of the CCFAP to change the climate in ICUs across America. A replication toolkit is available on the CCFAP Web site so any hospital could start its own program.

As program director of the Pardee ICU Caring Connection, I am pleased to already see our local ICU climate changing. Families are less stressed and are more informed. They are becoming more involved in, and less intimidated by, the ICU environment.

Staff are actually enjoying their interactions with families.

But Dr Hill is correct in his challenge for physicians to change themselves. While we can provide courses to educate house staff and nursing graduates on "what to say and how to say it," we cannot change their hearts to truly *care*. I believe that true compassion cannot be taught; it must be "caught." Those of us who have several years of experience need to resurrect the empathy needed to care *for* patients and their families, and to mentor the next generation of health professionals to do the same. Technology and compassion *can* be blended, and through the supportive efforts of initiatives like the CCFAP we can emulate a "lifestyle" of care and compassion that will change the face of medicine back to the honored profession that beloved

"It is an unfortunate reality that physicians often fail to adequately communicate information and compassion to patients"

Pardee ICU
THE Caring CONNECTION

doctors like Dr Hill once knew.

Dr Clary lives in Hendersonville, NC, and has practiced with Western Carolina Chest Consultants since 1991. She graduated

from the Medical College of Virginia in 1985 and trained in internal medicine and pulmonary/critical care medicine at the University of Alabama at Birmingham. She is board certified in internal medicine, pulmonary medicine, and critical care medicine.

An Open Letter to Residents and Residency Program Directors on Maintaining Medical Licensure

Dear Colleagues

To practice medicine is a privilege. After years of hard work, rigorous testing, and careful scrutiny into our character, we obtain a license to practice medicine. We start with a limited license that allows us to practice medicine as trainees. After more testing and scrutiny, we move on to full and unrestricted licensure. I can think of no other accreditation that has come at any higher price in terms of dollars invested, dedication, and hard work. I can think of no other "ticket" that holds more value in regard to my livelihood. It is a defining document and is uniquely mine. This license is something to be respected and guarded. It signifies my contract with society.

In order to maintain my license, I have an obligation to demonstrate continuing competence and learning. I must adhere to a high standard of behavior and ethics. To maintain my license, and the privilege that is attendant on it, I must comply with certain requirements set out in laws and rules. In North Carolina, these requirements include the need to renew my license registration annually. This is my license and my responsibility. I can delegate some of the regulatory tasks, such as annual renewal, but I cannot abdicate the ultimate responsibility for being sure that these tasks are completed and correctly done in a timely fashion. Importantly, it is a misdemeanor offense to practice medicine in any form without a license. Just as importantly, I cannot accept payment for medical services I may render if I am not actively licensed.

The North Carolina Medical Board has a history of requiring its full and unrestricted licensees who have practiced medicine with lapsed registration to accept some level of discipline as a condition of retroactive reinstatement. Frequently, this level of discipline is a public reprimand by way of a Consent Order: a significant consequence for a significant failure to attend to a required task. (And this does not even consider the potential liability risks such

practice entails.)

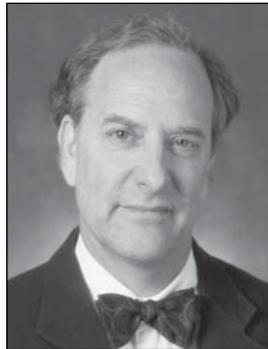
Recently, the Board's Licensing Committee was faced with a situation in which a resident in training practiced medicine for almost a year without a registered resident training license (RTL) and, as a result, now has a permanent record with the Medical Board! A string of missed communications involving the Office of Graduate Medical Education at the resident's institution led to this breach of rule and law. This unfortunate situation makes clear the importance of impressing on all residents that it is their responsibility to assure the RTL is registered each year as required, no matter who actually handles the paperwork.

All those who hold a North Carolina medical license, from full to limited to resident, have been and will be held to the same standard of compliance. It is our unambiguous position that a resident in training is as responsible for maintaining her or his medical license as any other licensee. Failure to do so will carry the same consequences as for a fully licensed physician. We encourage residents to be familiar with all the legal requirements related to maintaining a license. This information should

be as much a part of their orientation as learning where the call room is or knowing any other facet of the training program. The regulatory consequences of practicing without a license will be borne by the resident. The fiduciary and liability consequences will be borne by both the resident and the training program.

I love the practice of medicine and I jealously guard my license and take pains to protect it. I know that you share these feelings about our profession. Please take the time and effort to protect your license too.

With Mutual Respect I remain,
Michael Norins, MD
Chair, Licensing Committee
North Carolina Medical Board



Dr Norins

"A resident in training practiced medicine for almost a year without a registered resident training license (RTL) and, as a result, now has a permanent record with the Medical Board"



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LETTERS FROM OUR READERS



On Pharmacists and the Dispensing of Emergency Contraception

To the Editor:

I am writing with reference to Mr David Work's opinion piece in the latest issue [No. 3, 2005] of *Forum*.¹ I am appreciative of Mr Work's service on the Board of Pharmacy, and I am sure he has wrestled with many ethical issues in his long tenure there. Clearly, the issues involving family planning are "volatile." I agree with Mr Work that "some civil reflection on this matter is in order"; in fact, I think there has not been enough reflection on the implications of many of our decisions regarding family planning and the status of the embryo.

I also agree with Mr Work that "we need to settle on a standard definition of terms." This fact became clearer when I looked at the definition of "conception" in two different editions of a popular medical dictionary often used by laypersons.² While the definition for "pregnancy," "abortion," and "contraception" are the same in each edition, the definition for conception has changed. The earlier edition defines conception as "the union of the male sperm and female ovum," which would make conception synonymous with fertilization. The latter edition defines conception as "the onset of pregnancy marked by implantation of a fertilized ovum in the uterine wall," which would make conception synonymous with implantation. The implication of the definition shared by Mr Work and the latter edition of the dictionary is that any method of preventing implantation can be called contraception.

A uniform definition of conception is important, but it does not clear up the objections many have to "emergency contraception." Most conscientious objectors (pharmacists or physicians) have no concern about a method of contraception that prevents the union of sperm and egg; however, once fertilization has taken place, the situation has changed. One's belief concerning the status of the fertilized egg will likely inform their decision about what methods of contraception are acceptable. If the fertilized egg is considered a human being at the earliest point in his or her normal development, then any contraceptive method that destroys this early human is unacceptable. The key concern over Plan B[®] is with its mechanism of action. Mr Work notes that Plan B[®] acts "by preventing a fertilized egg from attaching to the uterine wall." This mechanism is technically not abortion as abortion involves the destruction of an established (conceived) pregnancy. While not being an abortion, the end result of using Plan B[®] is that the fertilized

ovum is destroyed.³ For this reason, simply saying that "emergency contraception" is not abortion does not legitimize the destruction of the fertilized embryo for those who believe that life begins at fertilization. If the fertilized egg is a human being, then preventing implantation (preventing pregnancy) and abortion (terminating pregnancy) are both forms of taking human life, which is unacceptable.

In conclusion, I agree that *civil* discourse on these ethical issues needs to continue. I also agree that a standard set of definitions is needed. For the discourse involves weighty matters such as the definition of human life, the protection human life should receive, proper informed consent to treatment, and, of course, the reasoning behind conscientious objections.

Jack P. Shepherd, MD
Charlotte, NC

1. D. Work, "Pharmacists and the Dispensing of Emergency Contraceptives," North Carolina Medical Board *Forum* (No. 3, 2005) pp 14-15.

2. *Täber's Cyclopedic Medical Dictionary*, 18th ed. (Philadelphia: F. A. Davis, 1997) and 19th ed. (Philadelphia: F. A. Davis, 2001).

3. Elsewhere in his essay, Mr Work notes that "in the normal life of a sexually active female, there are many instances where a fertilized egg fails to attach to the uterine wall and is expelled as a part of the menstrual cycle." While this statement is true, it is irrelevant with regards to any complicity in actively preventing the fertilized ovum from attaching to the uterus.

"I agree that civil discourse on these ethical issues needs to continue"

Response:

Thank you for the opportunity to comment on Dr Shepherd's "Letter to the Editor" in response to my recent article in the *Forum* (No. 3, 2005).

Dr Shepherd respectfully pointed out different definitions for conception in two editions of a particular medical dictionary. Prior to Dr Shepherd's letter, I had only seen the version defining conception as "the union of sperm and ovum" used by graduates of divinity schools. The implantation of a fertilized egg in the uterine wall is the orthodox version of conception, which is also used by the federal Food and Drug Administration. Use of the former produces an awkward and, I believe, untenable situation whereby females are unintentionally engaging in an abortive act when the fertilized ovum fails to attach to the uterine wall.

Thanks for the opportunity to comment.

David R. Work, Executive Director
North Carolina Board of Pharmacy

Position Statements of the North Carolina Medical Board

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[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 alter 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 docu-

mented 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.

¹See 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 TREATMENT OF OBESITY

It is the position of the North Carolina Medical Board that the cornerstones of the treatment of obesity are diet (caloric control) and exercise. Medications and surgery should only be used to treat obesity when the benefits outweigh the risks of the chosen modality.

The treatment of obesity should be based on sound scientific evidence and principles. Adequate medical documentation must be kept so that progress as well as the success or failure of any modality is easily ascertained.

(Adopted [as The Use of Anorectics in Treatment of Obesity] October 1987)
(Amended March 1996)
(Amended and retitled January 2005)

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)

POLICY FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN

- Appropriate treatment of chronic pain may include both pharmacologic and non-pharmacologic modalities. The Board realizes that controlled substances, including opioid analgesics, may be an essential part of the treatment regimen.
- All prescribing of controlled substances must comply with applicable state and federal law.
- Guidelines for treatment include: (a) complete patient evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate.
- Deviation from these guidelines will be considered on an individual basis for appropriateness.

Section I: Preamble

The North Carolina Medical Board recognizes that principles of quality medical practice dictate that the people of the State of North Carolina have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. For the purposes of this

policy, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

The diagnosis and treatment of pain is integral to the practice of medicine. The Board encourages physicians to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances. Accordingly, this policy has been developed to clarify the Board's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

Inappropriate pain treatment may result from physicians' lack of knowledge about pain management. Fears of investigation or sanction by federal, state and local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the Board will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The Board recognizes that controlled substances including opioid analgesics may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The Board will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

The North Carolina Medical Board is obligated under the laws of the State of North Carolina to protect the public health and safety. The Board recognizes that the use of opioid analgesics for other than legitimate medical purposes pose a threat to the individual and society and that the inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the Board expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Physicians should not fear disciplinary action from the Board for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice. The Board will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The Board will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors.

Allegations of inappropriate pain management will be evaluated on an individual basis. The Board will not take disciplinary action against a physician for deviating from this policy when contemporaneous medical records document reasonable cause for deviation. The physician's conduct will be evaluated to a great extent by the outcome of pain treatment, recognizing that some types of pain cannot be completely relieved, and by taking into account whether the drug used is appropriate for the diagnosis, as well as improvement in patient functioning and/or quality of life.

Section II: Guidelines

The Board has adopted the following criteria when evaluating the physician's treatment of pain, including the use of controlled substances:

Evaluation of the Patient—A medical history and physical examination must be obtained, evaluated, and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized

medical indications for the use of a controlled substance.

Treatment Plan—The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

Informed Consent and Agreement for Treatment—The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of a written agreement between physician and patient outlining patient responsibilities, including

- urine/serum medication levels screening when requested;
- number and frequency of all prescription refills; and
- reasons for which drug therapy may be discontinued (e.g., violation of agreement).

Periodic Review—The physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities.

Consultation—The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

Medical Records—The physician should keep accurate and complete records to include

1. the medical history and physical examination,
2. diagnostic, therapeutic and laboratory results,
3. evaluations and consultations,
4. treatment objectives,
5. discussion of risks and benefits,
6. informed consent,
7. treatments,
8. medications (including date, type, dosage and quantity prescribed),
9. instructions and agreements and
10. periodic reviews.

Records should remain current and be maintained in an accessible manner and readily available for review.

Compliance With Controlled Substances Laws and Regulations—To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S. Drug Enforcement Administration and any relevant documents issued by the state of North Carolina for specific rules governing controlled substances as well as applicable state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute Pain—Acute pain is the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. It is generally time-limited.

Addiction—Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of ex-

tended opioid therapy for pain and are not the same as addiction.

Chronic Pain—Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

Pain—An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence—Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction—The iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief seeking behaviors resolve upon institution of effective analgesic therapy.

Substance Abuse—Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance—Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

(Adopted September 1996 as "Management of Chronic Non-Malignant Pain.") (Redone July 2005 based on the Federation of State Medical Board's "Model Policy for the Use of Controlled Substances for the Treatment of Pain," as amended by the FSMB in 2004.)

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 Treat-*

ment 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 treat-

ment 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 writ-

ten 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 accor-

dance 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.

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.

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

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 con-

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

Equipment and Supplies

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

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

20. appropriate operating or procedure table.

Definitions

AAAAASF – 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 pre-operative 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 on 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 physician who provides medical supervision is expected to provide adequate oversight of licensed and non-licensed personnel both before and after the procedure is performed. The Board believes that the guidelines set forth in this Position Statement are applicable to every licensee of the Board involved in laser hair removal, whether as an owner, medical director, consultant or otherwise.

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

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

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

Surgery, which involves the revision, destruction, incision, or structural alteration of human tissue performed using a variety of methods and instruments, is a discipline that includes the operative and non-operative care of individuals in need of such intervention, and demands pre-operative assessment, judgment, technical skills, post-operative management, and follow up.

(Adopted July 1999)

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

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 following rules of the North Carolina Department of Health and Human Services regarding infection control in health care settings and HIV/HBV infected health care workers.

10A NCAC 41A .0206: INFECTION CONTROL—HEALTH CARE SETTINGS

- (a) The following definitions shall apply throughout this Rule:
- (1) "Health care organization" means hospital; clinic; physician, dentist, podiatrist, optometrist, or chiropractic office; home health agency; nursing home; local health department; community health center; mental health agency; hospice; ambulatory surgical center; urgent care center; emergency room; or any other health care provider that provides clinical care.
 - (2) "Invasive procedure" means entry into tissues, cavities, or organs or repair of traumatic injuries. The term includes the use of needles to puncture skin, vaginal and cesarean deliveries, surgery, and dental procedures during which bleeding occurs or the potential for bleeding exists.
- (b) Health care workers, emergency responders, and funeral service personnel shall follow blood and body fluid precautions with all patients.
- (c) Health care workers who have exudative lesions or weeping dermatitis shall refrain from handling patient care equipment and devices used in performing invasive procedures and from all direct patient care that involves the potential for contact of the patient, equipment, or devices with the lesion or dermatitis until the condition resolves.
- (d) All equipment used to puncture skin, mucous membranes, or other tissues in medical, dental, or other settings must be disposed of in accordance with 10A NCAC 36B after use or sterilized prior to reuse.
- (e) In order to prevent transmission of HIV and hepatitis B from health care workers to patients, each health care organization that performs invasive procedures shall implement a written infection control policy. The health care organization shall ensure that health care workers in its employ or who have staff privileges are trained in the principles of infection control and the practices required by the policy; require and monitor compliance with the policy; and update the policy as needed to prevent transmission of HIV and hepatitis B from health care workers to patients. The health care organization shall designate a staff member to direct these activities. The designated staff member in each health care organization shall complete a course in infection control approved by the Department. The course shall address:
- (1) Epidemiologic principles of infectious disease;
 - (2) Principles and practice of asepsis;
 - (3) Sterilization, disinfection, and sanitation;
 - (4) Universal blood and body fluid precautions;
 - (5) Engineering controls to reduce the risk of sharp injuries;
 - (6) Disposal of sharps; and
 - (7) Techniques that reduce the risk of sharp injuries to health care workers.
- (f) The infection control policy required by this Rule shall address the following components that are necessary to prevent transmission of HIV and hepatitis B from infected health care workers to patients:
- (1) Sterilization and disinfection, including a schedule for maintenance and microbiologic monitoring of equipment; the policy shall require documentation of maintenance and monitoring;
 - (2) Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules;
 - (3) Accessibility of infection control devices and supplies;
 - (4) Procedures to be followed in implementing 10A NCAC 41A .0202(4) and .0203(b)(4) when a health care provider or a patient has an exposure to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV or hepatitis B.

History Note: Authority G.S. 130A 144; 130A 145;

Eff. October 1, 1992; Amended Eff. December 1, 2003; July 1, 1994; January 4, 1994.

10A NCAC 41A .0207: HIV AND HEPATITIS B INFECTED HEALTH CARE WORKERS

- (a) The following definitions shall apply throughout this Rule:
- (1) "Surgical or obstetrical procedures" means vaginal deliveries or surgical entry into tissues, cavities, or organs. The term does not include phlebotomy; administration of intramuscular, intradermal, or subcutaneous

injections; needle biopsies; needle aspirations; lumbar punctures; angiographic procedures; endoscopic and bronchoscopic procedures; or placing or maintaining peripheral or central intravascular lines.

- (2) "Dental procedure" means any dental procedure involving manipulation, cutting, or removal of oral or perioral tissues, including tooth structure during which bleeding occurs or the potential for bleeding exists. The term does not include the brushing of teeth.
- (b) All health care workers who perform surgical or obstetrical procedures or dental procedures and who know themselves to be infected with HIV or hepatitis B shall notify the State Health Director. Health care workers who assist in these procedures in a manner that may result in exposure of patients to their blood and who know themselves to be infected with HIV or hepatitis B shall also notify the State Health Director. The notification shall be made in writing to the Chief, Communicable Disease Control Branch, 1902 Mail Service Center, Raleigh, NC 27699-1902..
- (c) The State Health Director shall investigate the practice of any infected health care worker and the risk of transmission to patients. The investigation may include review of medical and work records and consultation with health care professionals who may have information necessary to evaluate the clinical condition or practice of the infected health care worker. The attending physician of the infected health care worker shall be consulted. The State Health Director shall protect the confidentiality of the infected health care worker and may disclose the worker's infection status only when essential to the conduct of the investigation or periodic reviews pursuant to Paragraph (h) of this Rule. When the health care worker's infection status is disclosed, the State Health Director shall give instructions regarding the requirement for protecting confidentiality.
- (d) If the State Health Director determines that there may be a significant risk of transmission of HIV or hepatitis B to patients, the State Health Director shall appoint an expert panel to evaluate the risk of transmission to patients, and review the practice, skills, and clinical condition of the infected health care worker, as well as the nature of the surgical or obstetrical procedures or dental procedures performed and operative and infection control techniques used. Each expert panel shall include an infectious disease specialist, an infection control expert, a person who practices the same occupational specialty as the infected health care worker and, if the health care worker is a licensed professional, a representative of the appropriate licensure board. The panel may include other experts. The State Health Director shall consider for appointment recommendations from health care organizations and local societies of health care professionals.
- (e) The expert panel shall review information collected by the State Health Director and may request that the State Health Director obtain additional information as needed. The State Health Director shall not reveal to the panel the identity of the infected health care worker. The infected health care worker and the health care worker's attending physician shall be given an opportunity to present information to the panel. The panel shall make recommendations to the State Health Director that address the following:
- (1) Restrictions that are necessary to prevent transmission from the infected health care worker to patients;
 - (2) Identification of patients that have been exposed to a significant risk of transmission of HIV or hepatitis B; and
 - (3) Periodic review of the clinical condition and practice of the infected health care worker.
- (f) If, prior to receipt of the recommendations of the expert panel, the State Health Director determines that immediate practice restrictions are necessary to prevent an imminent threat to the public health, the State Health Director shall issue an isolation order pursuant to G.S. 130A 145. The isolation order shall require cessation or modification of some or all surgical or obstetrical procedures or dental procedures to the extent necessary to prevent an imminent threat to the public health. This isolation order shall remain in effect until an isolation order is issued pursuant to Paragraph (g) of this Rule or until the State Health Director determines the imminent threat to the public health no longer exists.
- (g) After consideration of the recommendations of the expert panel, the State Health Director shall issue an isolation order pursuant to G.S. 130A 145. The isolation order shall require any health care worker who is allowed to continue performing surgical or obstetrical procedures or dental procedures to, within a time period specified by the State Health Director, successfully complete a course in infection control procedures approved by the Department of Health and Human Services, General Communicable Disease Control Branch, in accordance with 10A NCAC 41A .0206(e). The isolation order shall require practice restrictions, such as cessation or modification of some or all surgical or obstetrical procedures or dental procedures, to the extent necessary to prevent a significant risk of transmission of HIV or hepatitis B to patients. The isolation order shall prohibit the performance of procedures that cannot be modified to avoid a significant risk of transmission. If the State Health Director determines that there has been a significant risk of transmission of HIV or hepatitis B to a patient, the State Health Director shall notify the patient or assist the health care worker to notify the patient.
- (h) The State Health Director shall request the assistance of one or more health care professionals to obtain information needed to periodically review the clinical condition and practice of the infected health care worker who performs or assists in surgical

or obstetrical procedures or dental procedures.

(i) An infected health care worker who has been evaluated by the State Health Director shall notify the State Health Director prior to a change in practice involving surgical or obstetrical procedures or dental procedures. The infected health care worker shall not make the proposed change without approval from the State Health Director. If the State Health Director makes a determination in accordance with Paragraph (c) of this Rule that there is a significant risk of transmission of HIV or hepatitis B to patients, the State Health Director shall appoint an expert panel in accordance with Paragraph (d) of this Rule. Otherwise, the State Health Director shall notify the health care worker that he or she may make the proposed change in practice.

(j) If practice restrictions are imposed on a licensed health care worker, a copy of the isolation order shall be provided to the appropriate licensure board. The State Health Director shall report violations of the isolation order to the appropriate licensure board. The licensure board shall report to the State Health Director any information about the infected health care worker that may be relevant to the risk of transmission of HIV or hepatitis B to patients.

History Note: Authority G.S. 130A 144; 130A 145;

Eff. October 1, 1992; Amended Eff. April 1, 2003.

(Adopted November 1992)

(Amended May 1996; January 2005)

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:

- the basis on which fees are determined, including charges for specific services;
- methods of payment;
- 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)

THE MEDICAL SUPERVISOR -TRAINEE RELATIONSHIP

It is the position of the North Carolina Medical Board that the relationship between medical supervisors and their trainees in medical schools and other medical training programs is one of the most valuable aspects of medical education. We note, however, that this relationship involves inherent inequalities in status and power that, if abused, may adversely affect the educational experience and, ultimately, patient care. Abusive behavior in the medical supervisor-trainee relationship, whether physical or verbal, is a form of unprofessional conduct. However, criticism and/or negative feedback that is offered with the aim of improving the educational experience and patient care should not be construed as abusive behavior.

(Adopted April 2004)

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

August - September - October 2005

DEFINITIONS:

Annulment:

Retrospective and prospective cancellation of the practitioner's authorization to practice.

Conditions:

A term used in this report to indicate restrictions, requirements, or limitations placed on the practitioner.

Consent Order:

An order of the Board stating an agreement between the Board and the practitioner regarding the annulment, revocation, suspension, or surrender of the authorization to practice, or the conditions placed on the authorization to practice, or other action taken by the Board relative to the practitioner. (A method for resolving a dispute without a formal hearing.)

Denial:

Final decision denying an application for practice authorization or a request for reconsideration/modification of a previous Board action.

Dismissal:

Board action dismissing a contested case.

Inactive Medical License:

To be "active," a medical license must be registered on or near the physician's birthday each year. By not registering his or her license, the physician allows the license to become "inactive." The holder of an inactive license may not practice medicine in North Carolina. Licensees will often elect this status when they retire or do not intend to practice in the state. (Not related to the "voluntary surrender" noted below.)

NA:

Information not available or not applicable.

NCPHP:

North Carolina Physicians Health Program.

RTL:

Resident Training License. (Issued to those in post-graduate medical training who have not yet qualified for a full medical license.)

Revocation:

Cancellation of the authorization to practice. Authorization may not be reissued for at least two years.

Stay:

The full or partial stopping or halting of a legal action, such

as a suspension, on certain stipulated grounds.

Summary Suspension:

Immediate withdrawal of the authorization to practice prior to the initiation of further proceedings, which are to begin within a reasonable time. (Ordered when the Board finds the public health, safety, or welfare requires emergency action.)

Suspension:

Withdrawal of the authorization to practice for a stipulated period of time or indefinitely.

Temporary/Dated License:

License to practice 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 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. (Not related to the "inactive" medical license noted above.)

ANNULMENTS

NONE

REVOICATIONS

BERTLESON, Douglas Eugene, MD

Location: Pasadena, CA
 DOB: 7/09/1953
 License #: 0096-00414
 Specialty: OB/GYN (as reported by physician)
 Medical Ed: Loma Linda University (1979)
 Cause: Dr Bertleson's California medical license was revoked by the California Board in October 2004 for dishonesty and the making of false statements. He was also fined \$9,509.37.
 Action: 10/24/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 10/19/2005: Dr Bertleson's North Carolina medical license is revoked.

CRITTENDEN, John Jay, MD

Location: Pensacola, FL
 DOB: 3/12/1960
 License #: 0000-30796
 Specialty: OPH (as reported by physician)
 Medical Ed: University of South Alabama (1985)
 Cause: Dr Crittenden's Florida medical license was suspended by the Florida Board based on information he suffered a relapse in his addiction to cocaine.
 Action: 9/01/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/18/2005: Dr Crittenden's North Carolina medical license is revoked.

CYNN, Steven Jae, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 11/12/1936
 License #: 0000-19592
 Specialty: FP/Nutrition (as reported by physician)
 Medical Ed: Yonsei University, Korea (1961)
 Cause: Dr Cynn was convicted of several felonies in Mecklenburg County Superior Court (State of North Carolina v. Steven Jae Cynn) in 2004.
 Action: 8/25/2005. Entry of Revocation issued: Dr Cynn's North Carolina medical license is revoked by operation of law as of 7/10/2005.

KISSINGER, James Michael, MD

Location: Durham, NC (Durham Co)
 DOB: 5/25/1964
 License #: 0095-01571
 Specialty: IM (as reported by physician)
 Medical Ed: University of Miami (1990)
 Cause: In 1998, the Georgia Board suspended Dr Kissinger's Georgia medi-

cal license and he was to enter treatment for chemical dependency. In 2000, Florida ordered he comply with all terms of the Georgia order and remain under contract with the Florida Physicians Recovery Network. In December 2003, the Florida Board revoked Dr Kissinger's Florida license based on his being unable to practice with reasonable skill and safety due to his relapse on cocaine and alcohol.
 Action: 9/07/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 10/20/2004: Dr Kissinger's North Carolina medical license is revoked.

OLCHOWSKI, Steven Edward, MD

Location: Ionia, MI
 DOB: 11/24/1947
 License #: 0095-00169
 Specialty: GS/CRS (as reported by physician)
 Medical Ed: St. Louis University (1973)
 Cause: The Board found that Dr Olchowski committed the following acts of misconduct: he performed a surgical procedure on five patients other than the one for which he had obtained informed consent; he falsified the medical records of eight patients by indicating in various places on those records that he had performed a Roux-en-Y procedure when he had performed a loop bypass or a loop bypass with a Braun anastomosis; he falsified a patient's operative report to indicate he had performed a Roux-en-Y when he had performed a loop bypass with a Braun anastomosis; he billed eight insurance providers for Roux-en-Y procedures when he had performed a loop bypass or a loop bypass with a Braun anastomosis; he obtained express prior approval from, and/or billed, insurance providers for a Roux-en-Y procedure for eight patients on whom he actually performed a loop bypass or a loop bypass with a Braun anastomosis; the Georgia Board denied his medical license application; the Kentucky Board denied his medical license application; he provided false responses to questions on his application for a Georgia medical license; he provided false responses to questions on his application for a Texas medical license; he provided false responses to questions on his application for a Florida medical license.
 Action: 9/09/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/17/2005: Dr Olchowski's North Carolina medical license is revoked for each of the 10 Board findings noted above; may not make application for at least two years.

ROBINSON, Taylor, MD

Location: Eugene, OR
 DOB: 7/10/1945
 License #: 0000-21707
 Specialty: NA
 Medical Ed: Louisiana State University, New Orleans (1971)
 Cause: Dr Robinson last practiced medicine in Oregon, though he has not practiced there since 1993, when his license was revoked by the Oregon Board of Medical Examiners. In a Final Order dated 1/13/2005, the Or-

egon Board denied Dr Robinson's application for a medical license based on the fact he had provided false information to the Board, committed fraud or made misrepresentations to the Board, engaged in unprofessional or dishonorable conduct, and refused an invitation to meet with the Board.

Action: 9/09/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/17/2005: Dr Robinson's North Carolina medical license is revoked.

SUSPENSIONS

GARDEN, John Wells, MD

Location: Lexington, KY
 DOB: 5/15/1935
 License #: 0000-13106
 Specialty: OPH (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1961)
 Cause: Dr Garden's application for renewal of his Kentucky license was denied on a finding that he had refused to enter into a Letter of Agreement requiring a Kentucky Physicians Health Foundation aftercare contract for alcohol dependency. The Letter was a condition for renewal of his license.

Action: 9/01/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/18/2005: Dr Garden's North Carolina medical license is indefinitely suspended.

GOULD, James Douglas, MD

Location: Virginia Beach, VA
 DOB: 3/21/1968
 License #: 0096-01327
 Specialty: AN (as reported by physician)
 Medical Ed: State University of New York (1994)
 Cause: In December 2003, the Virginia Board placed conditions on Dr Gould's medical license due to diverting and self-administering controlled substances. He was ordered to continue to comply with his Treatment Program Agreement with the Medical Society of DC and with his Recovery Monitoring Contract.

Action: 9/02/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/18/2005: Dr Gould's North Carolina medical license is indefinitely suspended.

HAMVAS, Rania Kouatli, MD

Location: Marietta, GA
 DOB: 7/12/1957
 License #: 0000-36195
 Specialty: FP/GS (as reported by physician)
 Medical Ed: University of Damascus, Syria (1980)
 Cause: On 6/10/2004, the Georgia Board and Dr Hamvas entered into a Consent Order in which Dr Hamvas was suspended and reprimanded on information he abused opiates and was arrested for attempting to obtain controlled substances by fraud.

Action: 9/02/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/18/2005: Dr Hamvas' North Carolina medical license is indefinitely suspended.

JOHNSON, Pamela Lashmet, MD

Location: Bellaire, Tx
 DOB: 2/08/1959
 License #: 0000-35931
 Specialty: OB/GYN (as reported by physician)
 Medical Ed: University of Illinois (1989)
 Cause: In 2003, Dr Johnson entered into a Consent Order with the Michigan Board admitting she misrepresented her employment history on her application for a Michigan license by failing to disclose the circumstances of her change in staff privileges at three North Carolina hospitals and/or her employment contract with Triangle Obstetrics and Gynecology Associates. Michigan also charged her based on her being disciplined by the New Mexico Board for misrepresentations on an application and by the Virginia Board based on New Mexico's action. Her license was suspended by Michigan for 18 months.

Action: 8/31/2005. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 8/18/2005: Dr Johnson's North Carolina medical license is suspended for 18 months; suspension is stayed.

See Consent Orders:

FARRELL, Edwin Gayle, MD
FREEMAN, Tyler Ira, MD
HALL, Charles Daniel, MD
KING, David James, MD
KPEGLO, Maurice Kobra, MD
KULUBYA, Edwin Samuel, MD
LARSON, Michael Joseph, MD
McCALL, Michael Alvin, MD
PARIKH, Prashant Pramod, MD
PHILLIPS, Thomas Caldwell, III, MD

SEAL, James Hargett, Physician Assistant

SELLERS, Marc T., Physician Assistant

STOCKS, Lewis Henry, III, MD

SUTTON, Frank Morrison, Jr, MD

URETZKY, Ira David, MD

WARD, Amy Elizabeth, MD

WESSEL, Richard Frederick, MD

SUMMARY SUSPENSIONS

MERCIER, Randall Robert, MD

Location: Pinehurst, NC (Moore Co)
 DOB: 12/06/1953
 License #: 0000-26898
 Specialty: IM/ISM (as reported by physician)
 Medical Ed: Tulane University (1980)
 Cause: Dr Mercier may be unable to practice medicine with reasonable skill and safety to patients as shown by the Notice of Charges and Allegations/ Notice of Hearing filed 10/25/2005, which is available in the physician's record as it appears on the Board's Web site at www.ncmedboard.org.

Action: 10/25/2005. Order of Summary Suspension of License issued: Dr Mercier's North Carolina medical license is suspended on service of this Order at his last known address.

CONSENT ORDERS

ADKINS, Paula Clark, MD

Location: South Charleston, WV
 DOB: 11/26/1965
 License #: 0099-00745
 Specialty: EM (as reported by physician)
 Medical Ed: Marshall University School of Medicine (1996)
 Cause: On application for restoration of Dr Adkins' medical license. On 6/19/2004, Dr Adkins was charged by Pinehurst, NC, law enforcement officials with one count of obtaining a controlled substance by false pretense and eight counts of attempting to obtain controlled substances by false pretenses. As a result of her arrest, she surrendered her North Carolina medical license on 8/25/2004. On 9/09/2004, she pled guilty in Moore County District Court to nine misdemeanor counts of common law forgery arising from the original charges. She received a suspended sentence and probation. She submitted herself to an assessment by the NCPHP and the NCPHP recommended she undergo residential treatment for chemical dependency and opiate abuse. On 6/03/2005, the Board entered into a Consent Order with Dr Adkins whereby her medical license was indefinitely suspended. On 7/21/2005, a panel of the Board met with Dr Adkins and she reported she had completed a four-week outpatient program in Kentucky and a four-week inpatient program at Bellafonte Hospital. She also reported she is continuing with psychotherapy and AA meetings. She is seeing a psychiatrist every two months in Pinehurst for depression.

Action: 8/29/2005. Consent Order executed: The Board reissues Dr Adkins' medical license; should she relocate to North Carolina or intend to resume practice in North Carolina, the NCPHP will reevaluate the need for additional treatment prior to advocating for her return to practice here. In addition, she must notify the Board of her intention to resume practice in North Carolina, must demonstrate she has the NCPHP's advocacy, and must receive prior approval from the Board's president; unless lawfully prescribed by someone else, she shall refrain from the use of mind- or mood-altering substances, including alcohol, and she shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, she shall supply bodily fluids or tissues to allow screening for use of such substances; she shall maintain and abide by a contract with the NCPHP; she must continue to attend AA and NA meetings; must comply with other conditions.

BLACHE, Tonya Lashon, MD

Location: Wake Forest, NC (Wake Co)
 DOB: 04/29/1962
 License #: 2005-01685
 Specialty: Public Health (as reported by physician)
 Medical Ed: Morehouse School of Medicine (1989)
 Cause: On application for medical license. Dr Blache is licensed in California and Georgia, but she has not practiced medicine since July 2000. She has gotten CME credit since that time and has the Physician's Recognition Award from the AMA valid til September 2005. She shared with the Board a narrative plan to update her skills, though she does not intend to return to clinical practice at this time. Her intention is to practice only in an administrative setting, performing child health and safety consultations.

Action: 9/21/2005. Consent Order executed: Dr Blache is granted a limited administrative medical license that requires she restrict her practice to administrative medicine and not engage in clinical practice; prior to resuming clinical practice in North Carolina, she must submit a complete application for a license containing a plan to update her medical skills and must obtain approval of her practice site from the president of the

Board.

BROWN, Allen, Physician Assistant

Location: Raeford, NC (Union Co)
 DOB: 7/22/1949
 License #: 0001-01663
 PA Education: Alderson Broadbudds (1992)
 Cause: On 6/07/2005, Mr Brown was asked by a Board investigator to produce several of the documents required for his practice as a PA, which must be made available for inspection on request by a Board agent. Mr Brown could not produce them. He also stated he did not know he was supposed to maintain a quality improvement plan or a signed back-up supervising physician agreement. He knew the protocols of the clinic and was aware of the Scope of Practice and Prescription Authorization but did not remember signing it. He also reported having only six hours of CME in the past two years.

Action: 10/13/2005. Consent Order executed: Mr Brown is reprimanded.

CARLSON, James Lennart, MD

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)
 Cause: Amended Consent Order of 5/14/2003 is amended.
 Action: 9/30/2005. Amended Consent Order executed: Lifts the requirement in Dr Carlson's Amended Consent Order of 5/14/2003 for use of a chapron.

CAULFIELD, Walter Harry, III, MD

Location: Gastonia, NC (Gaston Co)
 DOB: 6/12/1962
 License #: 0096-00399
 Specialty: PS (as reported by physician)
 Medical Ed: University of Pittsburgh (1988)
 Cause: Dr Caulfield and his partners at Southeastern Plastic Surgery (SEPS) in Gastonia received sales and marketing materials from Toxin Research International, Inc, promoting Botulinum Neurotoxin Type A (BNTA) as a safe and effective therapy for treatment of wrinkles and they ordered a supply of BNTA. Separate consent forms were prepared and provided to patients of SEPS receiving the TRI product advising them they were to get non-FDA-approved BNTA. The form also included language that BNTA had been "proven safe in clinical trials." Dr Caulfield was aware BNTA, the same active ingredient in both the FDA-approved BOTOX and the TRI product, had been proven safe in clinical trials relating to Allergan BOTOX. However, SEPS failed to exercise due diligence in confirming the accuracy of the statement "proven safe in clinical trials" in its consent form, in that it was not known whether TRI had conducted such trials. In January 2005, Dr Caulfield and SEPS learned through the media that a problem may have been encountered with non-FDA approved BNTA products in another state and that the FDA was investigating TRI and other makers. SEPS immediately ceased use of the TRI product; it notified all patient who received the TRI product and inquired about any problems encountered as a result of its use. To date, no patients have reported unusual side effects or complications. Dr Caulfield and SEPS have fully cooperated with the Board's investigation. Dr Caulfield has no prior history of patient complaints with the Board and SEPS provides plastic, reconstructive, and hand surgery services to the underinsured and uninsured in Gaston, Cleveland, Lincoln, and Rutherford Counties. Dr Caulfield also has a record of service to underserved areas of western North Carolina and has volunteered surgical services overseas. He voluntarily wrote to his patients regarding this issue and met with those who wished it. He has expressed remorse and apologizes for the lack of due diligence in this matter.

Action: 9/23/2005. Consent Order executed: Dr Caulfield is reprimanded.

CLARK, Vivian Elizabeth, MD

Location: Chapel Hill, NC (Orange Co)
 DOB: 3/30/1953
 License #: 0000-30614
 Specialty: OB/GYN (as reported by physician)
 Medical Ed: Boston University (1981)
 Cause: On 7/23/2004, Dr Clark was on call for her hospital. That morning, she had performed a caesarian section at Durham Regional Hospital and then left for home. Having completed on-call duties at 9:30 AM, she returned home, had a glass of wine with lunch, and became involved with a stressful matter that involved running errands. During her errands, she was involved in a minor auto accident in a store parking lot, striking a parked car while she was pulling into the adjacent parking space. She left her name and number on the other car's windshield and went home. Unsettled by the incident, she had another glass of wine at home. Someone called the police and the police went to Dr Clark's home. By the time they arrived, she had consumed more than half a bottle of wine. She was arrested and charged with driving under the influence of alcohol. She returned to the hospital that night after her arrest, but was not

needed. She later pled guilty to reckless driving and the DUI charge was dropped. She self-referred to and has been assessed by the NCPHP, which reported its opinion that she is not an alcoholic and that this behavior will not be repeated. She has expressed sincere sorrow over these events.

Action: 10/18/2005. Consent Order executed: Dr Clark is reprimanded.

COLEMAN, Elizabeth Anne, MD

Location: Wilmington, NC (New Hanover Co)
 DOB: 2/21/1951
 License #: 0000-29062
 Specialty: P (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1983)
 Cause: On application for reissuance of her license. Dr Coleman asked her license become inactive in 1991 and she has not practiced since then. She now wishes to practice with a volunteer license under supervision of a practicing psychiatrist for a limited time each week. She has had a neuropsychological examination that she would like to have made public. She has kept her CME up to date.

Action: 9/01/2005. Consent Order executed: Dr Coleman's license is reissued; she is approved to practice under supervision of a physician to be approved by the president of the Board; she must have prior approval by the president of the Board before changing practice locations; her supervising physician shall send the Board a quarterly report on the level of her demonstrated clinical skill; she shall practice no more than 16 hours a week; the result of her neuropsychological examination shall be attached to this Consent Order; must comply with other conditions.

CRANFORD, Marian Elaine, Physician Assistant

Location: Chapel Hill, NC (Orange Co)
 DOB: 1/02/1948
 License #: 0001-00143
 PA Education: University of North Carolina (1975)
 Cause: The license of Ms Cranford's supervising physician became inactive in June 1999. From that time through August 2003, she practiced as a PA without submitting the required intent to practice forms with the Board.
 Action: 8/17/2005. Consent Order executed: Ms Cranford is reprimanded; must inform the Board of any change of residence or practice address within 10 days of change.

DYER, Eric Wayne, Physician Assistant

Location: Southport, NC (Brunswick Co)
 DOB: 4/01/1974
 License #: 0010-00320
 PA Education: South University (2005)
 Cause: Between August 1998 and October 2002, Mr Dyer practiced as an athletic trainer in Tennessee without a Tennessee license. He obtained a license in October 2002. In 2003, his athletic training certificate was placed on probation by the National Athletic Trainers Association and he was required to do 40 additional hours of CEU due to his neglecting to provide his CEU requirements for 2000-2002. On 2/03/2004, he received a Letter of Reprimand from the Tennessee State Medical Board for practicing as an athletic trainer without a license.
 Action: 10/21/2005. Consent Order executed: Mr Dyer is reprimanded. He is issued a North Carolina PA license.

EMERSON, Eric Tomson, MD

Location: Gastonia, NC (Gaston Co)
 DOB: 9/16/1964
 License #: 0097-00938
 Specialty: PS (as reported by physician)
 Medical Ed: Vanderbilt University (1990)
 Cause: Dr Emerson and his partners at Southeastern Plastic Surgery (SEPS) in Gastonia received sales and marketing materials from Toxin Research International, Inc, promoting Botulinum Neurotoxin Type A (BNTA) as a safe and effective therapy for treatment of wrinkles and they ordered a supply of BNTA. Separate consent forms were prepared and provided to patients of SEPS receiving the TRI product advising them they were to get non-FDA-approved BNTA. The form also included language that BNTA had been "proven safe in clinical trials." Dr Emerson was aware BNTA, the same active ingredient in both the FDA-approved BOTOX and the TRI product, had been proven safe in clinical trials relating to Allergan BOTOX. However, SEPS failed to exercise due diligence in confirming the accuracy of the statement "proven safe in clinical trials" in its consent form, in that it was not known whether TRI had conducted such trials. In January 2005, Dr Emerson and SEPS learned through the media that a problem may have been encountered with non-FDA approved BNTA products in another state and that the FDA was investigating TRI and other makers. SEPS immediately ceased use of the TRI product; it notified all patient who received the TRI product and inquired about any problems encountered as a result of its use. To date, no patients have reported unusual side effects or complications. Dr Emerson and SEPS have fully cooperated with the Board's investigation. Dr Emerson has no prior history of patient complaints with the Board and SEPS provides

plastic, reconstructive, and hand surgery services to the underinsured and uninsured in Gaston, Cleveland, Lincoln, and Rutherford Counties. Dr Emerson also has a record of service to underserved areas of western North Carolina. He has expressed remorse and apologizes for the lack of due diligence in this matter.

Action: 9/23/2005. Consent Order executed: Dr Emerson is reprimanded.

FARRELL, Edwin Gayle, MD

Location: McLeansville, NC (Guilford Co)
 DOB: 3/13/1945
 License #: 0000-17345
 Specialty: Ped/Adol Med (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1971)
 Cause: Dr Farrell prescribed oxycodone to Patient A on several occasions while he had a significant emotional relationship with Patient A. He thought at first the patient had a legitimate need for the drug. He later realized he should not be prescribing to the patient and informed the patient of that fact. He also called local pharmacies to tell them not to fill the prescriptions. The patient became upset with Dr Farrell and approached him to write a prescription for the drug to another person with whom Dr Farrell did not have a patient/physician relationship. Dr Farrell says he felt threatened and wrote the prescription. When the Board discovered this, it gave him the choice of surrendering his license or being summarily suspended. He surrendered his license on 12/07/2004.

Action: 4/07/2005. Consent Order executed: Dr Farrell's license is suspended indefinitely.

FENN, Tracy Ann, Physician Assistant

Location: Henderson, NC (Vance Co)
 DOB: 7/21/1966
 License #: 0010-00278
 PA Education: Emory University (1995)
 Cause: Ms Fenn failed to reveal on her application for a PA license that she had been charged with driving under the influence, a question specifically asked on the application form. The Board requests fingerprints of license applicants and conducts criminal background checks. As a result of its background check on Ms Fenn, the Board learned she had been arrested in Georgia for DUI in 1987. She had pled no contest to the charge and the Georgia court withheld adjudication of the charge on condition she not commit any further offenses for a set period of time. Ms Fenn complied with the condition and the charge was never adjudicated. She explained that her failure to disclose her 1987 arrest was unintentional.

Action: 10/11/2005. Consent Order executed: Ms Fenn is granted a full and unrestricted PA license; she shall abide by all laws, rules, and regulations in the future.

FREEMAN, Tyler Ira, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 2/01/1934
 License #: 0000-25706
 Specialty: IM/OM (as reported by physician)
 Medical Ed: Chicago Medical School (1959)
 Cause: Dr Freeman served as medical director of NeoGenesis in Charlotte, NC, from 2002 to 2005. The founder of NeoGenesis, William Pearce, is not a physician, but he performed chelation therapy and medical acts on patients at NeoGenesis and issued prescriptions in Dr Freeman's name without Dr Freeman examining the patients or establishing a physician-patient relationship. Dr Freeman learned during his tenure that Mr Pearce was performing medical acts and was not a physician. Dr Freeman did not come to the clinic on a regular basis, did not examine patients, and did not prepare or review medical records on a regular basis. Dr Freeman's conduct was unprofessional and constituted aiding and abetting the unlicensed practice of medicine.

Action: 10/19/2005. Consent Order executed: Dr Freeman's North Carolina medical license is suspended indefinitely and he may not apply for reinstatement for at least six months; he shall not be entitled to issue prescriptions; he shall surrender his DEA privileges; he shall continue to practice only in the area of disability determination upon his resumption of practice; must comply with other conditions.

GREENBERG, Richard Paul, MD

Location: Shelby, NC (Cleveland Co)
 DOB: 01/06/1944
 License #: 0097-01758
 Specialty: NS (as reported by physician)
 Medical Ed: University of Bologna School of Medicine (1969)
 Cause: Dr Greenberg's privileges at Gaston Memorial Hospital were restricted in 2005 as the result of peer review of his patients. He was required to obtain a concurring opinion prior to performing any spinal surgery and to have a board certified surgeon scrub with him when doing spinal surgery. The Medical Board had an expert medical review conducted of 11 of Dr Greenberg's cases thought to be problematic. Three of those cases were criticized as below the standard of care. A fourth case, from 2002, was also found to be below the standard of care. Dr Greenberg has had limited vision in one eye since he was injured at the age of three and he

has limited color vision in both eyes, but the identified surgical problems did not result from Dr Greenberg's vision problems. However, he never informed those making licensing and credentialing decisions relating to him about his visual limitations, and he acknowledges he should have done so.

Action: 10/19/2005. Consent Order executed: Dr Greenberg's license is hereby limited: he shall not perform any surgery in the state of North Carolina; he shall disclose his vision problems—whether asked or not—when applying for any medical or surgical privileges; he will be allowed to evaluate and treat patients as long as he does not perform surgery; he agrees to random chart reviews by the Board; must comply with other conditions.

HALL, Charles Daniel, MD

Location: Supply, NC (Brunswick Co)
 DOB: 5/25/1964
 License #: 0094-01205
 Specialty: N (as reported by physician)
 Medical Ed: Duke University School of Medicine (1990)
 Cause: Dr Hall was arrested in the fall of 2004 for driving while impaired and pled guilty to misdemeanor DWI. At the time of his arrest, he was a participant in the NCPHP for past substance abuse problems. He has successfully completed a three-month residential treatment program. He has a contract with the NCPHP, which reports he is compliant.

Action: 8/18/2005. Consent Order executed: Dr Hall's North Carolina medical license is indefinitely suspended; said suspension is stayed and he is placed on probation under specific conditions; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; he shall practice only in a setting approved in advance by the Board's president; must comply with other conditions.

HARRISON, Joy Gwendolyn, MD

Location: Oyster Bay, NY
 DOB: 1/18/1946
 License #: 0098-01296
 Specialty: EM/IM (as reported by physician)
 Medical Ed: Hahnemann University (1981)
 Cause: In January 2005, the Massachusetts Board and Dr Harrison entered into a Consent Order in which Dr Harrison was reprimanded, fined \$1,500, and required to complete CME hours. This action was based on the Board's finding that she had improperly prescribed medications to a patient without performing a medical examination.

Action: 9/15/2005. Consent Order executed: Dr Harrison is reprimanded.

HAYWARD, Thomas Zander, III, MD

Location: Indianapolis, IN
 DOB: 10/13/1966
 License #: 0098-00563
 Specialty: GS/CCS (as reported by physician)
 Medical Ed: Northwestern University (1994)
 Cause: While in an operating room at Duke University Medical Center in May 2004, Dr Hayward grabbed a nurse's arm and raised his voice to her in the presence of a patient. The nurse had repositioned the patient, who had already been positioned by Dr Hayward, had lowered the room temperature, and had failed to promptly respond to a trauma page. In September 2004, a nurse on duty in the Duke surgical step-down unit saw that the jejunal feeding tube of one of Dr Hayward's patients had become dislodged and paged a resident to insert a new tube. Prior to the resident's arrival, Dr Hayward entered the room and verbally scolded the nurse for failing to replace the tube. She told him she had discarded the tube. Dr Hayward retrieved the tube and tried to re-insert it in the patient. When the resident entered the room, Dr Hayward put his hand on the resident's collar, pointed him in the direction of the feeding tubes, and told him, in effect, "You have five minutes to find a pediatric feeding tube." Dr Hayward's conduct was the result of fatigue and his concern for patient safety, but he accepts that does not excuse his actions and that the working atmosphere should always remain collegial. The Board has taken into consideration that Dr Hayward has admitted his conduct was ill-advised and has apologized to the appropriate individuals.

Action: 8/30/2005. Consent Order executed: Dr Hayward is reprimanded; he shall obtain an assessment by the Indiana State Medical Association's Physician Assistance Program and comply with any resulting recommendations.

JONES, Frielden Bertie, III, MD

Location: Marshall, NC (Madison Co)
 DOB: 5/02/1950
 License #: 0000-20925
 Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1976)
 Cause: In April 2002, Dr Jones saw Patient A, his patient for seven years, and

renewed Patient A's prescriptions for Percocet® and diazepam, both controlled substances that were appropriate for Patient A's chronic pain at the time. Thereafter, Dr Jones prescribed periodic renewal prescriptions for Patient A at the request of Patient A's sister, who picked up the prescriptions at Dr Jones' office. Dr Jones reports the periodic renewal prescriptions were inadvertently issued for 16 months without Dr Jones examining or talking to Patient A for a periodic assessment. During nearly all that period, Patient A was incarcerated in the North Carolina prison system, a fact of which Dr Jones was unaware. Dr Jones reports that his usual practice was regularly to see and evaluate any patient receiving such prescriptions, but he had no system in place at the time in question in order to ensure such assessments. He reports this situation was an aberration and a departure from his usual practice and there was no intent on his part to depart from prevailing and acceptable medical practice. Neither Dr Jones nor the clinic by which he was employed received any payment or financial gain from the issuance of the renewal prescriptions and Dr Jones had no dishonest or selfish motive. No patient was injured or harmed and Dr Jones has no prior disciplinary action or allegation against him. He has indicated his remorse and has fully cooperated with the Board. He informs the Board that he and the clinic have instituted appropriate remedial measures.

Action: 10/19/2005. Consent Order executed: Dr Jones is reprimanded.

KING, David James, MD

Location: Louisburg, NC (Franklin Co)
 DOB: 12/03/1951
 License #: 0000-33388
 Specialty: IM (as reported by physician)
 Medical Ed: Rutgers (1982)
 Cause: Dr King discussed with several of his patients a personal relationship that had occurred between him and a former employee. He asked a patient to approach the former employee in order to relay a message to her on Dr King's behalf. He discussed his personal feelings about the former employee with his receptionist and caused her to resign. These were inappropriate conversations. He submitted himself for an assessment to the NCPHP and it recommended he undergo a thorough evaluation at the Professional Renewal Center and have additional education and training regarding boundary violations. He had his assessment at the PRC in June 2005. He was admitted to the treatment phase at the PRC and completed it on 7/15/2005. In August, he completed a CME course on maintaining proper boundaries. He understands discussing his personal problems with patients and employees is unprofessional.

Action: 10/19/2005. Consent Order executed: Dr King's North Carolina medical license is suspended for two years; suspension is stayed for all but 90 days, which are deemed to have been served, and he is placed on probation; he will agree to adhere to the requirements of his NCPHP contract; he shall ensure a female chaperone who has read this Consent Order is present when he examines a female patient who is partially or fully undressed; the chaperone shall document she was present and that there was no misconduct or boundary violation; must comply with other conditions.

KPEGLO, Maurice Kobla, MD

Location: Greensboro, NC (Guilford Co)
 DOB: 1/04/1949
 License #: 0000-29314
 Specialty: GP/PD (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1983)
 Cause: Dr Kpeglo has a history of substance abuse. A urine sample taken from him on 4/01/2005 tested positive for alcohol and he admitted having consumed alcohol on the day the sample was collected. He voluntarily surrendered his North Carolina medical license on 4/25/2005. He recently completed an inpatient treatment program for his abuse of alcohol and has entered into a contract with the NCPHP. The NCPHP reports he is compliant with his contract thus far.

Action: 8/17/2005. Consent Order executed: Dr Kpeglo's North Carolina medical license is indefinitely suspended

KULUBYA, Edwin Samuel, MD

Location: Laredo, TX
 DOB: 3/12/1957
 License #: 0000-28770
 Specialty: AN (as reported by physician)
 Medical Ed: Howard University (1982)
 Cause: On 3/01/2004, the California Board ordered a stayed revocation of Dr Kulubya's California medical license on findings of gross negligence, repeated negligence, incompetence, and failure to maintain adequate and accurate medical records. It further ordered he be placed on probation for five years and pay costs of \$13,000.

Action: 8/12/2005. Consent Order executed: Dr Kulubya's North Carolina medical license is indefinitely suspended; said suspension is stayed for five years of probation under the terms and conditions stated in the California Order; this Consent Order mirrors and runs concurrently with the California Order.

LARSON, Michael Joseph, MD

Location: Chapel Hill, NC (Orange Co)
 DOB: 3/17/1951
 License #: 0000-28661
 Specialty: P/GP (as reported by physician)
 Medical Ed: University Saint Thomas, Philippines (1979)
 Cause: Dr Larson began treating Patient A in May 2001. In June 2001, he phoned Patient A and asked her to go on a date with him. Through August 2001, during the physician-patient relationship, Dr Larson and Patient A engaged in a sexual relationship. During August, 2001, Dr Larson and Patient A had sexual intercourse in his office at the Albemarle Mental Health Center and he falsified her medical record to indicate she was seen for an office visit. Dr Larson left Albemarle Mental Health Center and moved to Chapel Hill in late August 2001. He did not advise Patient A of the move.

Action: 10/19/2005. Consent Order executed: Dr Larson's North Carolina medical license is suspended indefinitely as of 11/01/2005; he may not apply for reinstatement until 11/01/2006.

McALISTER, Linda Theresa, MD

Location: Fayetteville, NC (Cumberland Co)
 DOB: 10/20/1950
 License #: 0000-28667
 Specialty: OB/GYN (as reported by physician)
 Medical Ed: University of California, San Francisco (1978)
 Cause: After 2000, Dr McAlister restricted her practice to gynecology, referring many patients to other practitioners for care. After May 2003, she restricted her practice to office-based gynecology, performing no surgeries beyond Level I (as defined in the Board's position statement, "Office Based Procedures") and having no hospital privileges. In July 2004, she obtained a two-day assessment of her gynecology training and practice skills at the Center for Personalized Education for Physicians, located in Colorado. Results of the assessment caused the Board concerns about her clinical competence. Dr McAlister disagrees with the results of the CPEP assessment and submitted comments to CPEP.

Action: 8/18/2005. Consent Order executed: Dr McAlister agrees to limit her practice to office-based gynecology, performing no surgical procedures other than Level I procedures until she gains the approval of the Board to expand her practice; she shall undertake a program of professional development to be approved by the Board, arrangements for which shall be made within 60 days.

McCALL, Michael Alvin, MD

Location: Atlanta, GA
 DOB: 11/04/1961
 License #: 0000-36569
 Specialty: OB/GYN (as reported by physician)
 Medical Ed: University of Florida College of Medicine (1989)
 Cause: In a Consent Order of 2/03/2005, the Georgia Board indefinitely suspended Dr McCall's medical license. In January 2005, he re-entered a substance abuse facility after a relapse and remains in treatment. He has complied with his Consent Order thus far and has an expected discharge date near the end of this year.

Action: 10/19/2005. Consent Order executed: Dr McCall's North Carolina medical license is indefinitely suspended.

MORRIS, Adrian Anthony, MD

Location: Troy, NY
 DOB: 10/07/1956
 License #: 0000-31597
 Specialty: P (as reported by physician)
 Medical Ed: University of Witwatersrand, South Africa (1979)
 Cause: On 9/28/2004, the New York Board and Dr Morris entered into a Consent Order in which Dr Morris received a censure and reprimand, and was prohibited from entering into a patient-physician relationship with Patient A. He admitted he failed to maintain a patient record for Patient A that accurately reflected the patient's evaluation and treatment.

Action: 9/15/2005. Consent Order executed: Dr Morris is reprimanded.

PARIKH, Prashant Pramod, MD

Location: Lansdale, PA
 DOB: 4/19/1962
 License #: 2005-00796
 Specialty: FP (as reported by physician)
 Medical Ed: Grant Medical College, University of Mumbai (1984)
 Cause: In May 2004, Dr Parikh submitted a letter of recommendation to the Board from a fellow physician, but the Board discovered he had written the letter himself and had signed the fellow physician's name. In fact, the Board had previously received an authentic letter of recommendation from the physician in question. The Board received evidence that Dr Parikh's record of service is otherwise unblemished.

Action: 5/09/2005. Consent Order executed: Dr Parikh is issued a license; his license is suspended for one year, that suspension being stayed on condition he be evaluated by the NCPHP and comply with any treatment rec-

ommendations made by the NCPHP; he shall receive written approval of his future practice setting from the president of the Board, which the president is under no obligation to give; must comply with other conditions. [Consent Order terminated on 12/22/05.]

PHILLIPS, Thomas Caldwell, III, MD

Location: Sanford, NC (Lee Co)
 DOB: 8/24/1957
 License #: 0000-32830
 Specialty: NEP/IM (as reported by physician)
 Medical Ed: Emory University (1982)
 Cause: Dr Phillips has a history of substance abuse dating to 1983. On his 1988 North Carolina license application, he failed to inform the Board of his substance abuse history. He admits having used cocaine in November 2003 and February 2004. On 9/11/2004, he became intoxicated and, as a result of a domestic dispute to which law enforcement responded, he entered and completed three months inpatient treatment for substance abuse. He is a participant in the NCPHP and the NCPHP reports he is in compliance with his NCPHP contract.
 Action: 9/23/2005. Consent Order executed: Dr Phillips' North Carolina medical license is suspended indefinitely, beginning 10/15/2005; suspension is stayed after 60 days on terms and conditions; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

RUTLEDGE, Robert, MD

Location: Henderson, NV
 DOB: 8/27/1951
 License #: 0000-29656
 Specialty: GS (as reported by physician)
 Medical Ed: University of Florida (1978)
 Cause: In applying for a medical license in Nevada, Dr Rutledge did not disclose on his application that the North Carolina Medical Board had investigated his practice in 2001 and 2002. On reflection, he acknowledges that information was necessary for the Nevada Board to make an informed decision, though the Court in Washoe County, Nevada, ruled Dr Rutledge did not attempt to mislead the Nevada Board.
 Action: 10/19/2005. Consent Order executed: Dr Rutledge is reprimanded; he shall affirmatively reveal the Board's inquiries discussed in this Consent Order in all his applications for a medical license, hospital or health care facility privileges, or participation as a health care provider.

SEAL, James Hargett, Physician Assistant

Location: Ocracoke, NC (Hyde Co)
 DOB: 4/07/1969
 License #: 0001-02454
 PA Education: Medical University of South Carolina (1997)
 Cause: Mr Seal performed an extensive laceration repair of the bicep of a patient, placed a patient under conscious sedation to remove a pilonidal cyst from the patient's sacrum, and sutured a patient's index finger wound in violation of his obligations under the statute. He also failed to ensure that patient charts were countersigned by his supervising physician in a timely manner. Further, he falsified the medical records of one patient and made false entries in the office narcotic inventory record, including entries for Demerol® injections that were not administered to the patient. Mr Seal surrendered his PA license in December 2002 and has not performed medical acts as a PA since that time. He suffered from substance abuse and diagnosed psychological conditions at the time of some or all of the above actions and is now under contract with the NCPHP. He is not able to return to practice as a result of these conditions. Investigation into Mr Seal's actions began as a result of a complaint made by his acting supervising physician.
 Action: 8/18/2005. Consent Order executed: Mr Seal's PA license is suspended indefinitely.

SELLERS, Marc T., Physician Assistant

Location: Andrews, NC (Cherokee Co)
 DOB: 6/15/1963
 License #: 0001-01580
 PA Education: Bowman Gray (1992)
 Cause: Mr Sellers has a history of abusing hydrocodone and other substances. In August 2003, he entered into a Consent Order with the Board in which he received a 30-day stayed suspension and agreed to refrain from use of mind- or mood-altering substances and all controlled substances. On 9/02/2004, he was arrested and charged in Cherokee County with Driving While Impaired. Mr Sellers admitted to consuming five beers. He surrendered his PA license on 9/10/2004.
 Action: 10/19/2005. Consent Order executed: Mr Sellers' North Carolina PA license is indefinitely suspended.

SILVER, Danny, MD

Location: North Richland Hills, TX

DOB: 10/26/1963
 License #: 0095-00723
 Specialty: FP/EM (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1991)
 Cause: On 5/17/2005, Dr Silver pled guilty to five counts of misdemeanor failure to pay taxes due and six counts of misdemeanor willful failure to file North Carolina income tax returns.
 Action: 10/04/2004. Consent Order executed: Dr Silver is reprimanded.

SPEROS, Thomas Lee, MD

Location: Washington, NC (Beaufort Co)
 DOB: 10/26/1949
 License #: 0000-20967
 Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1976)
 Cause: On application for reissuance of license. Dr Speros voluntarily inactivated his license in December 2004 due to health reasons. He has been a compliant participant in the NCPHP and has undergone treatment for his health issues.
 Action: 8/31/2005. Non-Disciplinary Consent Order executed: Dr Speros is reissued a full and unrestricted license; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

STEADMAN, Brent Thomas, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 11/07/1975
 License #: RTL
 Specialty: IM (as reported by physician)
 Medical Ed: Medical College of Georgia School of Medicine (2005)
 Cause: On application for an RTL at Carolinas Medical Center. On 1/31/2001, Dr Steadman was arrested and charged with disorderly conduct for indecent exposure. As a result, he sought the help of the Medical College of Georgia's Committee for Medical Student Well-Being, which advised him to contact the Behavioral Medicine Institute. He enrolled in BMI's extensive cognitive behavior group therapy program. After completing 54 weekly meetings, Dr Steadman continued to meet in group sessions once a month for a year. In May 2005, he applied for an RTL in North Carolina and disclosed he pled no contest to a misdemeanor disorderly conduct charge on 12/01/2004. After making his application, he submitted to an assessment by the NCPHP and signed a monitoring agreement with the NCPHP. In July 2005, the Board reviewed information from the BMI and the NCPHP and concluded Dr Steadman shows no evidence of substance abuse or dependence.
 Action: 8/12/2005. Consent Order executed: Dr Steadman is issued an RTL; he shall maintain and abide by a contract with the NCPHP; he shall regularly attend Caduceus meetings; must comply with other conditions.

STOCKS, Lewis Henry, III, MD

Location: Raleigh, NC (Wake Co)
 DOB: 7/21/1941
 License #: 0000-18344
 Specialty: GS (as reported by physician)
 Medical Ed: Medical College of Wisconsin (1971)
 Cause: A review of Dr Stocks' medical records revealed he consistently failed to keep coherent and accurate records. He has taken steps and has agreed to take steps to insure he is able to practice in a professional manner.
 Action: 8/22/2005. Consent Order executed: Dr Stocks' medical license is suspended for three months, that suspension being stayed on terms and conditions; he shall strictly comply with the Board's position statement titled "Medical Record Documentation"; within six months he shall attend the Intensive Course in Medical Record Keeping with Individual Preceptorships offered at Case Western Reserve University; he shall provide the Board proof of satisfactory completion of that course; must comply with other conditions.

SUTTON, Frank Morrison, Jr, MD

Location: Kinston, NC (Lenoir Co)
 DOB: 7/31/1970
 License #: 2003-01065
 Specialty: AN (as reported by physician)
 Medical Ed: Wake Forest University School of Medicine (1997)
 Cause: Between 12/01/2000 and 11/02/2004, Dr Sutton prescribed various controlled substances and non-controlled substances to Patient A, a close relative. In December 2003, he issued several prescriptions to Patient B, a close relative. Between 4/05/2004 and 7/26/2004, he prescribed several controlled substances to Patient C and had an intimate personal relationship with Patient C. In April 2004, he prescribed a controlled substance to Patient D, the brother of Patient C. In May 2004, he issued several prescriptions to Patient E, a friend of his. Dr Sutton did not maintain appropriate medical charts for any of these patients.
 Action: 8/18/2005. Consent Order executed: Dr Sutton's license is suspended for 12 months beginning on 10/15/2005; all but 30 days of the suspension shall be stayed on conditions; he shall prescribe controlled substances only to those patients to whom anesthesia or pain management services are provided at Lenoir Memorial Hospital; he shall strictly comply

with the Board's position statements related to prescribing; must comply with other conditions. [Amended on 12/22/05 to read ". . . to prescribe substances to anesthesia and pain management patients at any hospital or ambulatory surgical facility licensed by the State of North Carolina.]

SZTULMAN, Luciano, MD

Location: Greenville, AL
 DOB: 5/6/1959
 License #: 0096-00050
 Specialty: OBG/GYN (as reported by physician)
 Medical Ed: FUABC Medical School, Brazil (1983)
 Cause: According to a Consent Order ratified in 2003 by the Rhode Island Board, Dr Sztulman accepted restriction of his hospital privileges and agreed to enroll in a practitioner remediation and enhancement project because the Rhode Island Board found his care for a 29-year-old patient failed to meet minimal standards of care. He failed to recognize a uterine perforation while performing a dilatation and evacuation.
 Action: 10/19/2005. Consent Order executed: Dr Sztulman is reprimanded; he shall comply in all respects with the Rhode Island Consent Order, must comply with other conditions.

TIMMONS, Benson Ellison Lane, IV, MD

Location: Gastonia, NC (Gaston Co)
 DOB: 11/29/1957
 License #: 0000-39341
 Specialty: PS/GS (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1985)
 Cause: Dr Timmons and his partners at Southeastern Plastic Surgery (SEPS) in Gastonia received sales and marketing materials from Toxin Research International, Inc, promoting Botulinum Neurotoxin Type A (BNTA) as a safe and effective therapy for treatment of wrinkles and they ordered a supply of BNTA. Separate consent forms were prepared and provided to patients of SEPS receiving the TRI product advising them they were to get non-FDA-approved BNTA. The form also included language that BNTA had been "proven safe in clinical trials." Dr Timmons was aware BNTA, the same active ingredient in both the FDA-approved BOTOX and the TRI product, had been proven safe in clinical trials relating to Allergan BOTOX. However, SEPS failed to exercise due diligence in confirming the accuracy of the statement "proven safe in clinical trials" in its consent form, in that it was not known whether TRI had conducted such trials. In January 2005, Dr Timmons and SEPS learned through the media that a problem may have been encountered with non-FDA approved BNTA products in another state and that the FDA was investigating TRI and other makers. SEPS immediately ceased use of the TRI product; it notified all patient who received the TRI product and inquired about any problems encountered as a result of its use. To date, no patients have reported unusual side effects or complications. Dr Timmons and SEPS have fully cooperated with the Board's investigation. Dr Timmons has no prior history of patient complaints with the Board and SEPS provides plastic, reconstructive, and hand surgery services to the underinsured and uninsured in Gaston, Cleveland, Lincoln, and Rutherford Counties. Dr Timmons also has a record of service to underserved areas of western North Carolina and on missions to Haiti and Nicaragua. He has expressed remorse and apologizes for the lack of due diligence in this matter.
 Action: 9/23/2005. Consent Order executed: Dr Timmons is reprimanded.

URETZKY, Ira David, MD

Location: Raleigh, NC (Wake Co)
 DOB: 10/21/1966
 License #: 0099-00706
 Specialty: OTO/FPS (as reported by physician)
 Medical Ed: George Washington University (1992)
 Cause: In November 2004, Dr Uretzky became medical director of Premier Body Laser and Skin Clinics, which offered laser hair removal. Premier gave or sold to its laser hair removal clients a product known as LaserGel Plus 10/10, a cream compounded by Triangle Compounding Pharmacy, consisting of active ingredients lidocaine 10%, tetracaine 10%, and phenylephrine 0.5%, for use as an anesthetic. Federal law prohibits dispensing LaserGel without a prescription. Shortly after becoming medical director of Premier, Dr Uretzky contacted Triangle Compounding by e-mail, introducing himself and purporting to authorize Triangle to continue supplying Premier with tubes of LaserGel. During his time as medical director, Triangle supplied Premier with 142 tubes of LaserGel. No physician or other authorized prescriber, including Dr Uretzky, took a medical history or performed a physical examination on any of Premier's clients before Premier sold or gave the client a tube or tubes of LaserGel. During his time as medical director, Dr Uretzky failed to take steps to ensure the staff of Premier safely administered LaserGel, properly dispensed LaserGel, and appropriately instructed patients on the safe use and application of LaserGel. Dr Uretzky had originally agreed to take over as medical director of Premier in January 2005 but was pressed into service early on the unanticipated departure of his predecessor as medical director. He intended to review all Premier's policies, protocols, procedures, and forms, but having begun as medical director six weeks before he

intended, he did not have the opportunity to do so before he began. He was relying on his predecessor to have Premier was operating in accord with good medical practices and the law. His e-mail to Triangle was in keeping with his predecessor's arrangements. In his first days as medical director, he asked personnel at Premier if there had been any issues with Premier, particularly regarding safety, of which he should be aware and if they had any concerns or questions of him before he took over. He was told there had not been issues of safety and that they had no concerns or questions. As he was taking over, he made several attempts to meet with his predecessor, but the two never met. He began to review Premier's policies, protocols, procedures, and forms before he learned any client of Premier's had had any problems. When he first learned of a potential problem with LaserGel, he directed a number of changes in Premier's operations. By the end of December 2004, he directed Premier not use any anesthetic at all. He cooperated fully with the Board in its investigation of this matter.

Action: 9/08/2005. Consent Order executed: Dr Uretzky's North Carolina medical license is indefinitely suspended beginning 10/01/2005; suspension will be stayed as of 3/31/2006; the Notice of Charges and Allegations issued against Dr Uretzky on 4/13/2005 is dismissed; Dr Uretzky shall not serve as medical director of any enterprise providing laser hair removal; must comply with other conditions; no provision of the Consent Order shall constitute an admission for any purpose other than for the relevant proceeding before the North Carolina Medical Board and shall not be admissible in or be made part of any proceeding outside the North Carolina Medical Board.

WARD, Amy Elizabeth, MD

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 9/19/1969
 License #: 0096-00833
 Specialty: AI/PD (as reported by physician)
 Medical Ed: Bowman Gray School of Medicine (1995)
 Cause: On several occasions in late 2004 and early 2005, Dr Ward was observed by colleagues to be in an impaired state during working hours. She was observed falling asleep while attending a patient, spending long periods in the restroom, slurring her speech, and being lethargic. At least once, one of her coworkers saw a used "butterfly" syringe and spattered blood in the office restroom just after Dr Ward exited the restroom. Dr Ward was in inpatient substance abuse treatment for opioid dependence from January to March 2005. She returned to practice on a part-time basis in April 2005, with frequent monitoring by and drug screens conducted by the NCPHP. During the week of 4/11-15/2005, Dr Ward was again seen by her coworkers to be impaired, slurring her speech, and having difficulty walking. On 4/15, her father was contacted to pick her up from the office because she was displaying behavior consistent with intoxication. A syringe was found in her purse. On 4/16, Dr Ward met with a Board investigator and did not deny the allegations. On 4/18, she surrendered her North Carolina medical license.
 Action: 10/19/2005. Consent Order executed: Dr Ward's North Carolina medical license is indefinitely suspended.

WESSEL, Richard Frederick, MD

Location: Coinjock, NC (Currituck Co)
 DOB: 1/24/1959
 License #: 0096-00772
 Specialty: C/IM (as reported by physician)
 Medical Ed: Eastern Virginia Medical School (1990)
 Cause: In 1999, Dr Wessel entered a Consent Order with the Board based on an incident in which he consumed alcohol while on call and attempted to mislead hospital officials who requested a sample of his blood for testing. He was a participant in the NCPHP. From October 2002 through February 2004, on six occasions, Dr Wessel wrote prescriptions for Xanax and hydrocodone for Patient A. He neither examined nor created a medical record for Patient A. The Board requested he submit to a urine screen and, in February 2004, he tested positive for cocaine and hydrocodone. The Board gave him the choice of surrendering his license or having it summarily suspended. He surrendered his license on 4/14/2004.
 Action: 10/19/2005. Consent Order executed: Dr Wessel's North Carolina medical license is indefinitely suspended.

WHITMER, Gilbert Gomer, Jr, MD

Location: Dunn, NC (Harnett Co)
 DOB: 9/04/1961
 License #: 0000-36854
 Specialty: ORS/ORS-Hand (as reported by physician)
 Medical Ed: The Johns Hopkins (1987)
 Cause: On application for reissuance of license surrendered on 7/08/2004. His license was suspended by Consent Order on 2/08/2005 based on his having tested positive for marijuana in violation of a prior Consent Order. Since surrendering his license, Dr Whitmer has completed over three months of residential treatment for chemical dependence and has a contract with the NCPHP. The NCPHP reports he is compliant.
 Action: 8/09/2005. Consent Order executed: Dr Whitmer is issued a license to expire on the date shown on the license [12/07/2005]; unless law-

fully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

YAO, Zhenhai, MD

Location: Chapel Hill, NC (Orange Co)
 DOB: 7/17/1963
 License #: 2001-00203
 Specialty: AN (as reported by physician)
 Medical Ed: Sun Yat-Sen University, China (1987)
 Cause: In August 2002, the U.S. PHS entered into a Voluntary Exclusion Agreement with Dr Yao and the University of North Carolina. In the agreement, the U.S. PHS and UNC found Dr Yao had engaged in scientific misconduct in animal research funded by the National Heart, Lung, and Blood Institute of the NIH. Dr Yao reports the U.S. PHS found 10 graphs in a grant application he and his team at UNC submitted had errors. As a result, Dr Yao, as principle investigator of the grant application, agreed to be excluded from and not seek federal research grants for five years. Dr Yao also reports the grant application was neither relevant to medical practice nor a clinical study involving patients. Experiments were to be in a laboratory using rats.
 Action: 10/19/2005. Consent Order executed: Dr Yao is reprimanded.

MISCELLANEOUS ACTIONS

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL

ANSARI, Tawfiq Sahib, MD

Location: Durham, NC (Durham Co)
 DOB: 8/01/1932
 License #: NA
 Specialty: FP (as reported by physician)
 Medical Ed: University of Baghdad, Iraq (1956)
 Cause: Dr Ansari made false statements or representations to the Board or willfully concealed material information from the Board in connection with the license application. Specifically, Dr Ansari answered "no" to the question on the application asking if his privileges had ever been limited, suspended, or placed on probation at any hospital. If fact, Dr Ansari's privileges were suspended or limited between September and December 2004.
 Action: 10/05/2005. Letter issued denying Dr Ansari's application for a North Carolina license.

DAUITO, Ralph, MD

Location: Vineland, NJ
 DOB: 3/31/1956
 License #: NA
 Specialty: R (as reported by physician)
 Medical Ed: Georgetown University School of Medicine (1984)
 Cause: Dr Dauito failed to satisfy the Board of his qualifications for a medical license. He had his license in New Jersey acted against by the New Jersey Board, entering a Consent Order in which he was reprimanded, received a two-year stayed suspension, was required to take an ethics course, and was fined. He admitted to inappropriate treatment and/or diagnosis of a patient. The medical boards of Florida, West Virginia, and Pennsylvania mirrored the actions taken by New Jersey.
 Action: 9/06/2005. Letter issued denying Dr Dauito's application for a North Carolina medical license.

SOLAN, Gwen Emily, MD

Location: Beaufort, NC (Carteret Co)
 DOB: 6/25/1958
 License #: 0094-00399
 Specialty: GP/FP (as reported by physician)
 Medical Ed: George Washington University School of Medicine and Health Sciences (1985)
 Cause: The Board found Dr Solan was unable to practice medicine with reasonable skill and safety by reason of illness, excessive use of drugs, chemicals, or other material, or by reason of any physical or mental abnormality. It further acted for reasons set forth in her Consent Order of 10/16/2003.
 Action: 10/13/2005. Letter issued denying Dr Solan's application for reinstatement of her North Carolina medical license.

SURRENDERS

GARDNER, James Eric, MD

Location: Pinehurst, NC (Moore Co)
 DOB: 9/18/1970
 License #: 2002-00116
 Specialty: VS/GS (as reported by physician)
 Medical Ed: University of Tennessee (1996)

Action: 9/21/2005. Voluntary surrender of North Carolina medical license.

SMITH, Tracey, Physician Assistant

Location: Wilmington, NC (New Hanover Co)
 DOB: 2/13/1962
 License #: 0001-02582
 PA Education: University of Washington (1998)
 Action: 8/30/2005. Voluntary surrender of North Carolina PA license.

STROUD, Joan Marie, Physician Assistant

Location: Gastonia, NC (Gaston Co)
 DOB: 4/24/1956
 License #: 0001-01476
 PA Education: Pennsylvania State University (1980)
 Action: 8/17/2005. Voluntary surrender of North Carolina PA license.

COURT APPEALS/STAYS

NONE

CONSENT ORDERS LIFTED

BHIRO, Thakurdeo M., Physician Assistant

Location: Laurel Hill, NC (Scotland Co)
 DOB: 10/29/1948
 License #: 0001-01561
 PA Education: U.S. Army Academy (1989)
 Action: 8/26/2005. Order issued lifting Consent Order of 10/21/2003.

CHALMERS, Thomas Henry, MD

Location: Asheville, NC (Buncombe Co)
 DOB: 5/09/1956
 License #: 0093-00436
 Specialty: AN (as reported by physician)
 Medical Ed: Medical University of Florida (1983)
 Action: 9/08/2005. Order issued lifting the Consent Order of 10/19/1003.

MANN, John Robert, MD

Location: Dunn, NC (Harnett Co)
 DOB: 2/09/1947
 License #: 0000-20417
 Specialty: FP (as reported by physician)
 Medical Ed: Medical University of South Carolina (1974)
 Action: 9/08/2005. Order issued lifting the Consent Orders of 8/10/1994 and 5/18/1995.

TUCKER, Peter Loren, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 4/07/1955
 License #: 0000-31213
 Specialty: PS (as reported by physician)
 Medical Ed: Bowman Gray School of Medicine (1981)
 Action: 8/29/2005. Order issued lifting Consent Order of 11/20/2003.

TEMPORARY/DATED LICENSES:

ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES

AARONS, Mark Gold, MD

Location: Southern Pines, NC (Moore Co)
 DOB: 5/07/1958
 License #: 0000-31233
 Specialty: NEP/IM (as reported by physician)
 Medical Ed: Baylor College of Medicine (1984)
 Action: 9/22/2005. Temporary/dated license extended to expire 3/31/2006.

CARLSON, James Lennart, MD

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: 9/22/2005. Temporary/dated license extended to expire 9/30/2006.

CRUMP, Carolyn Faydene, MD

Location: Lexington, NC (Davidson Co)
 DOB: 1/27/1950
 License #: 2005-01115
 Specialty: GP (as reported by physician)
 Medical Ed: George Washington University School of Medicine (1976)
 Action: 9/22/2005. Temporary/dated license extended to expire 3/31/2006.

KOMJATHY, Steven Ferenc, MD

Location: Lenexa, KS
 DOB: 5/19/1969
 License #: 0097-01440
 Specialty: IM/GPM (as reported by physician)
 Medical Ed: University of Maryland School of Medicine (1996)
 Action: 9/22/2005. Temporary/dated license extended to expire 9/30/2006.

MOIR, Ronald Jeffrey, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 12/30/1956
 License #: 0000-31176
 Specialty: AN/ADDM (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1984)
 Action: 9/22/2005. Full and unrestricted medical license issued.

MORTER, Gregory Alan, MD

Location: Wilmington, NC (New Hanover Co)
 DOB: 12/31/1959
 License #: 0000-36401
 Specialty: PD (as reported by physician)
 Medical Ed: University of Pittsburgh (1986)
 Action: 9/22/2005. Temporary/dated license extended to expire 3/31/2006.

NGUYEN, Tuong Dai, MD

Location: Waxhaw, NC (Mecklenburg Co)
 DOB: 4/11/1967
 License #: 2000-00566
 Specialty: IM (as reported by physician)
 Medical Ed: Temple University School of Medicine (1996)
 Action: 9/22/2005. Temporary/dated license extended to expire 5/31/2006.

ROSNER, Michael John, MD

Location: Hendersonville, NC (Henderson Co)
 DOB: 12/04/1946
 License #: 0090-00632
 Specialty: NS/NCC (as reported by physician)
 Medical Ed: Virginia Commonwealth University School of Medicine (1972)
 Action: 9/22/2005. Temporary/dated license extended to expire 9/30/2006.

WHITE, Steven William, Physician Assistant

Location: Cameron, NC (Harnett Co)
 DOB: 12/19/1962
 License #: 0001-02116
 PA Education: Midwestern University (1996)
 Action: 9/22/2005. Temporary/dated license extended to expire 3/31/2006.

See Consent Orders:

WHITMER, Gilbert Gomer, MD

REENTRY AGREEMENTS**BOWERS, Howard Edward, Jr, Physician Assistant**

Location: Burnsville, NC (Yancey Co)
 DOB: 10/31/1942
 License #: 0010-00212
 PA Education: University of Florida (1977)
 Cause: On application for a PA license. Mr Bowers was in pharmaceutical sales from August 1983 to March 2004. He served in the Florida Army National Guard as a PA from 1981 to 1999. He has not practiced as a PA since 1999.
 Action: 8/25/2005. Reentry Agreement and Order executed: Mr Bowers is issued a PA license; he shall arrange to have his supervising physician observe his practice for six months following his resumption of practice; after the six-month observation period, his supervising physician shall deliver to the Board a letter reporting in detail on his observations and stating an opinion on the level of Mr Bowers' skill; Mr Bowers must obtain all required CME in a timely manner; must comply with other conditions.

LARE, Sandra Bernice, DO

Location: Wilmington, NC (New Hanover Co)
 DOB: 11/21/1969
 License #: 2005-01564
 Specialty: P (as reported by physician)
 Medical Ed: University of Medicine and Dentistry of New Jersey (1996)
 Cause: On application for a medical license. Dr Lare has not practiced medicine since December 2002.
 Action: 8/31/2005. Reentry Agreement and Order executed: Dr Lare is issued a full and unrestricted medical license; she shall arrange for a physician colleague acceptable to the Board to observe her practice for six months and, at the end of that time, have that physician report within 30 days to the Board in detail on her practice and the level of her skill; she must obtain 30 hours of CME before meeting again with the Board in January 2006; must comply with other conditions.

LEGGETT, Jerry Curtis, Physician Assistant

Location: Greenville, NC (Pitt Co)
 DOB: 7/04/1955
 License #: 0001-00674
 PA Education: Wake Forest University School of Medicine (1983)
 Cause: On application for a PA license. Mr Leggett has not practiced since July 1997 and his CME is not yet up to date.
 Action: 8/24/2005. Reentry Agreement and Order executed: Mr Leggett is issued a PA license; he shall arrange to have his supervising physician

observe his practice for six months following his resumption of practice; his supervising physician shall deliver to the Board monthly evaluations during the six-month observation period reporting in detail on his observations and stating an opinion on the level of Mr Leggett's skill; Mr Leggett must obtain all required CME in a timely manner; must comply with other conditions.

MORAN, Harriet Jane, MD

Location: Wilmington, NC (New Hanover Co)
 DOB: 7/03/1952
 License #: 0000-39043
 Specialty: END/IM (as reported by physician)
 Medical Ed: Medical University of South Carolina College of Medicine (1984)
 Cause: Dr Moran has not practiced clinical medicine since 1996.
 Action: 10/27/2005. Reentry Agreement and Order executed: Dr Moran is issued a full and unrestricted license to practice medicine; she shall arrange to have a physician colleague acceptable to the Board observe her practice for the first six months following her resumption of practice; she shall have that physician send the Board a letter within 30 days after the end of the six-month period in which he or she shall describe in detail the nature of the observations made and stating an opinion as the level of Dr Moran's clinical skill.

PELTZER, Sonia Rapaport, MD

Location: Newton, NC (Catawba Co)
 DOB: 3/28/1962
 License #: 0094-01297
 Specialty: FP (as reported by physician)
 Medical Ed: University of Virginia School of Medicine (1991)
 Cause: On application for a medical license. Dr Peltzer has not practiced actively in North Carolina since November 1997, though she has maintained her CME and occasionally saw patients and performed consultation work from 1997 to December 2003. At her request, in January 2004, her license was made inactive-retired. She recognizes the need for a program of reentry to ensure her safe transition back into practice.
 Action: 9/30/2005. Reentry Agreement and Order executed: Dr Peltzer is issued a full and unrestricted license to practice medicine; she shall work part-time as a family practitioner in the outpatient clinics of Catawba Valley Medical Center in Hickory and Denver; her practice shall be observed by Dana L. Chambers, MD, director of the clinics and he shall serve as a mentor and advisor to Dr Peltzer; she shall meet with Dr Chambers bi-weekly to review her cases from the past two weeks; after six months, Dr Peltzer shall provide the Board a letter from Dr Chambers detailing Dr Chambers' observations of Dr Peltzer's practice and giving an assessment of Dr Peltzer's fund of knowledge, clinical skills, and other information as to whether Dr Peltzer is safe to practice medicine; Dr Peltzer shall not modify the reentry program without prior approval by the Board president; she must comply with other conditions.

DISMISSALS**GLOVER, William James, MD**

Location: Bath, NC (Beaufort Co)
 DOB: 3/21/1926
 License #: 0000-32370
 Specialty: GS (as reported by physician)
 Medical Ed: Loyola University, Stritch School of Medicine (1949)
 Action: 8/25/2005. Notice of Dismissal issued: Charges and Allegations issued against Dr Glover on 5/11/2005 are dismissed without prejudice.

NESLEN, George Quayle, Jr, MD

Location: Sylva, NC (Jackson Co)
 DOB: 1/19/1945
 License #: 0000-24090
 Specialty: OS (as reported by physician)
 Medical Ed: George Washington University (1974)
 Cause: Motion by Dr Neslen to dismiss charges against him related to CME requirements. As shown in attached documentation, the CME requirements had been satisfied prior to 12/21/2004, though approximately 13 hours were not reported to the Board, for which he is regretful.
 Action: 10/19/2005. Order issued dismissing any and all charges currently pending against Dr Neslen without prejudice.

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 licenses 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.

North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: February 15-16, 2006; March 15-17, 2006; April 12-13, 2006
May 17-19, 2006; June 14-15, 2006

Residents Please Note USMLE Information

United States Medical Licensing Examination

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the Federation of State Medical Board's Web site at www.fsmb.org. If you have additional questions, please e-mail Amy Ingram, the Board's GME Coordinator, at amy.ingram@ncmedboard.org or visit the Board's Web site at <http://www.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.

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