



forum

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From the Executive Director

On Cooperation Among Boards and a Recent Joint Statement on Albuterol Inhalers



R. David Henderson

The practice of medicine, more than most other professions, is a joint endeavor. Physicians must work closely with many different allied health professionals in order to deliver quality health care. Similarly, health care regulatory boards—particularly the Medical Board, the Board of Nursing, and the Board of Pharmacy—must work together in order to effectively regulate health care in North Carolina.

Our medical, nursing, and pharmacy boards have a long history of working together on matters of shared concern. In 1999, these boards adopted a “Joint Statement on Pain Management in End-of-Life Care,” which was one of the first of its kind in the country.* Beginning in 2005, these boards, along with the Board of Dental Examiners, began meeting each year to learn more about topics of mutual interest, such as alcohol and substance abuse and efforts to ensure the continued competence of licensees. Last year, all four boards worked together to produce and disseminate a brochure designed to inform the public about their work and their service to the people of the state.* The Nurse Practitioner Joint Subcommittee, comprising three members each from the medical and nursing boards, is working more closely than ever as a group to review license applications and investigative cases.

A more recent example of successful collaboration between boards is a joint statement adopted by the medical and pharmacy boards that permits pharmacists to substitute hydrofluoroalkane

(HFA)-propellant inhalers for chlorofluorocarbon (CFC)-propellant inhalers unless the prescriber specifically indicates otherwise.* This important statement appears below.

The members and staff of the North Carolina Medical Board value our good working relationship with the state’s various health care boards as we strive to effectively and collaboratively regulate health care “for the benefit and protection of the people of North Carolina.”

Joint Statement of the North Carolina Medical and Pharmacy Boards Concerning CFC and HFA Albuterol Metered Dose Inhalers

The United States Food and Drug Administration has ruled that by December 31, 2008, manufacturers may no longer use chlorofluorocarbon(CFC)-based propellants in prescription drugs formulated for inhalation, such as albuterol metered dose inhalers. Accordingly, manufacturers are shifting production to metered dose inhalers that use a hydrofluoroalkane (HFA) propellant. As a result, drug wholesalers and pharmacies are experiencing progressively worsening shortages of CFC-based albuterol inhalers as manufacturers phase them out. These shortages will, of course, only increase over time.

The Medical and Pharmacy Boards recognize that patients must have timely access to albuterol as a means of avoiding the morbidity and increased health care costs associated with poor control of asthma and other respiratory disorders. Furthermore, the medical literature available on the subject indicates no clinical problems associated with substituting CFC-propellant albuterol inhalers with HFA-propellant albuterol inhalers. Finally, recognizing substitution of CFC-propellant albuterol inhalers with HFA-propellant albuterol inhalers will reduce both the number of call-backs to prescribers and the frustration of patients.

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Primum Non Nocere

forum

NC MEDICAL BOARD

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

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Under North Carolina law governing drug product selection, when a prescriber indicates on the prescription that product selection is permitted, pharmacists may substitute HFA-propellant albuterol inhalers for CFC-propellant albuterol inhalers. Therefore, a prescriber who wishes to maintain a patient on a CFC-based albuterol product must clearly indicate on the prescription that no substitution occur. As discussed above, however, CFC-based albuterol inhalers are being phased out and are increasingly unavailable to patients.

Prescribers and pharmacists should consult with their patients who use albuterol inhalers and explain the reason for any switch to an HFA-based product. Prescribers and pharmacists should also take care to reassure these patients that they are continuing to receive the same drug that they previously have used to control their respiratory problems.

* These documents can be viewed at www.ncmedboard.org.

FDA Responds to Rise in Fatal Methadone Overdoses

Since 1999, mortality rates from poisonings have increased 50% nationally and 134% in North Carolina. This unprecedented upsurge in fatal injuries has been caused by an increase in unintentional poisonings, primarily from drugs and biological substances, most of which are narcotics. Data from 2005 death certificates indicate that 81% of the poisons that caused or contributed to the 872 fatalities from unintentional drug overdoses were narcotics. Cocaine caused or contributed to 31% of the unintentional fatal overdoses of narcotics in our state. Similar to the percentage of deaths from the street drug cocaine, methadone was identified by state medical examiners as having caused or contributed to another 30% of these deaths. No other drugs or biological substances have resulted in similarly high percentages of fatal drug overdoses. According to the National Center for Health Statistics, 11 U.S. states have reported substantial increases in methadone-related deaths since 1999. The number of deaths from unintentional methadone overdoses in North Carolina has increased eight-fold since 1999. North Carolina currently has the third highest methadone mortality rate from unintentional drug overdoses in the nation.

To address the increase of fatal methadone-related drug overdoses, the Food and Drug Administration (FDA) issued on November 27, 2006, a Public Health Advisory on Methadone for health care professionals and patients stating that "methadone use for pain control may result in life-threatening changes in breathing and heart beat." The full FDA advisory on methadone is posted on the North Carolina Medical Board's Web site (www.ncmedboard.org). A more detailed account of the drug-related fatalities that have occurred in North Carolina, and what is currently being done to abate this epidemic, will be published in the an upcoming number of the *Forum*.

Catherine (Kay) Sanford, MSPH
Head, Epidemiology Unit
Injury and Violence Prevention Branch
N.C. Division of Public Health

Governor Names Judge Lewis, of Farmville, to NCMB; Reappoints Dr Rhyne, of Wilmington, and Dr Saunders, of Shallotte

R. David Henderson, executive director of the North Carolina Medical Board, has announced that Governor Easley has appointed Judge John B. Lewis, Jr, as a public member of the North Carolina Medical Board to complete the term of Mr Dicky Walia, of Raleigh, who recently left the Board. He also announced that Drs Janelle A. Rhyne and George L. Saunders, III, have been reappointed for their second terms.

John B. Lewis, Jr, LLB



Judge Lewis

John B. Lewis, Jr, LLB, is a native of Farmville, North Carolina, and a graduate in history of the University of North Carolina, Chapel Hill. He took his law degree from the University of North Carolina Law School and served as president of the Third Year Class.

His distinguished legal career has included the private practice of law in Farmville for 16 years and serving as town attorney for Farmville, Fountain, and Hookerton for 12 of those years; being a Special Superior Court judge for six years; and serving on the North Carolina Court of Appeals for 11 years. He is currently a Court of Appeals recall judge, a temporary administrative law judge, and an emergency Special Superior Court judge.

He did active duty in the U.S. Navy and served on the USS Coral Sea (CV-43) off Vietnam. He was later a captain in the Naval Reserve, serving as a certified military judge. He retired from those duties in 1990.

Among his many other activities and responsibilities, he has been chair of the North Carolina Property Tax Commission and the Judicial Standards Commission, a member of the North Carolina Sentencing Commission, the Rules Review Commission, the Wake Forest University School of Law Board of Visitors, the Board of Directors of the North Carolina Arts Council, and a variety of civic and service organizations.

Judge Lewis married Kay Ellen "Kelly" Isley on 25 February 1967. "Kelly" Lewis died on 20 July 2006. Their two sons, Benjamin May Lewis, II, and John Thomas Carlyle Lewis, are, as were their parents, happily married. Thomas and his wife, Amanda, live in Charlotte; Ben and his wife, Michelle, and their daughters, Margaret May and Ellen, live in Richmond, Virginia.

Janelle A. Rhyne, MD

Dr Janelle A. Rhyne, of Wilmington, 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



Dr Rhyne

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 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 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 has served as the Board's

secretary and treasurer, and is currently the Board's president elect.

George L. Saunders, III, MD



Dr Saunders

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

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

state award for quality and efficiency of service.

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

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

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

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

He was appointed to the Board in 2003 and has served on its Policy, Complaints, and Executive Committees. He is now secretary of the Board.

Dr Kirby Named Assistant Medical Director of NCMB



Dr Kirby

Scott G. Kirby, MD, was named assistant medical director of the North Carolina Medical Board in November 2006. Dr Kirby earned his undergraduate degree from the University of Miami in 1970 and his MD degree from Tulane University in New Orleans in 1974. After an internship at Charity Hospital in New Orleans, he completed an internal medicine residency and fellowship in rheumatology at the Medical College of Georgia (MCG) in Augusta, Georgia.

Combining a practice of internal medicine and emergency medicine for several years, he entered the full time practice of emergency medicine by joining the faculty of

MCG's Department of Surgery, Section of Emergency Medicine, in 1983. In that role, he participated in the development of the trauma service and a new emergency medicine residency program. In 1987, he was named chief, Section of Emergency Medicine, Department of Medicine, at Tulane Medical School and medical director of the Emergency Department of Tulane Medical Center. In 1989, he became medical director of the Emergency Department at Touro Infirmary, also in New Orleans, and continued as a staff physician at Charity Hospital with faculty appointments as assistant professor of medicine at both Tulane and Louisiana State University Medical Schools.

In 1991, he moved to Raleigh, where he was Emergency Department physician at Raleigh Community Hospital, now Duke Health Raleigh Hospital, and partner in Capital Emergency Physicians.

In 1991, he moved to Raleigh, where he was Emergency Department physician at Raleigh Community Hospital, now Duke Health Raleigh Hospital, and partner in Capital Emergency Physicians.

North Carolina Medical Society Seeks Nominations for Positions on North Carolina Medical Board

The North Carolina Medical Society (Society) Board of Directors is seeking nominations for membership on the North Carolina Medical Board (Board). The Society submits nominations to the governor for a total of seven

positions (altogether, there are 12 members on the Board). In 2007, three positions will be open for consideration. If you are interested in serving in one these positions, please submit your nomination form and resume to Darlyne

Menscer, MD, President, NCMS, PO Box 27167, Raleigh, NC 27611-7167. The deadline for receiving nominations is June 15. For a nomination packet, please contact Linda Carter, NCMS, at 919-833-3836, 800-722-1350 or by e-mail: lcarter@ncmedsoc.org. Current membership of the

Board is listed on the Board's Web site (www.ncmedboard.org) and on the second page of this *Forum*.

Nominees for all Society-nominated positions must be physicians, though they need not be members of the Society.

NC Medical Society and NC Bar Association Update the *Medico-Legal Guidelines of North Carolina*

Melanie G. Phelps, JD
North Carolina Medical Society

Professional discord between physicians and attorneys is not a recent phenomenon. The emotional debate that has been raging during the past few years over medical liability reform, however, seems to have heightened the level of distrust between the professions. Because these two respected and necessary professions must work in concert on many levels, the recent revisions of the *Medico-Legal Guidelines of North Carolina*¹ by both state professional associations could not have been better timed to provide some parameters for professional interaction.

History

This year marks the 50th anniversary of the *North Carolina Medico-Legal Code* (the *Code*), which was originally adopted in 1956 by the North Carolina Bar Association (NCBA) and the North Carolina Medical Society (NCMS). To reflect changes in the law and the environment in which the two professions interacted, the *Code* was revised in 1972 and 1986, and, in 1991, the title of the *Code* was changed to the *Medico-Legal Guidelines of North Carolina* (the *Guidelines*).²

More recently, in 2000, the *Guidelines* underwent a major revision in an attempt to increase their overall effectiveness “[i]n resolving certain recurring disputes between physicians and attorneys.”³ Such disputes are discussed briefly in the preamble to the *Guidelines*.⁴ The 2005 revision of the *Guidelines* does not fundamentally alter the approach but simply incorporates changes to the law, especially the HIPAA privacy regulations, as well as changes to other authorities cited in the *Guidelines*.

The task of revising the 2000 *Guidelines* fell to the Medical-Legal Liaison Committee of the NCBA, which consists of plaintiff and defense attorneys, a judge, corporate counsel for hospitals, and counsel for the NCMS and the North Carolina Medical Board (NCMB).⁵ The recommended revisions from the Medical-Legal Liaison Committee were then presented to the Executive Committee of the NCBA and the Board of Directors of the NCMS, and were approved by both entities in the fall of 2005. As with the 2000 *Guidelines*, the 2005 *Guidelines* will be published with other North Carolina Rules.⁶

Scope and Purpose

While an ambitious document, the *Guidelines* do not

attempt to specifically address interactions in a medical malpractice action, although many of the principles outlined in the document certainly apply in that context. Those who look to the *Guidelines* to resolve tensions directly related to medical malpractice actions will be disappointed. What the *Guidelines* do provide, however, are the two professional associations' recommendations on how to work together more harmoniously in litigation involving medical issues and to foster mutual respect, courtesy, and understanding.⁷

Structure of the *Guidelines*

The utilitarian portion of the *Guidelines* begins with the definition section on page two. Defined terms include: “physician,” “medical record,” “medical report,” and “independent medical examination.” The term “medical record”⁸ was the subject of significant discussion during the 2005 revisions. Numerous definitions of this term exist in North Carolina law, but none are comprehensive. The 2005 *Guidelines* attempt to define medical records as broadly and clearly as possible to avoid confusion and potential conflict over the meaning of the term, particularly in the context of litigation involving medical issues.

Beginning with the 2000 version, the *Guidelines* also distinguish between different types of medical witnesses, which include definitions of: “retained expert witness,” “fact expert witness,” and “independent expert witness.” This distinction is important because it assigns the term “expert” to treating and non-treating physicians alike and implicitly recognizes the value of a physician's input in all aspects of litigation.

The next major section of the *Guidelines*, entitled “Specific Situations,”¹⁰ addresses issues relating to medical records, including ownership, inspection, and copying. The 2005 revisions included minor modifications in light of the HIPAA privacy regulations. This section also contains recommendations regarding consultations and physician deposition testimony. Like the rest of the *Guidelines*, this portion, if read and adhered to by all attorneys and physicians when dealing with medical issues in litigation, serves to encourage mutual understanding, manage expectations, and ease distrust and resentment.

The last major section of the *Guidelines* addresses trial situations.¹¹ Subpoenas are covered first, and witness subpoenas and subpoenas for medical records

“What the Guidelines do provide, however, are the two professional associations' recommendations on how to work together more harmoniously in litigation involving medical issues”

are specifically addressed. The section dealing with subpoenas for medical records changed significantly in the 2005 revision to accommodate changes due to the HIPAA privacy regulations, particularly the section dealing with subpoenas for medical records issued without authority.¹² Releasing medical records without proper authority is a major concern for physicians, especially in the wake of the HIPAA privacy regulations. The *Guidelines* suggest that attorneys, whenever possible, should secure proper authorization from their client for the release of medical records and include this authorization with the subpoena. This will not only expedite the process but will also reduce the level of distrust between the professionals.

“Notice for Trial” is the next area covered in the trial section of the *Guidelines*.¹³ This section encourages attorneys to provide as much notice as possible to physicians to minimize the disruption to the physician’s practice and his or her other patients. Physicians, likewise, need to be aware that attorneys do not have absolute control over the trial schedule.

The next area covered, “Medical Witnesses,” clarifies the roles of the physician and attorney in trial settings.¹⁴ The *Guidelines* continue to emphasize that the physician should be treated as an expert regardless of whether he or she is providing fact or opinion testimony. The term “fact expert witness” furthers this goal and is expanded on in this section. Finally, the issue of fees is addressed for various situations.¹⁵

The last section of the *Guidelines* addresses the Joint Committee of the NCMS and the NCBA.¹⁶ While this committee has been defunct for a number of years, the two associations have agreed to attempt to revive it.

A discussion of the *Guidelines* would not be complete without mention of the nine appendices that accompany the *Guidelines*. Appendix A-1¹⁷ contains the pertinent HIPAA Privacy Regulation definitions relating to medical records, and Appendix A-2¹⁸ provides a compendium of North Carolina’s statutes and rules regarding medical records. Appendix B¹⁹ provides a sample Administrative Office of the Court’s subpoena for medical records without authorization and without court order or other authority to inspect. Appendix C²⁰ contains a sample letter to accompany records sent to the court in response to a subpoena for medical records without authorization and without court order or other authority to inspect. Appendix D²¹ provides a sample affidavit of the medical records custodian. Appendix E²² has a sample letter requesting medical records. Selected position statements of the NCMB appear in Appendix F.²³ And, appendices G-1 and G-2 contain sample medical record releases.²⁴

Conclusion

The *Guidelines* are of course just that—guidelines. They are not mandatory and do not supplant any Rule of Civil Procedure or Evidence. But the more they are used by attorneys, physicians, judges, and others, the better the chances for civility in litigation involving medical issues.

The two state professional associations, recognizing the need for guidance, set out on this journey 50 years ago, and though the *Guidelines* still are not widely known, they have endured over five decades. While not a panacea, the *Guidelines*, if more universally followed, would foster better relations between these two noble professions.

Endnotes

1. The *Medico-Legal Guidelines of North Carolina* can be accessed at: www.ncmedsoc.org/non_members/2005%20Final%20M-L%20Guidelines.pdf, and all citations in this article will refer to this version of the document. The *Guidelines* also can be viewed on the North Carolina Bar Association’s Web site at: www.ncbar.org/download/committees/medicoLegalGuidelines2005.pdf
2. *Medico-Legal Guidelines of North Carolina*, p. iii, 2005.
3. Id.
4. Id. at p. iv.
5. Committee members for the years 2004-05 and 2005-06 include: Jacqueline Grant, chair; Michelle Frazier, NCBA staff liaison, Dr. Anne Akwari, Patrick Balestrieri, Bruce Berger, Brian Blankenship, Jeremy Bomar, Thomas Boyd, Katherine Bricio, Stuart Brock, Ronald Burris, David Craft, Lorrie Dollar, Christina Douglas, Lynne Marie Holtkamp, Phillip Jackson, Stephen Keene, Judge John McCullough, Jason Newton, Elizabeth O’Keefe, Walter Patterson, Melanie Phelps, Karen Rabenau, Michael Rousseaux, Harriett Smalls, Richard Stuart, Lauren Trustman, Marion Walker, and Randolph Ward.
6. The *Medico-Legal Guidelines* are published as part of the official Annotated Rules of North Carolina. See N.C.G.S. Annotated Rules of North Carolina at 989-1033 (2005 ed. LexisNexis). Please note that the 2000 version of the *Guidelines* appear in the 2005 edition. The 2005 *Guidelines*, however, will be submitted to LexisNexis and Thompson West for publication.
7. The *Guidelines* also may be used by other health care professionals who, like physicians, find themselves involved in medical litigation. See *Medico-Legal Guidelines of North Carolina*, p. 2.
8. The 2005 *Guidelines* define medical records as: “The medical record is a collection of protected health information for a particular individual, that: is created or received by a physician or other health care provider; relates to the past, present, or future physical or mental health or condition of the individual; and includes information about the provision of health care to that individual and the past, present, or future payments by or on behalf of that individual for the provision of health care.” Medical records are inherently sensitive and personal and contain information that relates to an individual’s physical or mental condition, medical history, medical diagnosis, or medical treatment,¹⁰ as well as demographic and other information that identifies or has the potential to identify the individual (e.g., patient name, address, social security number, unique identifier, etc.).” See *Medico-Legal Guidelines of North Carolina*, p. 2.
9. Id. at p. 3.
10. Id. at pp. 4-8.
11. Id. at pp. 9-17.
12. Id. at pp. 11-13.
13. Id. at pp. 13-14.
14. Id. at pp. 14-17.
15. Id. at pp. 15-17.
16. Id. at p. 18.
17. Id. at App. A-1.
18. Id. at App. A-2.
19. Id. at App. B.
20. Id. at App. C.
21. Id. at App. D.
22. Id. at App. E.
23. Id. at App. F.
24. Id. at Apps. G-1 and G-2.

“Releasing medical records without proper authority is a major concern for physicians, especially in the wake of the HIPAA privacy regulations”

The author is associate general counsel of health policy for the North Carolina Medical Society.

Position Statements of the North Carolina Medical Board as of 12/31/2006

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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.]

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 duty of the physician is to provide competent, compassionate, and economically prudent care to all his or her patients. Having assumed care of a patient, the physician may not neglect that patient nor fail for any reason to prescribe the full care that patient requires in accord with the standards of acceptable medical practice. Further, it is the Board's position that it is unethical for a physician to allow financial incentives or contractual ties of any kind to adversely affect his or her medical judgment or patient care.

Therefore, it is the position of the North Carolina Medical Board that any act by a physician that violates or may violate the trust a patient places in the physician places the relationship between physician and patient at risk. This is true whether such an act is entirely self-determined or the result of the physician's contractual relationship with a health care entity. The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship remains inviolate. The physician who puts the physician-patient relationship at risk also puts his or her relationship with the Board in jeopardy.

Elements of the Physician-Patient Relationship

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

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

- there be adequate communication between the physician and the patient;
- the physician report all significant findings to the patient or the patient's legally designated surrogate/guardian/personal representative;
- there be no conflict of interest between the patient and the physician or third parties;
- personal details of the patient's life shared with the physician be held in confidence;
- the physician maintain professional knowledge and skills;
- there be respect for the patient's autonomy;
- the physician be compassionate;
- the physician respect the patient's right to request further restrictions on medical information disclosure and to request alternative communications;
- the physician be an advocate for needed medical care, even at the expense of the

physician's personal interests; and

- the physician provide neither more nor less than the medical problem requires.

The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on patient trust, is considered sacred, and when the elements crucial to that relationship and to that trust—communication, patient privacy, 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. A copy of such notification is to be included in the medical record. 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, September 2006)

MEDICAL RECORD DOCUMENTATION

The North Carolina Medical Board takes the position that physicians and physician extenders should maintain accurate patient care records of history, physical findings, assessments of findings, and the plan for treatment. The Board recommends the Problem Oriented Medical Record method known as SOAP (developed by Lawrence Weed).

SOAP charting is a schematic recording of facts and information. The S refers to "subjective information" (patient history and testimony about feelings). The O refers to objective material and measurable data (height, weight, respiration rate, temperature, and all examination findings). The A is the assessment of the subjective and objective material that can be the diagnosis but is always the total impression formed by the care provided after review of all materials gathered. And finally, the P is the treatment plan presented in sufficient detail to allow another care provider to follow the plan to completion. The plan should include a follow-up schedule.

Such a chronological document:

- records pertinent facts about an individual's health and wellness;
- enables the treating care provider to plan and evaluate treatments or interventions;
- enhances communication between professionals, assuring the patient optimum continuity of care;
- assists both patient and physician to communicate to third party participants;
- allows the physician to develop an ongoing quality assurance program;
- provides a legal document to verify the delivery of care; and
- is available as a source of clinical data for research and education.

Certain items should appear in the medical record as a matter of course:

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

The record should be legible. When the caregiver will not write legibly, notes should be dictated, transcribed, reviewed, and signed within reasonable time. Signature, date, and time should also be legible. All therapies should be documented as to indications, method of delivery, and response of the patient. Special instructions given to other caregivers or the patient should be documented: Who received the instructions and did

they appear to understand them?

All drug therapies should be named, with dosage instructions and indication of refill limits. All medications a patient receives from all sources should be inventoried and listed to include the method by which the patient understands they are to be taken. Any refill prescription by phone should be recorded in full detail.

The physician needs and the patient deserves clear and complete documentation. (Adopted May 1994) (Amended May 1996)

ACCESS TO MEDICAL RECORDS

A physician's policies and practices relating to medical records under their control should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient's care. Such policies and practices should conform to applicable federal and state laws governing health information.

It is the position of the North Carolina Medical Board that notes made by a physician in the course of diagnosing and treating patients are primarily for the physician's use and to promote continuity of care. Patients, however, have a substantial right of access to their medical records and a qualified right to amend their records pursuant to the HIPAA privacy regulations.

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

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

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

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

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

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

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

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 September 2006)

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.

The physician must clearly communicate to the patient orally and provide instructions in writing for securing after hours care if the physician is not generally available after hours or if the physician discontinues after hours coverage.

(Adopted July 1993)(Amended May 1996, January 2001, October 2003, July 2006)

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, electro-myograms, 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 sexual exploitation of a patient is unprofessional conduct and undermines the public trust in the medical profession. Sexual exploitation encompasses a wide range of behaviors which have in common the intended sexual gratification of the physician. These behaviors include sexual intercourse with a patient (consensual or non-consensual), touching genitalia with ungloved hands, sexually suggestive comments, asking patients for a date, inappropriate exploration of the patients or physician's sexual phantasias, touching or exposing genitalia, breast, or other parts of the body in ways not dictated by an appropriate and indicated physical examination, exchanging sexual favors for services. Sexual exploitation is grounds for the suspension, revocation, or other action against a physician's license. This position statement is based upon the Federation of State Medical Board's guidelines regarding sexual boundaries.

Sexual misconduct by physicians and other health care practitioners is a form of behavior that adversely affects the public welfare and harms patients individually and collectively. Physician sexual misconduct exploits the physician-patient relationship, is a violation of the public trust, and is often known to cause harm, both mentally and physically, to the patient.

Regardless of whether sexual misconduct is viewed as emanating from an underlying form of impairment, it is unarguably a violation of the public's trust.

As with other disciplinary actions taken by the Board, Board action against a medical licensee for sexual exploitation of a patient 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.

(Adopted May 1991) (Amended April 1996, January 2001, September 2006)

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) (Reviewed March 2005)

SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS AND OTHERS WITH WHOM SIGNIFICANT EMOTIONAL RELATIONSHIPS EXIST*

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

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

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

*This position statement was formerly titled, "Treatment of and Prescribing for Family Members." (Adopted May 1991) (Amended May 1996; May 2000; March 2002; September 2005)

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 auto-transfusion 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) (Reviewed November 2005) (Reviewed March 2006)

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 have 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 extended 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 Treatment of Acute Pain and Cancer Pain*, 4th Edition (1999) (American Pain Society, Glenview, IL); *Hospice Care: A Physician's Guide* (1998) (Hospice for the Carolinas, Raleigh); and the *Oxford Textbook of Palliative Medicine* (1993) (Oxford Medical, Oxford).

^{*}Steven A. Schroeder, MD, President, Robert Wood Johnson Foundation. (Adopted October 1999)

Joint Statement on Pain Management in End-of-Life Care

(Adopted by the North Carolina Medical, Nursing, and Pharmacy Boards)

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

- the legal scope of practice for each of these licensed health professionals;

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

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

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

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

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

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

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

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

It is important to remind health professionals that licensing boards hold each licensee accountable for providing safe, effective care. Exercising this standard of care requires

the application of knowledge, skills, as well as ethical principles focused on optimum patient care while taking all appropriate measures to relieve suffering. The healthcare team should give primary importance to the expressed desires of the patient tempered by the judgment and legal responsibilities of each licensed health professional as to what is in the patient's best interest.

(October 1999)

OFFICE-BASED PROCEDURES

Preface

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

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

General Guidelines

The Physician's Professional and Legal Obligation

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

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

Exemptions

These guidelines do not apply to Level I procedures.

Written Policies and Procedures

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

Emergency Procedure and Transfer Protocol

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

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

Infection Control

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

Performance Improvement

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

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

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

Medical Records and Informed Consent

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

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

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

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

Credentialing of Physicians

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

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

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

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

Accreditation

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

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

Patient Selection

The physician who performs the surgical or special procedure should evaluate the condition of the patient and the potential risks associated with the proposed treatment plan. The physician also is responsible for determining that the patient has an adequate

support system to provide for necessary follow-up care. Patients with pre-existing medical problems or other conditions, who are at undue risk for complications, should be referred to an appropriate specialist for preoperative consultation.

ASA Physical Status Classifications

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

Candidates for Level II Procedures

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

Candidates for Level III Procedures

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

Surgical or Special Procedure Guidelines

Patient Preparation

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

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

The physician performing the surgical or special procedure also should:

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

Discharge Criteria

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

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

Information to the Patient

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

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

Reportable Complications

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

1. physician's name and license number;
2. date and time of the occurrence;
3. office where the occurrence took place;

4. name and address of the patient;
5. surgical or special procedure involved;
6. type and dosage of sedation or anesthesia utilized in the procedure; and
7. circumstances involved in the occurrence.

Equipment Maintenance

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

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

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

Compliance with Relevant Health Laws

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

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

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.

Level II Guidelines

Personnel

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

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

Surgical or Special Procedure Guidelines

Intraoperative Care and Monitoring

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

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

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

Postoperative Care and Monitoring

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

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

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

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

Equipment and Supplies

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

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

Level III Guidelines

Personnel

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

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

Surgical or Special Procedure Guidelines

Intraoperative Monitoring

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

1. direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
2. pulse oximetry should be performed continuously. Any alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness;
3. an electrocardiogram monitor should be used continuously on the patient;
4. the patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes;
5. monitoring should be provided by a separate health care professional not otherwise involved in the surgical or special procedure;
6. end-tidal carbon dioxide monitoring should be performed on the patient continuously during endotracheal anesthesia;

7. an in-circuit oxygen analyzer should be used to monitor the oxygen concentration within the breathing circuit, displaying the oxygen percent of the total inspiratory mixture;
8. a respirometer (volumeter) should be used to measure exhaled tidal volume whenever the breathing circuit of a patient allows;
9. the body temperature of each patient should be measured continuously; and
10. an esophageal or precordial stethoscope should be utilized on the patient.

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

Postoperative Care and Monitoring

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

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

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

Monitoring in the recovery area should include pulse oximetry and 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

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

AAAHC – the Accreditation Association for Ambulatory Health Care

ABMS – the American Board of Medical Specialties

ACGME – the Accreditation Council for Graduate Medical Education

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

Advanced cardiac life support certified – a licensee that has successfully completed and recertified periodically an advanced cardiac life support course offered by a recognized accrediting

organization appropriate to the licensee's field of practice. For example, for those licensees treating adult patients, training in ACLS is appropriate; for those treating children, training in PALS or APLS is appropriate.

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

Anesthesia provider – an anesthesiologist or CRNA.

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

AOA – the American Osteopathic Association

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

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

ASA – the American Society of Anesthesiologists

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

Board – the North Carolina Medical Board.

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

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

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

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

FDA – the Food and Drug Administration.

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

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

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

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

Immediately available – within the office.

JCAHO – the Joint Commission for the Accreditation of Health Organizations

Level I procedures – any surgical or special procedures:

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

Level II procedures – any surgical or special procedures:

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

Level III procedures – any surgical or special procedures:

- a. that require, or reasonably should require, the use of major conduction blockade, deep

sedation/analgesia, or general anesthesia; and

- b. where there is only a moderate risk of surgical and/or anesthetic complications and the need for hospitalization as a result of these complications is unlikely.

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

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

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

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

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

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

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

OSHA – the Occupational Safety and Health Administration.

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

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

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

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

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

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

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

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

[A Position Statement on Office-Based Surgery was adopted by the Board 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.

Licenses 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 THE PATIENT UNDERGOING SURGERY OR OTHER INVASIVE PROCEDURE*

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 post-operative 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.

(Invasive procedures includes, but is not limited to, endoscopies, cardiac catheterizations, interventional radiology procedures, etc. Surgeon refers to the provider performing the procedure) *This position statement was formerly titled, "Care of the Surgical Patients." (Adopted September 1991) (Amended March 2001, September 2006)

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(c). 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) (Reviewed September 2005)

SALE OF GOODS FROM PHYSICIAN OFFICES

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) (Amended March 2006)

REFERRAL FEES AND FEE SPLITTING

Payment by or to a physician solely for the referral of a patient is unethical. A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company, or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source. In each case, the payment violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

It is unethical for physicians to offer financial incentives or other valuable considerations to patients in exchange for recruitment of other patients. Such incentives can distort the information that patients provide to potential patients, thus distorting the expectations of potential patients and compromising the trust that is the foundation of the patient-physician relationship.

Furthermore, referral fees are prohibited by state law pursuant to N.C. Gen. Stat. Section 90-401. Violation of this law may result in disciplinary action by the Board.

Except in instances permitted by law (NC Gen Stat § 55B-14(c)), it is the position of the Board that a physician cannot share revenue on a percentage basis with a non-physician. To do so is fee splitting and is grounds for disciplinary action.
(Adopted November 1993) (Amended May 1996, July 2006)

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)

COMPETENCE AND RE-ENTRY TO THE ACTIVE PRACTICE OF MEDICINE

The ability to practice medicine results from a complex interaction of knowledge, physical skills, judgment, and character tempered by experience leading to competence. Maintenance of competence requires a commitment to lifelong learning and the continuous practice of medicine, in whatever field one has chosen. Absence from the active practice of medicine leads to the attenuation of the ability to practice competently.

It is the position of the North Carolina Medical Board, in accord with NC Gen Stat § 90-6(a), that practitioners seeking licensure, or reactivation of a North Carolina medical license, who have had an interruption, for whatever reason, in the continuous practice of medicine greater than two (2) years must reestablish, to the Board's satisfaction, their competence to practice medicine safely.

Any such applicant must meet all the requirements for and completion of a regular license application. In addition, full-scale assessments, engagement in formal training programs, supervised practice arrangements, formal testing, or other proofs of competence may be required.

The Board will cooperate with appropriate entities in the development of programs and resources that can be used to fulfill the above requirements, including the issuance, when necessary and appropriate, of a time or location limited and/or restricted license (e.g., residency training license).

It shall be the responsibility of the applicant to develop a reentry program subject to the approval of the Board.

(Adopted July 2006)

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

August - September - October 2006

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.

Licenses 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.

Public Letter of Concern:

A letter in the public record expressing the Board's concern about a practitioner's behavior or performance. Concern has not risen to the point of requiring a formal proceeding but should be known by the public. If the practitioner requests a formal disciplinary hearing regarding the conduct leading to the letter of concern, the letter will be vacated and a formal complaint and hearing initiated.

Reentry Agreement:

Arrangement between the Board and a practitioner in good standing who is "inactive" and has been out of clinical practice for two years or more. Permits the practitioner to resume active practice through a reentry program approved by the Board to assure the practitioner's competence.

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.)

For the full text version of each summary and for public documents, please visit the Board's Web site at www.ncmedboard.org

ANNULMENTS

NONE

REVOCATIONS

STROUD, Joan Marie, Physician Assistant

Location: Gastonia, NC (Gaston Co) | DOB: 4/24/1956

License #: 0001-01476

PA Education: Pennsylvania State University (1980)

Cause: Ms Stroud violated her Consent Order of November 2003 and has a history of substance abuse.

Action: 9/18/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 4/12/2006: Ms Stroud's North Carolina PA license is revoked.

WINEGARDNER, Stephen Duane, MD

Location: Grand Forks, ND | DOB: 6/27/1948

License #: 0000-30522 | Specialty: AM/GP (as reported by physician)

Medical Ed: East Carolina University School of Medicine (1985)

Cause: The North Dakota Board revoked Dr Winegardner's North Dakota medical license in November 2005.

Action: 10/26/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 8/17/2006: Dr Winegardner's North Carolina medical license is revoked.

WOHLER, Johnathan Baumann, MD

Location: Durham, NC (Durham Co); (Honolulu, Hawaii) | DOB: 8/28/1950

License #: 0098-00423 | Specialty: GPM (as reported by physician)

Medical Ed: University of Oklahoma (1992)

Cause: In November 2005, the North Dakota Board ordered Dr Wohler's North Dakota medical license be revoked based on the decision of an administrative law judge that, among other things, Dr Wohler was terminated from his postgraduate training because of the habitual use of alcohol, and habitually used alcohol while licensed in North Dakota. Action: 8/23/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 8/16/2006: Dr Wohler's North Carolina medical license is revoked.

SUSPENSIONS

BRODERSON, Joe Thomas, MD

Location: Lexington, KY | DOB: 2/15/1947

License #: 0000-24137 | Specialty: P (as reported by physician)

Medical Ed: University of Kentucky (1972)

Cause: In February 2006, the Kentucky Board issued an Order of Emergency Suspension of Dr Broderon's Kentucky license based on inappropriate prescribing of controlled substances. Dr Broderon agreed to surrender his Kentucky license. Review of his records by Kentucky indicated a pattern of ignorance of the law related to controlled substances.

Action: 8/25/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/16/2006: Dr Broderon's North Carolina medical license is indefinitely suspended.

JEMSEK, Joseph Gregory, MD

Location: Huntersville, NC (Mecklenburg Co) | DOB: 4/16/1949

License #: 0000-23386 | Specialty: ID/IM (as reported by physician)

Medical Ed: University of Illinois (1974)

Cause: Dr Jemsek diagnosed and treated several patients for Lyme Disease in a way that departed from acceptable and prevailing standards of medical practice. He also failed to educate and inform those patients about his approach to diagnosing and treating Lyme Disease in ways that were a departure from recognized standards.

Action: 8/21/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearings on 6/21-22/2006 and 7/20/2006: Dr Jemsek is suspended for 12 months, suspension stayed on terms and conditions; he shall develop an informed consent form approved by the Board's president; if a patient's diagnosis is not supported by current CDC criteria, the patient must have a consultation or second opinion by a North Carolina infectious disease physician approved by the Board's president; must comply with other requirements.

LOCKE, Charles John, MD

Location: Luray, VA | DOB: 5/23/1946

License #: 0000-40045 | Specialty: GS (as reported by physician)

Medical Ed: Jefferson Medical College (1972)

Cause: Dr Locke's New York medical license was surrendered in July 2005. New York had charged him with prescribing large amounts of controlled substances without justification.

Action: 8/23/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/16/2006: Dr Locke's North Carolina medical license is suspended indefinitely.

MASELLY, Michael Joseph, MD

Location: Long Beach, CA | DOB: 11/02/1949
 License #: 0000-31169 | Specialty: GS (as reported by physician)
 Medical Ed: University Autonoma Guadalajara (1978)
 Cause: Dr Maselly's New York medical license was censured and reprimanded and he was placed on probation for three years in October 2005. New York charged his care of four patients had fallen below the standard of care.
 Action: 8/23/2006. Findings of Fact, Conclusions of Law, and Order of Suspension issued following hearing on 8/16/2006: Dr Maselly's North Carolina medical license is suspended for 30 days, suspension being stayed.

PETTIT, John Charles, MD

Location: Durham, NC (Durham Co) | DOB: 4/05/1954
 License #: 0000-27504 | Specialty: FP (as reported by physician)
 Medical Ed: University of California, San Diego (1982)
 Cause: In 2005, Dr Pettit was reprimanded in a Stipulated Agreement with the California Board.
 Action: 8/29/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/16/2006: Dr Pettit's North Carolina medical license is suspended for 30 days, suspension being stayed.

RASALINGAM, Sittampalam, MD

Location: Lackawanna, NY | DOB: 10/17/1940
 License #: 0000-23076 | Specialty: IM/GER (as reported by physician)
 Medical Ed: Royal College of P&S, Ireland (1969)
 Cause: In 2005, the New York Board reprimanded Dr Rasalingam for negligence and failure to keep adequate records.
 Action: 8/25/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/16/2006: Dr Rasalingam's North Carolina medical license is suspended for 30 days, suspension being stayed.

WILLIAMS, Cleveland, MD

Location: Washington, DC | DOB: 6/20/1949
 License #: 0095-00287 | Specialty: PH/LM (as reported by physician)
 Medical Ed: University of Florida (1977)
 Cause: Dr Williams was denied a license by Florida in April 2005 based on his failing to disclose material facts on his application form and on disciplinary proceedings against his medical licenses in other states.
 Action: 10/26/2006. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 10/18/2006: Dr Williams' North Carolina medical license is suspended indefinitely.

See Consent Orders:

BIDDLE, Virginia, MD
 BLAIR, James Seaborn, III, MD
 BOTWRIGHT, Gene Robert, Jr, MD
 BRAY, Anthony David, MD
 BULLARD, Dennis Eugene, MD
 COYNE, Mark Dennis, MD
 DERBES, Linda Kaufman, MD
 DRAKE, Miles Edward, Jr, MD
 GRAVATT, Steven James, Physician Assistant
 JONES, Robert Glen, MD
 KRZYZANIAK, Raymond Leonard, MD
 LANGSTON, Jonathan Lawrence, Physician Assistant
 LONG, Joseph Watson, Nurse Practitioner
 MARCINKUS, Susan Rita, MD
 ROBERTSON, Elisabeth M., MD
 ROBINSON, Lindwood Allen, MD
 SAPPINGTON, John Shannon, MD
 WALTER, Gregory William, MD
 WOGLOM, Peter B., Physician Assistant

SUMMARY SUSPENSIONS

NONE

CONSENT ORDERS**BARBER, Robert Anthony, DO**

Location: Morehead City, NC (Carteret Co) | DOB: 9/30/1954
 License #: 2003-00222 | Specialty: FP (as reported by physician)

Medical Ed: University of Health Sciences College of Osteopathic Medicine (1989)
 Cause: Dr Barber began prescribing controlled substances to a patient who was also receiving prescriptions for controlled substances from an out of state physician. When confronted about this, he said he was unaware the patient was getting the other prescriptions and he would no longer prescribe for her. On 7/21/2005, he noted in the patient's chart he would no longer prescribe her controlled substances. Two days later, he did prescribe a controlled substance for her and did not record the new prescription in the patient's chart. He explained he felt the patient had done nothing wrong. He did not know that on 7/21/2005, the patient had gotten a prescription for a controlled substance from another physician, and that physician had noted in his chart that the patient said Dr Barber had fired her as a patient.
 Action: 8/17/2006. Consent Order executed: Dr Barber is reprimanded; he shall attend a prescribing course within six months; he agrees to review of his charts by the Board in six months.

BARR, John Findley, MD

Location: Cleveland, NC (Rowan Co) | DOB: 7/07/1954
 License #: 0000-26186 | Specialty: FP (as reported by physician)
 Medical Ed: Hahnemann Medical College (1980)
 Cause: Dr Barr failed to discover that his PA ordered laboratory and other testing for patients in a manner that departed from acceptable standards. This failure indicated inadequate supervision of his PA.
 Action: 8/16/2006. Consent Order executed: Dr Barr is reprimanded.

BEATTY, Mary Ellen, MD

Location: Tampa, FL | DOB: 2/18/1954
 License #: 0000-26189 | Specialty: PS (as reported by physician)
 Medical Ed: University of Florida (1977)
 Cause: Florida reprimanded Dr Beatty in 2006 and suspended her license, placing her on probation with restrictions. She had performed surgery on the wrong finger of a patient.
 Action: 9/14/2006. Consent Order executed: Dr Beatty is reprimanded.

BIDDLE, Virginia, MD

Location: Winston-Salem, NC (Forsyth Co) | DOB: 7/04/1929
 License #: 0000-33617 | Specialty: IM/FP (as reported by physician)
 Medical Ed: Columbia University (1965)
 Cause: In December 2005, the Maine Board entered a Consent Order with Dr Biddle, finding she had issued prescriptions over the Internet for patients with whom she had no relationship. She issued from 200-300 prescriptions a day. She retired from practice in December 2004.
 Action: 10/25/2006. Consent Order executed: Dr Biddle's North Carolina medical license is suspended for two years; suspension is stayed predicated on her compliance with the Maine Consent Order.

BLAIR, James Seaborn, III, MD

Location: Avon, NC (Dare Co) | DOB: 8/19/1956
 License #: 0000-32636 | Specialty: FP (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1987)
 Cause: In May 2000, Dr Blair formally ended his physician-patient relationship with Patient A. He subsequently began and continues a romantic relationship with Patient A. In January 2003, he prescribed a controlled substance for Patient A. He began treating Patient B in 1997, prescribing Methadone as part of his treatment plan. In August 2005, Patient A presented to Dr Blair in pain. Dr Blair was on call and went to the home of Patient B to obtain several doses of Methadone from Patient B for Patient A, later administering it to Patient A. He contacted Patient A's pain management specialist about treating Patient A with Methadone. In December 2005, he prescribed Methadone to Patient A. In January 2006, he prescribed other controlled substances to Patient A. He accepts his responsibility for this unprofessional conduct and has cooperated with the Board. He has completed a 7-day residential treatment program and is under contract with the NCPHP. He is in compliance with his NCPHP contract.
 Action: 8/16/2006. Consent Order executed: Dr Blair's license is suspended for 12 months, suspension being stayed after 60 days subject to terms and conditions; he shall be on probation for 12 months; his active suspension will begin on 10/16/2006; he shall

take the Vanderbilt course on maintaining proper boundaries; he shall attend a course on prescribing; must comply with other conditions.

BORDEN, Britt Michael, MD

Location: Flossmore, IL | DOB: 10/14/1961
 License #: 2004-00816 | Specialty: NS (as reported by physician)
 Medical Ed: University of Medicine and Dentistry of New Jersey (1991)
 Cause: The West Virginia Board entered a Consent Order with Dr Borden in May 2005 wherein he received a public reprimand due to making a misrepresentation on his license renewal. Illinois issued him a license in January 2006 with a reprimand due to the earlier action.
 Action: 10/23/2006. Consent Order executed: Dr Borden is reprimanded.

BOTWRIGHT, Gene Robert, Jr, MD

Location: Wagram, NC (Scotland Co) | DOB: 8/23/1955
 License #: 0000-36462 | Specialty: FP (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1990)
 Cause: Dr Botwright has a history of substance abuse, including alcohol. He was arrested for driving while impaired in February 2006. The Board learned of his arrest after having filed charges against him in March 2006 for his testing positive for drug use. He then had a relapse of his problem with alcohol in June 2006, at which time he surrendered his medical license.
 Action: 9/19/2006. Consent Order executed: Dr Botwright's North Carolina medical license is indefinitely suspended.

BRAY, Anthony David, MD

Location: Burlington, NC (Alamance Co) | DOB: 11/15/1961
 License #: 0094-00023 | Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1992)
 Cause: Improperly accepted return of unused 40mg OxyContin® tablets from a patient and wrote the patient a new prescription for 20mg tablets. He asserts he destroyed the returned tablets. He surrendered his Schedule II prescribing privileges on 9/14/2005. In January 2006, he entered into an agreement with the DEA permitting him to prescribe Schedules 2N, 3, 3N, 4, and 5, and requiring him to submit monthly reports of his controlled substance prescribing for two years.
 Action: 8/18/2006. Consent Order executed: Dr Bray's North Carolina medical license is suspended for 18 months, such suspension being stayed on probationary terms; he shall abide by the January 2006 DEA agreement; must comply with other conditions.

BULLARD, Dennis Eugene, MD

Location: Raleigh, NC (Wake Co) | DOB: 6/10/1950
 License #: 0000-26088 | Specialty: NS (as reported by physician)
 Medical Ed: St Louis University (1975)
 Cause: Five female patients have alleged and the Board has charged that Dr Bullard inappropriately touched them or caused them to touch him. He denies any intentional contact of an inappropriate nature but acknowledges he may have touched the patients in a manner they may have perceived as a boundary violation. He regrets the patients felt uncomfortable and apologizes. He has been assessed by the NCPHP and is reported to be fully compliant with all recommendations. He has a long record of quality and service.
 Action: 9/21/2006. Consent Order executed: Dr Bullard's license is suspended for six months, suspension being stayed on probationary terms and conditions; he shall maintain and abide by a contract with the NCPHP; shall ensure a chaperone is present when he examines a female patient; must comply with other conditions.

COYNE, Mark Dennis, MD

Location: Stoney Creek, NC (Guilford Co) | DOB: 8/12/1949
 License #: 0000-33493 | Specialty: EM (as reported by physician)
 Medical Ed: Chicago Medical School (1983)
 Cause: Dr Coyne ordered musculoskeletal ultrasounds that were ultimately interpreted by physicians who did not possess active North Carolina medical licenses. This constituted unprofessional conduct. Dr Coyne contends he was not aware of the status of the physicians' licenses.
 Action: 8/16/2006. Consent Order executed: Dr Coyne's license is suspended for 24 months as of 8/01/2006, suspension being stayed and Dr Coyne placed on probation for the duration of the suspen-

sion period on terms and conditions.

CROW, Jimmie Ray, MD

Location: Tulsa, OK | DOB: 7/18/1953
 License #: 0000-31006 | Specialty: SO/GS (as reported by physician)
 Medical Ed: University of Kansas (1978)
 Cause: The Colorado Board admonished Dr Crow for treatment of a patient that fell below accepted standards.
 Action: 9/06/2006. Consent Order executed: Dr Crow is reprimanded.

DEAN, Patrick Joseph, MD

Location: Memphis, TN | DOB: 3/23/1951
 License #: 2006-01478 | Specialty: Path (as reported by physician)
 Medical Ed: Georgetown University School of Medicine (1979)
 Cause: On application of Dr Dean for a North Carolina license. From July 2004 to November 2005, Dr Dean evaluated and provided reports on specimens taken from North Carolina patients though he was not licensed in North Carolina. This constitutes the unlicensed practice of medicine.
 Action: 9/14/2006. Consent Order executed: Dr Dean is issued a North Carolina license and is reprimanded for his flagrant disregard of North Carolina law.

DERBES, Linda Kaufman, MD

Location: Honolulu, HI | DOB: 1/29/1960
 License #: 0095-00112 | Specialty: P/CHP (as reported by physician)
 Medical Ed: University of South Florida College of Medicine (1990)
 Cause: To amend and replace the Consent Order of 3/13/2006.
 Action: 8/17/2006. Consent Order executed: Dr Derbes North Carolina medical license is suspended for six months, suspension being stayed subject to probationary terms; must comply with other conditions.

DeVAUL, Mary Lou Varney, DO

Location: Cary, NC (Wake Co) | DOB: 3/13/1963
 License #: 0098-00234 | Specialty: P (as reported by physician)
 Medical Ed: West Virginia School of Osteopathic Medicine (1992)
 Cause: Dr DeVaul failed to register her license in 2006 and her license became inactive on 6/05/2006.
 Action: 10/09/2006. Consent Order executed: Dr DeVaul is reprimanded; her license is reactivated on the date of this Consent Order.

DRAKE, Miles Edward, Jr, MD

Location: Columbus, OH | DOB: 10/07/1952
 License #: 0000-25266 | Specialty: N (as reported by physician)
 Medical Ed: Duke University School of Medicine (1977)
 Cause: Dr Drake's Ohio license was suspended in 2005 through two Consent Agreements arising from his history of alcohol-related traffic incidents.
 Action: 8/17/2006. Consent Order executed: Dr Drake's North Carolina medical license is suspended for five months, suspension to run retroactively and concurrently with the suspension ordered by the Ohio Board; he must comply with the terms of his Consent Agreements with the Ohio Board.

ENDE, Maurice Joseph, MD

Location: Nacogdoches, TX | DOB: 1/10/1946
 License #: 0000-27171 | Specialty: R (as reported by physician)
 Medical Ed: University of Texas, San Antonio (1977)
 Cause: In April 2004, Dr Ende entered an Agreed Order with Texas Board that held he had failed to properly interpret X rays on five occasions but also stated he maintained he met the standard of care and neither admitted nor denied the Board's conclusions. He was ordered to have a monitoring physician for three years and pay an administrative penalty of \$500. The West Virginia Board entered a Consent Order with Dr Ende in March 2005 that held he had failed to note on his West Virginia renewal application that his Texas license had been disciplined. The West Virginia Board ordered he surrender his license.
 Action: 10/26/2006. Consent Order executed: Dr Ende is reprimanded; the admissions and finding in this Consent Order are intended solely to resolve the case at hand or in connection with other matters before the Board involving Dr Ende.

FARRELL, Edwin Gayle, MD

Location: McLeansville, NC (Guilford Co) | DOB: 3/13/1945
 License #: 0000-17345 | Specialty: PD/ADL (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1971)

Cause: On Dr Farrell's application for reissuance of his North Carolina medical license. He surrendered his license in December 2004 at the Board's request due to information he had prescribed inappropriately to a person with whom he had significant emotional relationship. In a Consent Order of April 2005, his license was indefinitely suspended. He has a contract with the NCPHP, is compliant with it, and has attended formal programs on prescribing.

Action: 10/23/06. Consent Order executed: Dr Farrell's license is reissued to expire on the date shown on the license [4/21/2007]; he shall maintain and abide by his contract with the NCPHP; shall arrange to have a physician colleague observe his practice for four months; must comply with other conditions.

FLEISCHHAUER, Thomas Frazee, MD

Location: Fuquay-Varina, NC (Wake Co) | **DOB:** 2/07/1953

License #: 0000-33653 | **Specialty:** NEP/IM (as reported by physician)

Medical Ed: University of Virginia (1979)

Cause: Dr Fleischhauer pled guilty to misdemeanor charges of willfully failing to file state income tax returns for four years. He was given a suspended 45 day jail sentence, was placed on probation for one year, required to do 100 hours of community service, and fined \$100.

Action: 10/16/2006. Consent Order executed: Dr Fleischhauer is reprimanded.

GEORGE, Pazhayldathe K., MD

Location: Zebulon, NC (Wake Co) | **DOB:** 5/16/1939

License #: 0000-27457 | **Specialty:** IM/Gastro (as reported by physician)

Medical Ed: Trivandrum, India (1964)

Cause: To amend his Consent Order of 4/21/2004.

Action: 8/22/2006. Amended Consent Order executed: Dr George has obtained the 10 hours of CME regarding breast examinations required by his Consent Order of 4/21/2004 and the section of that Order requiring him to do so is amended to end that requirement.

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 2003, the Virginia Board placed terms and conditions on Dr Gould's medical license for diverting and self-administering controlled substances. He was required to comply with a treatment program of the DC Medical Society and have a recovery monitoring contract with the Virginia Intervention Program. In March 2001, his North Carolina medical license went inactive.

Action: 8/29/2006. Consent Order executed: Dr Gould must comply with the Virginia order and the DC agreement; should he reapply for a North Carolina medical license, he must demonstrate full compliance with the Virginia order and the DC agreement; however, the North Carolina Board is under no obligation to allow his application for reactivation.

GRAVATT, Steven James, Physician Assistant

Location: Chapel Hill, NC (Orange Co) | **DOB:** 8/27/1960

License #: 0001-01713

PA Education: Duke University (1993)

Cause: Mr Gravatt has a history of substance abuse. He and the Board entered into a Consent Order related to that abuse on 2/17/2005. In May 2006, in violation of his Consent Order, he tested positive for THC. He surrendered his PA license on 5/31/2006.

Action: 8/16/2006. Consent Order executed: Mr Gravatt's PA license is suspended indefinitely.

GREENBERG, Richard Paul, MD

Location: Shelby, NC (Cleveland Co) | **DOB:** 1/06/1944

License #: 0097-01758 | **Specialty:** NS (as reported by physician)

Medical Ed: University of Bologna School of Medicine (1969)

Cause: Request to amend his Consent Order of 10/19/2005.

Action: 8/17/2006. Amended Consent Order executed: Restrictions in Dr Greenberg's Consent Order of 10/19/2005 remain, but he is permitted to perform and supervise performance of laser hair removal, though in the event any patient requires surgical intervention Dr Greenberg shall refer that patient to another surgeon.

GUARINO, Clinton Toms Andrew, MD

Location: Hickory, NC (Catawba Co) | **DOB:** 2/04/1966

License #: 0099-00062 | **Specialty:** IM (as reported by physician)

Medical Ed: Wake Forest University School of Medicine (1996)

Cause: On application for reinstatement of license. Dr Guarino surrendered his license due to his arrest for various traffic offenses on 12/10/2005. He has a substance abuse/dependency condition and is compliant with his NCPHP contract. The Board suspended Dr Guarino's license in January 2006; he pled guilty to DUI, etc, in September 2006. Documentation makes clear that the state did not intend his plea to negatively affect his ability to be relicensed.

Action: 10/16/2006. Consent Order executed: Dr Guarino's license is reissued; he may practice on terms and restrictions related to his substance abuse/dependency condition; he may not be a primary supervisor for any allied health professional.

JONES, Robert Glen, MD

Location: Raleigh, NC (Wake Co) | **DOB:** 4/06/1959

License #: 0094-00536 | **Specialty:** OSM/SM (as reported by physician)

Medical Ed: Emory University (1988)

Cause: Dr Jones has a history of substance abuse (alcohol) abuse. He was arrested for driving while impaired in June 2006. He surrendered his license in that month.

Action: 9/20/2006. Consent Order executed: Dr Jones' North Carolina medical license is indefinitely suspended.

KHAYATA, Mazen H., MD

Location: Paradise Valley, AZ | **DOB:** 2/01/1960

License #: 2006-01233 | **Specialty:** NS (as reported by physician)

Medical Ed: Cornell University Medical College (1984)

Cause: Dr Khayata has a 2004 Consent Order with Arizona accepting reprimand for doing a bilateral laminectomy at the wrong level. He has a 2005 Consent Order with Illinois reciting the action by Arizona and issuing a reprimand.

Action: 8/01/2006. Non-Disciplinary Consent Order executed: Dr Khayata is issued a North Carolina medical license pursuant to terms of this Consent Order.

KLEPACH, Garron Lewis, Jr, MD

Location: Farmington Hills, MI | **DOB:** 2/23/1941

License #: 0000-28994 | **Specialty:** OPH (as reported by physician)

Medical Ed: Cornell University (1968)

Cause: In 2004, Virginia issued an Order reprimanding Dr Klepach and ordering him to pay a \$2,000 penalty should he ever decide to renew or seek reinstatement of his lapsed license. This action was based on his failure to submit information for his practitioner profile. He subsequently acted to become compliant with the Virginia law. In 2005, he signed a Consent Order with Michigan based on his failure to report the Virginia action to Michigan.

Action: 8/02/2006. Consent Order executed: Dr Klepach is reprimanded.

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: On Dr Kpeglo's application for reissuance of his license. Dr Kpeglo has a history of substance abuse. [He was suspended by the Board in August 2005.] He has signed a contract with the NCPHP and has been in compliance with that contract.

Action: 8/11/2006. Consent Order executed: Dr Kpeglo is issued a license to expire on the date shown on the license [1/30/2007]; specific restrictions apply to the license that relate to his substance abuse; he shall maintain and abide by a contract with the NCPHP; he shall regularly attend AA and Caduceus meetings; must comply with other conditions.

KRZYZANIAK, Raymond Leonard, MD

Location: Monroe, NC (Union Co) | **DOB:** 10/19/1952

License #: 0000-31854 | **Specialty:** PTH/HEM PATH (as reported by physician)

Medical Ed: Indiana University (1979)

Cause: Dr Krzyzaniak was arrested in December 2005 for having 321.7 grams of marijuana in his vehicle. As a result of that arrest, in May 2006, in Buncombe County Superior Court, he pled guilty to possession of more than one and a half ounces of marijuana.

Action: 9/21/2006. Consent Order executed: Dr Krzyzaniak's North Carolina medical license is suspended indefinitely.

LANGSTON, Jonathan Lawrence, Physician Assistant

Location: Shallotte, NC (Brunswick Co) | DOB: 2/07/1948
 License #: 0001-00214
 PA Education: Medical University of South Carolina (1974)
 Cause: Mr Langston issued prescriptions to five patients for narcotics for chronic pain without adequate documentation of a history or examination, a diagnosis, lab studies, or follow up. His management of one patient's hypertension was inadequate. In April 2006, a Board investigator also found Mr Langston did not have appropriate documentation available for inspection. Mr Langston has agreed to obtain CME on prescribing and to ensure closer supervision by his supervising physician.
 Action: 10/18/2006. Consent Order executed: Mr Langston's PA license is suspended for six months as of 11/01/2006; suspension shall be stayed after 30 days subject to probationary terms.

LONG, Joseph Watson, Nurse Practitioner

Location: Concord, NC (Cabarrus Co) | DOB: 8/29/1961
 Approval #: 0002-01774
 PA Education: NA
 Cause: In November 2005, Mr Long entered a Consent Agreement with the NC Nursing Board agreeing to voluntarily surrender his nursing license and complete a course on ethics and legal decision making. This was based on allegations of instances of prescribing without a supervising physician and without approval to practice from the two boards. In April 2006, he surrendered his NP approval to the Medical Board.
 Action: 10/18/2006. Consent Order executed: Mr Long's NP approval is hereby suspended indefinitely.

MARCINKUS, Susan Rita, MD

Location: Williamsburg, VA | DOB: 12/11/1955 |
 License #: 0096-01166 | Specialty: AN (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1992)
 Cause: Dr Marcinkus has a substance abuse problem and improperly treated and prescribed for herself.
 Action: 9/21/2006. Consent Order executed: Dr Marcinkus' North Carolina medical license is indefinitely suspended.

MATHEW, Roy Jacob, MD

Location: Durham, NC (Durham Co) | DOB: 7/02/1945
 License #: 0000-29624 | Specialty: P/ADDM (as reported by physician)
 Medical Ed: Trivandrum, India (1969)
 Cause: In 2000, having developed personal feelings for a patient, Dr Mathew terminated his professional relationship with the patient to pursue a personal relationship with her. After ending the professional relationship, Dr Mathew provided her with two doses of prescription medications for specific medical conditions. In February 2001, he advised the patient that he was terminating their personal relationship. She engaged an attorney and alleged negligence and unprofessional conduct on the part of Dr Mathew. After discussions with Duke University and the NCPHP, Dr Mathew voluntarily surrendered his North Carolina medical license in September 2001. At the suggestions of the Board and the NCPHP, he received counseling and voluntarily entered and obtained an assessment at the Behavioral Medicine Institute. After his surrender of his North Carolina license, Dr Mathew moved to Texas, where he had a medical license. He was allowed to practice in that state.
 Action: 8/09/2006. Consent Order executed: Dr Mathew's North Carolina medical license is permanently surrendered.

NEUMANN, Peter Ronald, MD

Location: Great Neck, NY | DOB: 1/18/1949
 License #: 2004-00390 | Specialty: PS/GS (as reported by physician)
 Medical Ed: State University of New York, Buffalo, School of Medicine (1975)
 Cause: In October 2004, Dr Neumann signed a Consent Order with New York accepting a reprimand based on his failure to maintain adequate records for three patients.
 Action: 8/22/2006. Consent Order executed: Dr Neumann is reprimanded based on the action by New York.

PIERSON, Mark Edward, MD

Location: Coral Springs, FL | DOB: 9/19/1950
 License #: 2006-01429 | Specialty: FP (as reported by physician)
 Medical Ed: University of Kansas School of Medicine (1980)

Cause: Dr Pierson has not practiced clinical medicine since 1995. He plans to practice only in an administrative setting.
 Action: 8/18/2006. Non-Disciplinary Consent Order executed: Dr Pierson is granted a limited administrative license; must comply with other conditions.

POLITI, Barry Joseph, MD

Location: Jackson, MS | DOB: 6/13/1968
 License #: 2006-01789 | Specialty: OM (as reported by physician)
 Medical Ed: St George University (1998)
 Cause: Dr Politi's Mississippi license is conditional on his compliance with a program designed to ensure physician health. He agreed to enter and maintain a contract with the NCPHP.
 Action: 10/31/2006. Consent Order executed: Dr Politi is issued a North Carolina medical license; he shall enter and maintain an NCPHP contract; he shall have a colleague observe his practice for the first year.

PRASAD, Sunil Narsing, MD

Location: Williamsville, NY | DOB: 4/29/1960
 License #: 2001-00079 | Specialty: AN (as reported by physician)
 Medical Ed: Gandhi Medical College (1984)
 Cause: In April 2006, the Massachusetts Board entered a Consent Order with Dr Prasad that said his medical center privileges had been summarily suspended in 2005 for falsification of a medical record and that he had mistakenly given Sufentanil rather than Fentanyl to a patient. Massachusetts imposed a reprimand and a fine of \$5,000 on Dr Prasad.
 Action: 10/1/2006. Consent Order executed: Dr Prasad is reprimanded.

RAYMOND, Elizabeth Gray, MD

Location: Research Triangle Park, NC (Wake Co) | DOB: 4/24/1959
 License #: 0000-30084 | Specialty: OB/GYN (as reported by physician)
 Medical Ed: Columbia University College of Physicians and Surgeons (1984)
 Cause: On request for reinstatement of license. She failed to register her license within 30 days of notice and her license was made inactive in September 2005. She now realizes the importance of timely registration of her license.
 Action: 10/20/2006. Consent Order executed: Dr Raymond is reprimanded; her license is reinstated as of the date of this Consent Order.

REYNOLDS, Craig Anthony, MD

Location: Lakewood, CO | DOB: 3/01/1950
 License #: 0000-23423 | Specialty: PS (as reported by physician)
 Medical Ed: University of Kentucky (1977)
 Cause: In a Consent Order between the Colorado Board and Dr Reynolds, he admits he performed five cosmetic procedures on an employee of his practice and, in November 2001, began what became a sexual relationship with her. He performed another cosmetic procedure on her while still involved in the sexual relationship. The Colorado Board's Consent Order constituted a letter of admonition and directed Dr Reynolds to meet with the Colorado Physician Health Program for evaluation. He was also ordered to comply with treatments determined by the CPHP. He was also to take a professional boundaries course and pay a fine of \$1,500.
 Action: 8/17/2006. Consent Order executed: Dr Reynolds is reprimanded.

ROBERTSON, Elisabeth M., MD

Location: Statesville, NC (Iredell Co) | DOB: 9/20/1957
 License #: 0000-34107 | Specialty: APM/EM (as reported by physician)
 Medical Ed: University of Michigan (1981)
 Cause: From June 2005 to April 2006, Dr Robertson, a former medical director of Hospice and Palliative Care in Iredell County, wrote prescriptions for Schedule II narcotics to a family member and seven patients of Hospice. However, she took these medications herself. The medications were paid for by Hospice from Medicare or other third-party funds intended to pay for the care of the patients. She had been an anonymous participant in the NCPHP since February 2005. In April 2006, she entered inpatient treatment for her substance abuse problem and surrendered her license on 5/26/2006. She has fully reimbursed Hospice for the medications.
 Action: 10/27/2006. Consent Order executed: Dr Robertson's North

Carolina medical license is suspended indefinitely effective 5/26/2006; she may not reapply for at least one year from the date of this Consent Order.

ROBINSON, Lindwood Allen, MD

Location: Raleigh, NC (Wake Co) | DOB: 7/08/1971
 License #: 2001-01126 | Specialty: EM (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1997)
 Cause: Dr Robinson has a history of substance abuse, which resulted in his participation in the NCPHP. In October 2006, he surrendered his North Carolina medical license.
 Action: 10/18/2006. Consent Order executed: Dr Robinson's North Carolina medical license is indefinitely suspended.

RUIZ, Estaban Alfonso, MD

Location: New Port Richey, FL | DOB: 1/25/1955
 License #: 0000-28333 | Specialty: IM (as reported by physician)
 Medical Ed: National University of Mexico (1979)
 Cause: In October 2005, the Florida Board issued a Final Order adopting a Consent Order fining Dr Ruiz \$10,000, issuing a reprimand, and requiring 50 hours of community service based on allegations he failed to practice medicine with a reasonable level of care and skill. Dr Ruiz did not admit to the truth of the allegations.
 Action: 8/10/2006. Consent Order executed: Dr Ruiz is reprimanded.

SAPPINGTON, John Shannon, MD

Location: Linville, NC (Avery Co) | DOB: 1/30/1962
 License #: 0094-00628 | Specialty: P/CHP (as reported by physician)
 Medical Ed: University of Texas, Houston (1989)
 Cause: Dr Sappington has a history of substance abuse. He surrendered his North Carolina medical license in August 2002 and that license was suspended in December 2002.. In 2005, while working as a counselor at a physician's office, he improperly got blank prescriptions forms from the physician's office and filled out prescriptions in the physician's name, giving them to other persons who used them to obtain controlled substances.
 Action: 8/16/2006. Consent Order executed: Dr Sappington's medical license continues to be suspended indefinitely and he may not petition for reinstatement for at least 24 months.

SHIVE, Robert MacGregor, MD

Location: Charlotte, NC (Mecklenburg Co) | DOB: 11/02/1933
 License #: 0000-13226 | Specialty: P (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1961)
 Cause: Dr Shive self-reported that between October 2005 and January 2006 he had telephone conversations with a female patient, engaging in seductive talk. He voluntarily surrendered his license in March 2006.
 Action: 10/10/2006. Consent Order executed: Dr Shive's license is permanently surrendered; he agrees to never apply for reinstatement and understands that should he do so the admissions in this Consent Order are the basis for denial; must comply with other conditions.

TEEL, Gregory Tyrone, MD

Location: Atlanta, GA | DOB: 4/04/1956
 License #: 0000-30773 | Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1984)
 Cause: A peer reviewer appointed by the Georgia Board found Dr Teel's treatment of five patients failed to meet minimum standards due to failure to thoroughly document examinations, to document appropriate discharge, and give follow-up instructions. As a result, Georgia placed his license on probation for three years and placed certain conditions on his practice. He was also reprimanded and fined \$3,000.
 Action: 10/04/2006. Consent Order executed: Dr Teel is reprimanded; his license is placed on probation for three years to run concurrently with the Georgia probation.

VISCARDI, Jeffrey Joseph, MD

Location: Greenville, NC (Pitt Co) | DOB: 6/28/1959
 License #: 0000-39344 | Specialty: OPH (as reported by physician)
 Medical Ed: State University of New York, Brooklyn (1985)
 Cause: From 1996 to 2005, Dr Viscardi prescribed medications, some controlled, for various family members and himself without entering the prescriptions in a patient chart. He was not aware of the Board's position statement on the subject of self-prescribing and

prescribing to family members and those with whom a significant emotional relationship exists.

Action: 8/17/2006. Non-Disciplinary Consent Order executed: No disciplinary action is taken; Dr Viscardi shall comply with the Board's position statements related to prescribing and shall attend a prescribing course within six months.

WALTER, Gregory William, MD

Location: Albany, GA | DOB: 12/06/1954
 License #: 0000-36286 | Specialty: EM (as reported by physician)
 Medical Ed: New York Medical College (1981)
 Cause: On 8/31/2005, Dr Walter pled guilty in U.S. District Court in Florence, SC, to conspiracy to launder money, a felony. He was sentenced to three years probation, 200 hours of community service, and restitution. The South Carolina Board gave him a reprimand and a stayed suspension, and fined him \$2,000. He also agreed to certain DEA restrictions on his prescribing of controlled substances for three years.
 Action: 9/27/2006. Consent Order executed: Dr Walter is reprimanded and his North Carolina license is suspended for the period of his federal court probation; suspension is stayed and his license is placed on probation based on his compliance with the South Carolina and federal conditions.

WHEELER, Acquenetta Vernecia, MD

Location: Baltimore, MD | DOB: 11/11/1951
 License #: 0000-27537 | Specialty: PD (as reported by physician)
 Medical Ed: Meharry Medical College (1980)
 Cause: On Dr Wheeler's application for a license in North Carolina. She was previously licensed in North Carolina but that license became inactive in 1999. She has been employed as medical director for United Health Care in Baltimore, a position that does not involve clinical practice. She has no intention of returning to clinical practice.
 Action: 9/14/2006. Consent Order executed: Dr Wheeler is granted a limited, administrative license in North Carolina; she shall limit her practice exclusively to administrative medicine.

WHITAKER, Albert, Jr, MD

Location: Gastonia, NC (Gaston Co) | DOB: 7/30/1948
 License #: 0000-23244 | Specialty: FP (as reported by physician)
 Medical Ed: Meharry Medical College (1977)
 Cause: Dr Whitaker wrote prescriptions for controlled substances for a family member who had had knee-replacement surgery and whose treating physician was located out of town. He did not prepare and keep a chart for the family member, nor did he keep a record of five prescriptions. He did keep copies of four of the prescriptions.

Action: 8/16/2006. Non-Disciplinary Consent Order executed: Dr Whitaker shall comply with the Board's statements regarding treating family members and keeping accurate medical records; he shall abide by all rules, regulations, and laws regarding medical practice.

WOGLOM, Peter B., Physician Assistant

Location: Colerain, NC (Bertie Co) | DOB: 7/28/1955
 License #: 0001-01652
 PA Education: George Washington University (1983)
 Cause: Mr Woglom issued medications in 2004 to several patients without noting full details on the patients' records as required by statute. Without the approval of his supervising physician, he prescribed controlled substances to several patients in a manner that violated his Delegation of Services Agreement with his supervising physician. In treating these patients for pain, he did not consistently use optimal pain management practices. He has now attended two pain management seminars and begun to implement improved practices. He will abide by laws and rules regarding prescribing and the Board's position statements.

Action: 8/21/2006. Consent Order executed: Mr Woglom's PA license is suspended for six months; after 30 days, suspension will be stayed on the terms of this probationary order; he shall meet weekly with his supervising physician and have all his patient charts reviewed and signed where controlled substances are prescribed; his supervising physician shall also review and sign a sample of all other patient charts; Mr Woglom shall improve his keeping of medical

records and comply with the Board's related position statements; he shall keep a log of all controlled substances he prescribes and have it available for inspections by a Board investigator for one year following the date of this Consent Order; must comply with other conditions.

MISCELLANEOUS ACTIONS

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL

BODINE, Victoria Lee, Physician Assistant

Location: Wilmington, NC (New Hanover Co) | DOB: 2/12/1982

License #: NA |

PA Education: Marywood University (2003)

Cause: Ms Bodine has not practiced clinically since her graduation from PA school. She also failed to respond to several Board inquiries about the possibility of her obtaining licensure by a Reentry Agreement.

Action: 8/04/2006. Letter issued denying Ms Bodine's application for a North Carolina PA license.

SURRENDERS

BOYD, William Scott, Physician Assistant

Location: Eden, NC (Rockingham Co) | DOB: 2/11/1975

License #: 0001-02927

PA Education: NA

Action: 10/16/2006. Voluntary surrender of NC PA license.

HENSLER, Rachel Hurst, Physician Assistant

Location: Wilmington, NC (New Hanover Co) | DOB: 4/1/1978

License #: 0010-00107

PA Education: Nova Southeastern University PA Program (2004)

Action: 8/25/2006. Voluntary surrender of NC physician assistant license.

ROBINSON, Lindwood Allen, MD

Location: Raleigh, NC (Wake Co) | DOB: 7/08/1971

License #: 2001-01126 | Specialty: EM (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1997)

Action: 10/05/2006. Voluntary surrender of NC medical license.

THRIFT-COTTRELL, Alesia Dawn, MD

Location: Red Springs, NC (Robeson Co) | DOB: 6/06/1964

License #: 2002-01318 | Specialty: FP (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1997)

Action: 9/13/2006. Voluntary surrender of NC medical license.

See Consent Orders:

MATHEW, Roy Jacob, MD

SHIVE, Robert MacGregor, MD

PUBLIC LETTERS OF CONCERN

IMAM, Naiyer, MD

Location: Coeur d'Alene, ID | DOB: 10/23/1965

License #: 2005-00428 | Specialty: DR (as reported by physician)

Medical Ed: Brown University School of Medicine (1990)

Cause: Dr Imam's application for a license in Alabama was denied based on Alabama's finding that he submitted false, misleading, or untruthful information in connection with it. There appears to be some dispute as to whether or not he was placed on probation at the University of South Florida College of Medicine. The North Carolina Medical Board decided not to begin formal action against his license but to issue a public letter of concern.

Action: 10/18/2006. Public Letter of Concern issued: Dr Imam is admonished and he is encouraged to be more candid in future license applications. Any further complaints of this kind may lead to disciplinary proceedings.

COURT APPEALS/STAYS

NONE

CONSENT ORDERS LIFTED

JOHNSON, James Carl, MD

Location: Brevard, NC (Transylvania Co) | DOB: 7/17/1936

License #: 0000-33685 | Specialty: ORS (as reported by physician)

Medical Ed: Medical College of Wisconsin (1964)

Action: 10/30/2006. Order issued lifting Consent Order of 10/28/2002.

NGUYEN, Tuong Dai, MD

Location: Charlotte, 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: 10/23/2006. Order issued lifting Consent Orders of 10/21/2004 and 5/26/2005.

PRESSLY, Margaret Rose, MD

Location: Boone, NC (Watauga Co) | DOB: 5/05/1956

License #: 0000-34548 | Specialty: FP (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1990)

Action: 8/04/2006. Order issued lifting Consent Orders of 10/11/1997 and 3/02/2000.

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: 9/21/2006. Temporary/dated license extended to expire 3/31/2007.

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: 9/21/2006. Full medical license issued.

HARDY, Stephen Carl, MD

Location: Waxhaw, NC (Mecklenburg Co) | DOB: 7/11/1957

License #: 0000-35911 | Specialty: NA

Medical Ed: University of Virginia (1985)

Action: 9/21/2006. Temporary/dated license extended to expire 5/31/2007.

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: 9/21/2006. Full and unrestricted medical license issued.

NGUYEN, Tuong Dai, MD

Location: Charlotte, 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: Full and unrestricted medical license issued.

NIEMEYER, Meindert Albert, MD

Location: Elon, NC (Alamance Co) | DOB: 6/16/1956

License #: 0000-30440 | Specialty: FP (as reported by physician)

Medical Ed: Faculty of Medicine, National University of Utrecht (1981)

Action: 9/21/2006. Full medical license issued.

ROGERS, Bruce William, MD

Location: Zebulon, NC (Wake Co) | DOB: 8/11/1947

License #: 0000-32563 | Specialty: FP/EM (as reported by physician)

Medical Ed: Medical College of Pennsylvania (1982)

Action: 9/21/2006. Temporary/dated license extended to expire 11/30/2006.

ROSNER, Michael John, MD

Location: Hendersonville, NC (Henderson Co) | DOB: 12/04/1946

License #: 0090-01321 | Specialty: NS/NCC (as reported by physician)

Medical Ed: Virginia Commonwealth University (1972)

Action: 9/21/2006. Temporary/dated license extended to expire 9/30/2007.

WADDELL, Roger Dale, MD

Location: Aberdeen, NC (Moore Co) | DOB: 11/17/1954

License #: 0000-30105 | Specialty: GP (as reported by physician)

Medical Ed: University of Colorado School of Medicine (1981)

Action: 9/21/2006. Temporary/dated license extended to expire 9/30/2007.

WHITMER, Gilbert Gomer, MD

Location: Raleigh, NC (Wake Co) | DOB: 9/04/1961

License #: 0000-36854 | Specialty: ORS/ORS, hand (as reported by physician)
 Medical Ed: The Johns Hopkins University (1987)
 Action: 9/21/2006. Temporary/dated license extended to expire 3/31/2007.

See Consent Orders:

FARRELL, Edwin Gayle, MD
 KPEGLO, Maurice Kobla, MD

DISMISSALS

ELBAOR, James Edward, MD

Location: Arlington, TX | DOB: 5/08/1944
 License #: 0000-21170 | Specialty: OS/IM (as reported by physician)
 Medical Ed: Loyola University, Stritch School of Medicine (1969)
 Action: 8/21/2006. Notice of Dismissal With Prejudice of Charges and Allegations of 5/15/2006.

WYBLE, Linda Gilbert, MD

Location: Tampa, FL | DOB: 1/01/1957
 License #: 0000-38871 | Specialty: AN (as reported by physician)
 Medical Ed: University of Maryland (1982)
 Action: 8/21/2006. Notice of Dismissal With Prejudice of Charges and Allegations of 5/15/2006.

REENTRY AGREEMENTS

CEH, Paula Jane, Physician Assistant

Location: Fayetteville, NC (Cumberland Co) | DOB: 3/05/1965
 License #: 0010-00559
 PA Education: Butler University (2003)
 Cause: Ms Ceh has not practiced as a PA since October 2003. Her CME is current.
 Action: 9/13/2006. Reentry Agreement executed: Ms Ceh is issued a PA license; she shall have her supervising physician observe her practice for her first 12 months and send the Board evaluation reports on Ms Ceh's practice at the six and 12 month intervals; she shall meet with the Board when asked.

EINHELLIG, Sandra Lynn, Physician Assistant

Location: Kernersville, NC (Forsyth Co) | DOB: 10/19/1975
 License #: 0010-00614
 PA Education: Wake Forest University (2005)
 Cause: Ms Einhellig has never practiced as a PA. Her CME is not current.
 Action: 9/25/2005. Reentry Agreement executed: Ms Einhellig is issued a PA license; her supervising physician shall observe her practice for the first six months and report to the Board in detail within 30 days after the end of the observation period; Ms Einhellig shall obtain all the required CME during the six month observation period; she shall meet with the Board if and when asked.

FOSTER, Darryl, Physician Assistant

Location: Fayetteville, NC (Cumberland Co) | DOB: 10/05/1960
 License #: 0010-00666
 PA Education: State University of New York, Stony Brook (1987)
 Cause: Mr Foster has not practiced since July 2002. His CME is current.
 Action: 10/19/2006. Reentry Agreement executed: Mr Foster is issued a PA license; his supervising physician shall observe his practice for the first 12 months and report to the Board in detail within 30 days after the end of the observation period; he shall meet with the Board if and when asked.

LASSITER, Jennifer Whorley, MD

Location: Matthews, NC (Mecklenburg Co) | DOB: 11/15/1969
 License #: 2006-01450 | Specialty: PD (as reported by physician)
 Medical Ed: University of Alabama, Birmingham (1996)
 Cause: Dr Lassiter has not practiced clinical medicine since 2004.
 Action: 8/21/2006. Reentry Agreement executed: Dr Lassiter is issued a full and unrestricted license; she shall have a colleague observe her practice for six months; at the end of that time, the observing physician shall report to the Board on Dr Lassiter's performance; she shall meet with the Board on request.

RICHARDSON, Wendell Llywellyn, MD

Location: Charleston, SC | DOB: 7/23/1960

License #: 2006-01430 | Specialty: FP (as reported by physician)
 Medical Ed: Medical University of South Carolina (1999)
 Cause: Dr Richardson has not practiced medicine since August 2002.
 Action: 8/18/2006. Reentry Agreement executed: Dr Richardson is issued a full and unrestricted license to practice medicine; the physician supervising his mini-fellowship in South Carolina shall report to the Board on the quality of Dr Richardson's skills within 30 days of the end of that fellowship; he shall then be observed by a colleague during his first four months of practice and that colleague shall report on the quality of Dr Richardson's skills within 30 days following the observation period; he shall meet with the Board as requested.

SIKES, Glenn Austin, Physician Assistant

Location: New Bern, NC (Craven Co) | DOB: 7/20/1950
 License #: 0010-00560
 PA Education: State University of New York, Stony Brook (1977)
 Cause: Mr Sikes has not practiced as a PA since 2000. His CME is current.
 Action: 9/14/2006. Reentry Agreement executed: Mr Sikes is issued a PA license; he shall have his supervising physician observe his practice for his first six months and send the Board evaluation reports on Mr Sike's practice on a monthly basis during the six months period; he shall meet with the Board when asked.

WALSH, Alicia Ann, MD

Location: Morganton, NC (Burke Co) | DOB: 8/09/1969
 License #: 2006-01237 | Specialty: OB/GYN (as reported by physician)
 Medical Ed: University of Medicine and Dentistry of New Jersey (1995)
 Cause: Dr Walsh has not practiced clinical medicine since 2002.
 Action: 8/11/2006. Reentry Agreement executed: Dr Walsh is issued a full and unrestricted license; she shall have a colleague observe her practice for six months; the observing physician shall discuss, review, and co-sign all of Dr Walsh's patient charts for the first three of the six months; after each three months of the observation period, the observing physician shall report on Dr Walsh's performance to the Board in writing; she shall meet with the Board on request.

WEINSTEIN, Lisa Jacobs, MD

Location: Raleigh, NC (Wake Co) | DOB: 5/26/1965
 License #: 2006-01474 | Specialty: PTH/PCP (as reported by physician)
 Medical Ed: The John Hopkins University School of Medicine (1993)
 Cause: Dr Weinstein has not practiced medicine actively since 2002.
 Action: 9/08/2006. Reentry Agreement executed: Dr Weinstein is issued a full and unrestricted medical license; she shall complete at least 50 hours of Category 1 CME and 100 hours of training at the Johns Hopkins Hospital; she shall have her practice observed by a physician colleague for the first six months following her resumption of practice, the observer reporting to the Board at the end of that period; should she begin practice in North Carolina before 3/31/2007, she must have a colleague observe her practice through that date.

A change of address form is now available on the Board's Web site at www.ncmedboard.org.

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

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National Provider Identifier: Get It. Share It. Use It.

All individual or group medical providers who bill a covered service with a public or private payer, either individually or by group, must apply for and be issued a National Provider Identifier (NPI) no later than May 23, 2007. Separate NPIs should be obtained for individual and group providers. All providers who do not obtain, use, and share their NPI may experience interruptions in timely payment of claims after May 23, 2007. All providers must share their NPI with other providers, health plans, clearinghouses, and any entity that may need it for billing purposes -- including designation of ordering or referring physicians. Providers may be requested to communicate their NPIs to health plans, clearinghouses, and other providers well before the compliance date for the development of crosswalks to aid in the transition to the NPI. Providers should also consider letting health plans, or institutions for whom they work, share their numbers for them. All individual and group medical providers should obtain and start communicating their NPIs immediately. NC Division of Medical Assistance has been collecting NPIs since September and strongly urges all Medicaid providers to report their NPIs as soon as possible. For more information regarding obtaining an NPI and Medicaid reporting forms, you may visit the NC Medical Society website, http://www.ncmedsoc.org/pages/public_resources/npi_info.html.

North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: February 21-22, 2007; March 21-23, 2007; April 18-19, 2007;
May 16-18, 2007; June 20-21, 2007

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.

Special Purpose Examination (SPEX)

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

North Carolina Medical Board
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