

forum

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President's Message

Trends in Maintaining Clinical Medical Expertise



Janelle A. Rhyne, MD

There is increasing public demand to ensure that physicians maintain up-to-date medical expertise (also called continued clinical competence). The American Board of Internal Medicine Foundation, in the publication titled *Medical Professionalism in the New Millennium*, says that physicians' professional responsibilities include the lifelong commitment to maintaining expertise in clinical medical treatment.

The Institute of Medicine (IOM) in its publication, *To Err Is Human*, challenges health professionals to make the health care system safer by periodically reexamining and relicensing providers "based on both competence and knowledge of safety practices."¹ Later IOM reports recommend that medical regulatory boards take a more proactive and involved approach to practitioner competence.^{2,3}

In 2007, the American Association of Retired Persons, in collaboration with the Citizens Advocacy Center, conducted a study in Virginia and reported that more than 95% of respondents (50 years of age and older) believed in requiring health care professionals to demonstrate that they have the up-to-date knowledge and skills needed to provide quality care in order to retain their licenses. In the opinion of respondents, such demonstration would include periodic reevaluation. The Federation of State Medical Boards (FSMB) adopted a policy in 2004 stating that state medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking relicen-

sure (called annual registration renewal in North Carolina).

Recent emphasis by the following medical organizations has focused on the continuous improvement process in medicine by incorporating principles of quality and performance enhancement:

The American Board of Medical Specialties (ABMS), comprising 24 member specialty boards, requires physicians meet the following criteria on a continuing basis to maintain board certification.

- Part I-Professional Standing
- Part II-Commitment to Lifelong Learning and Involvement in Periodic Self-Assessment
- Part III-Cognitive Expertise
- Part IV-Evaluation of Performance in Practice

Applicants for certification or recertification must show competence in six areas, namely: (1) medical knowledge; (2) patient care; (3) practice-based learning and improvement; (4) interpersonal and communication skills; (5) professionalism; and (6) systems-based practice.

In September 2006, the Accreditation Council for Continuing Medical Education (ACCME) released new standards for the accreditation of continuing medical education (CME) that adopt changes for both CME providers and learners. CME programs now strive to improve physician competence, physician performance, and/or patient outcomes. The Accreditation Council for Graduate Medical Education (ACGME) requires residency programs provide educational experiences through which their residents will acquire core competencies in the six aforementioned areas.

The Bureau of Osteopathic Specialists (BOS), comprising 18 osteopathic specialty boards, has begun to incorporate seven

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forum

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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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core competencies that include the six core competencies of the ABMS maintenance of certification program plus a core competency related to osteopathic philosophy and osteopathic manipulation medicine. The Joint Commission, responsible for the accreditation of health care organizations and programs in the United States, implemented new standards effective January 2007 and January 2008. These new standards require organizations to implement a Focused Professional Practice Evaluation and an Ongoing Professional Practice Evaluation in addition to evaluating physicians on multiple competencies such as the six developed by the ACGME. The Focused Professional Practice Evaluation Standards apply to (1) the evaluation of currently privileged practitioners who seek new privileges, and (2) situations in which the competence of a practitioner with existing privileges comes into question. The Ongoing Professional Practice Evaluation standards make continuous rather than periodic assessment of practitioners' performance.

The FSMB recommends state medical boards require physicians seeking relicensure demonstrate competence in their areas of daily practice. Draft recommendations by the FSMB include the following.⁴

1. Participation by physicians in an ongoing process of reflective self-evaluation, self-assessment and practice assessment, with subsequent completion of educational activities tailored to meet the needs or deficiencies identified by the assessment.

Evidence of self-evaluation, self-assessment and practice assessment could include participation in self-evaluation exercises or modules, such as self-review tests, home study courses and Web-based materials, or passage of a state medical board approved examination in the physician's current practice area.

Remedial and educational activities could include: (a) review of literature in the physician's current practice area; (b) CME in the physician's practice area that enhances patient care, performance in practice and/or patient outcomes; and (c) participation in other educational programs.

2. Demonstration of continued expertise in the six aforementioned areas of competence (seven in the case of osteopaths). The physician should pass a valid, secure, proctored examination in his or her current practice area at least every 10 years.
3. Demonstration of accountability for performance in practice by (a) peer assessment, such as 360 evaluations, letters of recommendation and attestation of clinical activities; or (b) by patient reviews, such as satisfaction surveys.

The draft FSMB report recommends participation in recognized quality improvement activities as well as collection and analysis of practice data, such as thorough review of office records, chart review, case review, and submission of a case log.

Documented evidence of compliance with the above recommendations could include proof of continuous participation in maintenance of certification processes

or participation in recognized quality improvement activities such as those required by the Joint Commission.

Currently, the NCMB does not require its licensees to engage in continued competence activities as described in the preceding paragraphs. The only continued competence activity currently required by the NCMB is 150 hours of CME every three years, of which at least 60 hours must be educational provider-initiated CME. However, in 2007 the North Carolina legislature gave the NCMB the authority to develop additional methods to ensure ongoing competence in its licensees. The NCMB's Continued Competence Committee will be looking at the FSMB draft report and will make recommendations to the NCMB. Increased regulatory

activity in this area seems inevitable. We welcome your input as to the evidence the NCMB will accept in the future as proof of maintenance of license requirements.

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Long Career in Medical Regulation Closes: Dale G Breaden Leaves NC Medical Board

*Dena M. Konkell, Assistant Director, Public Affairs
North Carolina Medical Board*



Mr Breaden

On January 31, 2008, the North Carolina Medical Board will say goodbye to a member of its staff, Dale G Breaden, director of its Department of Public Affairs and editor of its publication, the *Forum*. He will be moving along from his post with the Board, as he has said: "to visit the rest of my life."

For the past 33 years, Dale has served in the field of medical regulation, dedicating himself to public safety and welfare in the realm of health care. He began his career in the field in the 1970s, serving as director of the groundbreaking Utah Academy for Continuing Medical Education, which coordinated CME with PSRO data and aided in operation of the state's mandatory CME requirement. In the 1980s and 1990s, he was the Federation of State Medical Boards' associate executive vice president. While at the FSMB, he oversaw redevelopment of the organization's *Guide to the Essentials of a Modern Medical Practice Act* and development of the *Elements of a Modern State Medical Board*. He was instrumental in creating most of the FSMB's publications during those years. He also assisted in organizing the FSMB's first independent annual meeting in 1981. In the mid-1980s, following professional visits to the Soviet Union, China, and Australia, he began to pursue federal support for an international conference on medical regulation. This effort finally produced the First International Conference on Medical Licensure/Registration and Discipline, which was held under his direction in Washington, DC, in 1994, and led direct-

ly to the creation of the International Association of Medical Regulatory Authorities.

While with the FSMB, Dale testified before Congress in the late 1980s on the need for creation of the National Practitioner Data Bank, helped in promotion of the concept of a single examination pathway to licensure, which finally resulted in establishment of the United States Medical Licensing Examination, developed and administered several federal research projects, and assisted in the development of the FSMB's annual Board Action Report. In 1992, he assumed editorship of the FSMB's publication, the *Bulletin*, and turned it into the *Journal of Medical Licensure and Discipline*, of which he remains emeritus editor. He has received several awards for his work with the FSMB.

After retiring from the FSMB, Dale and his wife, Susannah, moved to North Carolina, where their children and grandchildren lived, and he was pleased to be given the opportunity to join the staff of the North Carolina Medical Board to guide development of a Public Affairs Department. He joined the Board in 1995, successfully creating a strong public affairs program, establishing the Board's quarterly publication, the *Forum*, now concluding its 12th year, and serving the public interest in a wide variety of ways. Thirteen years later, his contributions to the Department and to the Board have made a significant impact on public awareness and outreach. "The Board is the servant of the people and they must have confidence in its dedication to their safety and welfare. To that end, the Board must be as transparent and open as the law allows in all it does," he has said. On behalf of the North Carolina Medical Board, its staff, and the people of North Carolina, we thank Dale for his service and the difference he has made at the state, national, and international levels.

"The Board is the servant of the people and they must have confidence in its dedication to their safety and welfare"

Improving Your Practice Management Through Outsourcing: Part II—Information Technology, Human Resources, and Financial Planning

Marjorie A. Satinsky, MA, MBA
President, Satinsky Consulting, LLC



Ms Satinsky

As I noted in Part I of this article, if you are like most physicians in private practice, you know that running your business can sometimes seem as challenging as practicing medicine. Even if you have supplemented your clinical training with a business degree, you realize that you are dealing with a wide variety of issues that include quality of care, patient satisfaction, financial management, people, and supporting information technology.

My clients tell me that the longer they practice, the more complicated practice management becomes. Managed care companies and government payers continue to impact your revenue in unpredictable and usually negative ways. Patients expect more from their physicians and don't hesitate to say so. You keep operating expenses at a reasonable level by asking your staff to assume more responsibilities. If you are a small practice with 10 or fewer physicians, your practice manager, if you have one, may be deluged with the details of day-to-day operations. The very thought of taking responsibility for special projects that require a new knowledge base may be overwhelming.

You may be able to improve the management of your practice by outsourcing one or more functions that require specialized expertise that you don't have and are unlikely to hire. In this two-part article, I review five functions that you may be able to outsource to your advantage: managed care contracting, billing and collections, information technology, human resources, and financial planning. For each of these areas, I identify the problems that outsourcing may help you address, review the advantages and disadvantages of outsourcing, and offer helpful hints for selecting a vendor or consultant to help you. In part one, published in the previous number of the *Forum*, I covered managed care and billing and collections. In this number, I'll discuss information technology, human resources, and financial planning.

Information Technology

Information Technology (IT) is rapidly becoming a critical component of practice management. Physicians who are finishing their training and setting up their practices are thinking about ways in which tech-

nology can help them keep their overhead at a low rate. Physicians who are already in practice and who are dependent on paper records and systems are learning how their practice management system (PMS), electronic health records (EHR), and Web site, and the relationship among them can help them deliver higher quality and more efficient care. The handwriting is already on the wall. In the years to come, both public and private payers will continue to put in place financial incentives to support the growing acceptance of information technology applications. You'll want to make good decisions about the products you purchase, interconnectivity, ongoing IT support, and of course compliance with the HIPAA Privacy and Security Rules.

I see practices approaching IT planning and implementation in haphazard ways. Many start by looking at the products on the market, rather than by assessing their own needs. Seduced by the bells and whistles that they see at trade shows and that vendor salespeople promote, they skip the planning phase and rush to purchase systems or packages that turn out to be unsuitable for their particular practices. I know one physician who purchased three EHR systems within a six-month period before he found the "right" one! A 2005 article in the *Annals of Internal Medicine* describes the implementation problems that a Philadelphia internal medicine practice had with EHR (Baron, et al, 2005). With proper planning, the practice would have had a much more positive experience.

Another cause for poor IT decisions is reliance on internal staff who enjoy using computers but who know very little about current trends, external regulations, interconnectivity, proposals, and contracts. Still another common cause of trouble is seeking inexpensive or free advice from a friend or relative. Remember the adage—"You get what you pay for."

I think there's great value in asking an external consultant to help you plan, purchase, implement, and evaluate your information technology. You'll learn a great deal that you don't now know about industry trends, regulatory requirements, and available options. If you don't have internal expertise, I don't see any disadvantages in outsourcing your IT, assuming you give the vendor clear direction and feedback.

After dealing with so many clients that have made bad and costly mistakes with information technology, I've developed a comprehensive checklist that I give to potential IT vendors. My questions are related to general business direction, qualifications and staff training, security-related services, communication, costs, and

"I see practices approaching IT planning and implementation in haphazard ways. Many start by looking at the products on the market, rather than by assessing their own needs"

references. Here are some examples.

1. For how many years have you provided services to medical practices?
2. How many medical and/or dental practices do you currently serve?
3. What are your plans for future growth and expansion?
4. How do you recruit, train, and retain staff?
5. How many people are on your payroll, and what do you do when you need additional people to help on a project basis?
6. What certifications do your employees have?
7. What specific services do you provide for hardware and software?
8. If our practice has arrangements with multiple vendors, can you assist with interoperability?
9. Explain how you respond to typical inquiries from your medical practice clients. Who responds to requests? How long does it take? Do you document requests for help?
10. How do you charge for your services (eg, hourly and/or flat monthly fee)?
11. Is there a surcharge for after-hours services?
12. Do you have service performance goals for your staff?
13. Who can we call for references on your company?

Human Resources

Your employees are your most important assets. Recruiting, hiring, firing, supervising, training, doing regular performance evaluations, making sure you are in compliance with state and federal law, reviewing your benefit package, and upgrading salary scales are some of the things you should be doing on a regular basis. When I ran a pediatric specialty practice, there were weeks when I devoted 20 hours or more to human resources—way more time than I had for this task.

The human resources problems that I encounter most frequently are listed below.

- Many practices lack systematic ways to perform routine functions, so they treat employees inconsistently. Staff complain about favoritism, and rightly so, since different standards apply to different people.
- The practice manager has been promoted from within, and he/she is uncomfortable supervising and reviewing co-workers who were previously peers.
- Physicians are inexperienced and uncomfortable with employee performance reviews. They postpone the reviews or don't do them at all. Employees crave clarity of expectations and feedback. They become frustrated and rebellious when they don't receive it.

If you would like to explore external assistance for one or more of your human resource tasks, you have three options. First, you can engage a consultant to help you with one or more projects. For example, when I ran a practice, I relied upon an external consultant to develop and implement a performance evaluation system. Many of you may already outsource your payroll function. Second, you can outsource multiple human resource tasks to the same vendor in what is known as business processing outsourcing (BPO). Third,

you can go one step further than the BPO approach and partner with a professional employer organization (PEO). With the third option, your employees are actually on the payroll of the PEO and you "lease" them back.

Each of these three options has advantages and disadvantages. Here's my analysis for the third option, the PEO. When you partner with a company that specializes in HR, you may see the following advantages.

- You have access to professionally trained and experienced HR experts. They save you time and money, allowing you to concentrate on revenue generation and profitability.
- The benefit package that you can offer to your employees is richer than what you could offer as a single practice. The "workforce" of the PEO is larger than your own, and this leverage allows the purchase of more and better types of health and dental insurance, disability insurance, retirement packages, and other benefits.
- When your employees need counseling to better improve their job performance, experts can provide the services.
- The professional staff of the PEO can answer questions about benefits more quickly and accurately than you can.
- Your PEO develops the documentation that you need in your practice. Examples are your employee handbook, forms, and operating policies and procedures.
- You can reduce the risk to your practice by gaining access to professional advice on employment-related issues.

As with all outsourcing, there is a disadvantage if you outsource your HR to a PEO. You share, not give up, control of your employees.

If you would like to investigate outsourcing your HR to a PEO, BPO, or other external consultant, here are the questions you should ask.

1. How long has the organization/individual been in business?
2. What are the organization's/individual's future plans?
3. If you are talking to a PEO, does the entity have a license in the state where it is operating?
4. If you are talking to a PEO, is it accredited by the appropriate professional organization (eg, Employer Service Assurance Corporation)?
5. Who manages your account?
6. How does the organizational/individual involve specific experts as needed?
7. What do references say about the organization/individual?

Financial Planning

Just as physicians develop a diagnosis and treatment plan for their patients, they should put in place a financial plan for themselves as individuals and for their practice. It sounds like common sense, yet financial planning for many of my clients is limited to checking monthly cash flow and operating statements and balance sheets. Planning for the future is not part of the equation. The financial planning challenge is less visible

"When I ran a pediatric specialty practice, there were weeks when I devoted 20 hours or more to human resources—way more time than I had for this task"

yet just as important as the other opportunities for outsourcing that I have discussed throughout this article.

Since physicians are comfortable with research related to patient care, they may assume that they should apply their skills to their own investments. Sometimes they self-treat because the approach is less expensive than paying an outside advisor. Or, they may feel that they know more than professional financial advisors. Financial professionals believe that self-diagnosis can lead to what they call financial malpractice. The patient/physician is prescribing a treatment without fully understanding what ails him/her.

When you look for outside help with financial planning, here are some important points to consider.

- Plan first and then invest. The person who helps with your planning may or may not be the same person who makes or facilitates the investments. In my own situation as a small business, I engaged an independent financial planner and asked her to give me the names of reputable people who could help me make my investments. When I started, I specifically wanted the planning done by an individual who had no relationship to the investments. I paid two fees, one to the planner and the other to the firm that made my investments; that was my preference. Now that I have selected and work with a large brokerage firm that I like and trust, the same individual does my planning and investing. Another approach is to ask the same firm to do both the planning and investing. Some advisors in large firms are trained to do both. The advice is free, and their fees are earned from the investments. The advantage to this approach is that the advice can be ongoing as both your needs and circumstances change.
- Check the credentials of the financial advisor(s). Is he or she a Certified Financial Planner (CFP)? The CFP designation is earned after many hours of training, studying, and intense testing in all areas of financial planning and investments.
- Don't be put off by fees. You don't work for free and neither do financial planning professionals. Many fees are hidden, so the average investor thinks he or she is getting something for nothing. Variable annuities are a good example. The insurance company markets the product as having no annual fee, but in fact the mutual funds within the annuity may charge between 1% and 5% per year as expenses and management fees. Investors can't see the fee because it is deducted from performance. Annuities aren't bad; just don't think they are free.
- Stay involved with your financial plan and investments, but don't do it yourself unless you are sure you know what you are doing. Meet with your advisor at least twice each year for a financial check-up. Regular topics of discussion should be your risk tolerance, investment objectives, asset allocation, portfolio performance vs. the indices, and your cash flow needs. Rebalance the portfolio periodically to take advantage of changing trends in the economy. Tax management should be part of the overview, and your financial advisor can work collaboratively with your CPA and attorney. The

advisor may also be able to help you with insurance needs.

- Don't postpone establishing a retirement plan for your practice because you don't want to make contributions for your employees. In the end, you will be hurt more by not taking advantage of one of the best retirement opportunities.
- Finally, consider the parallels between medicine and financial management. Planning and investing goes beyond picking the right stock or bond. It's about having someone who acts like your primary care physician by diagnosing your problem, calling in the specialists, and coordinating your care. I call it the holistic approach to financial management.

Conclusion

If you would like to outsource managed care, billing and collections, information technology, human resources, financial planning, or other functions, remember that you are in charge. Take the time to develop clear goals, a budget that you can afford, and expectations for the relationship. You may be pleasantly surprised about the positive impact on your practice.

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Acknowledgements

Karen Diamond, CFP, CIMA, and Ed Barber, CFM, formerly with Merrill Lynch; and Jean Bailiff, Physician Discoveries.

Ms Satinsky is president of Satinsky Consulting, LLC. She earned her BA in history from Brown University, her MA in political science from the University of Pennsylvania, and her MBA in health care administration from the Wharton School of the University of Pennsylvania. She is the author of three books: *Medical Practice Management in the 21st Century* (Radcliffe Publishing, 2007), *The Foundation of Integrated Care: Facing the Challenges of Change* (American Hospital Publishing, 1997), and *An Executive Guide to Case Management Strategies* (American Hospital Publishing, 1995). The *Forum* has published several articles by Ms Satinsky, including Managing the Implementation of HIPAA and the Privacy Rule, in #4, 2002; How to Determine If Your Practice Could Use a Professional Practice Administrator, in #2, 2003; Using Information Technology to Improve Patient Care and Communication: A Practical Guide – Part 1, in #1, 2004; Using Information Technology to Improve Patient Care and Communication: A Practical Guide – Part 2, in #2, 2004; Electronic Medical Records and the Development of Electronic Health Records and Electronic Patient Records, in #3, 2004; Implementation of the HIPAA Security Rule in #4, 2004; What Are You Doing About Health Care Quality in Your Practice, Part I, #1, 2006, and Part II, #2, 2006; Improving Your Practice Management Through Outsourcing, Part I, #3, 2007. An adjunct faculty member at the University of North Carolina School of Public Health, Ms Satinsky is a member of the North Carolina Medical Society Quality of Care and Performance Improvement Committee, Medical Group Management Association, and North Carolina Medical Group Managers. She may be reached at (919) 383-5998 or margie@satinskyconsulting.com.

“Stay involved with your financial plan and investments, but don't do it yourself unless you are sure you know what you are doing”

New NCMB Officers: Janelle A. Rhyne, MD, President; George L. Saunders, III, MD, President Elect; Ralph C. Loomis, MD, Secretary; Donald E. Jablonski, DO, Treasurer

On November 1, 2007, Janelle A. Rhyne, MD, of Wilmington, took office as president of the NCMB. George L. Saunders, MD, of Shallotte, became president elect; Ralph C. Loomis, MD, of Asheville, became secretary; and Donald E. Jablonski, DO, of Etowah, became treasurer. Their terms of office run until October 31, 2008.

Janelle A. Rhyne, MD, President



Dr Rhyne

Dr Rhyne, the Board's new president, earned a BA degree in anthropology from the University of North Carolina at Chapel Hill and continued her education at Arizona State University, where she took an MA degree in physical anthropology. Following graduation, she returned to UNC Chapel Hill where she

completed additional studies and worked in neuropathology research. She earned her MD at Wake Forest University School of Medicine. She did her internship in internal medicine, her residency training, and a fellowship in infectious diseases at Wake Forest University Baptist Medical Center.

Dr Rhyne currently serves as clinical associate professor in the Department of Medicine at the University of North Carolina School of Medicine and has served Wilmington's New Hanover Regional Medical Center in many capacities, including chair of numerous medical staff committees, chief of staff, and member of the Board of Trustees. She was in private practice at Wilmington Health Associates for 18 years before moving to the New Hanover County Health Department in 2007.

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, of which she is a fellow, 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 Executive Committee. She has served as the Board's president elect, secretary, and treasurer, and was appointed a member of the Federation of State Medical Board's Finance Committee in 2005, 2006, and again in 2007. She served as a member of the FSMB Sexual Boundary Workgroup, and is currently a member of the FSMB Emergency Preparedness Ad Hoc Committee.

George L. Saunders, III, MD, President Elect



Dr Saunders

Dr Saunders, 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 medi-

cal 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 has also served as secretary and treasurer of the Board.

Ralph C. Loomis, MD, Secretary



Dr Loomis

A native of Kentucky, Dr Loomis took his undergraduate degree, cum laude, at Vanderbilt University, and his MD degree from Indiana University, where he received the Senior Honors Program Award. He did his internship at Indiana and his residency in neurosurgery at the same institution, during which he received the Willis Gatch General Surgery Award. He also took the Theodore Gildred Microsurgical Course and was co-author of an article in the *Annals of Surgery*.

Dr Loomis is certified by the American Board of Neurological Surgery and is a fellow of the American College of Surgeons. He is a member of the Congress of Neurological Surgery and the American Association of Neurological Surgery, an officer in the North Carolina Neurosurgical Society, and the North Carolina delegate to the national Council of State Neurosurgical Societies. Dr Loomis represents the neurosurgery

section of Mission Hospitals in the level II trauma section of the western region of North Carolina and is past chief of surgery for Mission Hospitals. He was appointed to the Board in 2005 and has served on the its Reentry, Complaint, Licensing, and CPP Committees. He has also served as the Board's treasurer and was appointed to the Bylaws Committee of the Federation of State Medical Boards in the spring of 2007.

He practices at the Mountain Neurological Center in Asheville.

Donald E. Jablonski, DO, Treasurer



Dr Jablonski

A native of Michigan, Dr Jablonski took his undergraduate degree at the University of Windsor, Windsor, Ontario, Canada, with graduate study at Oakland University, Rochester, Michigan. He received his DO degree from the Chicago College of Osteopathic Medicine. He did his internship at Lakeview

General Hospital in Battle Creek, Michigan, where he served as chief intern. He is certified by the American Osteopathic Board of Family Practice. In 1996-1997, he participated in the Academic Leadership Fellowship Program of the Ohio University College of Osteopathic Medicine.

Dr Jablonski is a member of numerous professional organizations, including the American Osteopathic Association, the American College of Osteopathic Family Physicians, the Association of Osteopathic Directors and Medical Educators, and the North Carolina Osteopathic Medical Association. He is a fellow of several professional groups.

He is licensed and has practiced in Florida and Ohio as well as North Carolina. Before coming to North Carolina, he was an associate professor of family medicine at the Ohio University College of Osteopathic Medicine. The list of his professional activities over the years contains over 50 citations. He is currently a member of the Mountain Area Health Education Center and a preceptor for Duke and North Carolina medical students. He is also president of the North Carolina Society of the American College of Osteopathic Family Physicians and of the North Carolina Osteopathic Medical Association. At the same time, he very active in community affairs.

Among other awards, he has been given the Outstanding Achievement Award of the Chicago College of Osteopathic Medicine and the Physician of the Year Award of the American College of Osteopathic Physicians. He was appointed to the Board in 2005 and serves on the Disciplinary and Licensing Committees.

He has published several articles on the management of diabetes.

Governor Names Pamela Blizzard, of Raleigh, to NCMB; Reappoints Judge Lewis, of Farmville

R. David Henderson, executive director of the North Carolina Medical Board, has announced that Gov Easley recently appointed Pamela Blizzard, of Raleigh, as a public member of the Board. He also announced the reappointment of John B. Lewis, Jr, LLB, of Farmville, as a public member. Mr Henderson said: "Ms Blizzard and Judge Lewis are fully committed to the work of the Board and to the health and safety of the people of North Carolina. We look forward to working with Ms Blizzard and to the continued dedicated service of Judge Lewis."

Pamela Blizzard



Ms Blizzard

Pamela Blizzard earned her bachelor's degree in urban studies from Brown University in Providence, RI, and her MBA in marketing and finance from the University of Santa Clara in Santa Clara, CA. She began her professional career at Hewlett Packard Company in Sunnyvale, CA, as a financial accountant in the Instrument and

Optoelectronic Division, and later became international product manager of the Personal Computer Division. Ms Blizzard served as partner and chief advertising officer of AlphaGraphics in Richmond, VA, and as chair and founder of the Board of directors for the Raleigh Charter High School, in Raleigh, NC, which was named the "9th Best High School in America" in 2005 by *Newsweek* magazine. She currently serves as executive director and founder of the Contemporary Science Center in Research Triangle Park, NC, where she established and now directs its science education non-profit program.

Ms Blizzard served as a member of the Institute for Emerging Issues, Innovation, Technology and Entrepreneurship Working Group at North Carolina State University from 2006 to 2007. From March 2005 to 2006, she was a member of the State Board of Education's E-Learning Commission and the Curriculum and Instruction subcommittee, where she was charged with creating

an online learning strategy for the State of North Carolina.

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.

It Seems to Me...

Words CAN Hurt

David P. Kimmel, MD

Children chant the phrase "sticks and stones can break my bones but words will never hurt me" as a shield against verbal assaults. Of course, the need for the chant contradicts its claim. All have felt the sting or balm words can engender. Physicians must take special care to choose words cultivating understanding,

conveying compassion, and combating fear.

The words we use not only express our thoughts but frame them as well. If we choose condescending words, our attitude may follow with an air of superiority. Lately, the word "customer" has crept into medical communication. It refers to the business patronage of

an individual. Consequently, the word has its focus on a financial relationship. This implies that the relationship is a mere transaction of services. For roughly a thousand years, the “patient” has been the dominant word in English for the person the physician cares for. It derives from a root word, “pati,” that refers to a state of suffering. The word patient stresses the human need requiring the physician’s care.

The commodification of human beings is as ancient as slavery and prostitution and continues today with those and other tragic evils. So it is no surprise that physicians, too, would be treated as mere commodities. As a primary care physician, I have often had the sense

that I was being treated like a vending machine—yet it is a loss to allow such reduction of the relationship between patient and physician. The suffering individual can benefit from a transaction of expertise or service, yet there are other aspects to the relationship, such as compassion and care.

I would urge us all to avoid the use of the word “customer” when referring to patients, and especially to avoid the notion that the relationship with our patients is primarily a financial one.

Dr Kimmel practices at Elk River Medical Associates in Banner Elk, NC.

Multiple Prescriptions for Schedule II Drugs

R. David Henderson, Executive Director, NCMB



Mr Henderson

Current federal law prohibits refills of Schedule II drugs. However, can a prescriber lawfully issue multiple prescriptions for Schedule II drugs to be filled sequentially, for the same schedule II controlled substance, with such multiple prescriptions having the combined effect of allowing a patient to receive over time, up to a 90-day supply of that controlled

substance (often accomplished by using the “do not fill before. . .” language)?

As many prescribers are aware, there has been some confusion regarding whether this is appropriate. A few years ago, the U.S. Department of Justice, Drug Enforcement Administration (DEA) issued an opinion that this practice did not violate the prohibition against refills. Soon thereafter, DEA reversed its decision. The overwhelming negative reaction to that reversal resulted in a proposed rule, published in September 2006, which would, if approved, reinstate the above policy.

The vast majority of comments from a wide variety of individuals and organizations supported adoption of this rule citing the time and money saved due to less frequent visits to prescribing practitioners, and the reduced physical toll resulting from the reduced visits. Consequently, DEA has announced that the proposed rule, with minor modifications, becomes effective December 19, 2007.

In announcing its decision, DEA reiterated its interest in ensuring that controlled substances are prescribed for legitimate medical purposes by prescribing practitioners acting in the usual course of professional practice and preventing, as much as possible, the diversion and abuse of controlled substances.

Note: Please remember that all prescriptions issued pursuant to the new rule must be dated the date the prescription was issued even though some prescriptions

will not be filled until a later date.

The new rule is presented below. For further information, go to http://www.deadiversion.usdoj.gov/fed_regs/rules/2007/fr1119.htm.

Sec. 1306.12 Refilling prescriptions; issuance of multiple prescriptions.

- (a) The refilling of a prescription for a controlled substance listed in Schedule II is prohibited.
- (b)(1) An individual practitioner may issue multiple prescriptions authorizing the patient to receive a total of up to a 90-day supply of a Schedule II controlled substance provided the following conditions are met:
 - (i) Each separate prescription is issued for a legitimate medical purpose by an individual practitioner acting in the usual course of professional practice;
 - (ii) The individual practitioner provides written instructions on each prescription (other than the first prescription, if the prescribing practitioner intends for that prescription to be filled immediately) indicating the earliest date on which a pharmacy may fill each prescription;
 - (iii) The individual practitioner concludes that providing the patient with multiple prescriptions in this manner does not create an undue risk of diversion or abuse;
 - (iv) The issuance of multiple prescriptions as described in this section is permissible under the applicable state laws; and
 - (v) The individual practitioner complies fully with all other applicable requirements under the Act and these regulations as well as any additional requirements under state law.

(2) Nothing in this paragraph (b) shall be construed as mandating or encouraging individual practitioners to issue multiple prescriptions or to see their patients only once every 90 days when prescribing Schedule II controlled substances. Rather, individual practitioners must determine on their own, based on sound medical judgment, and in accordance with established medical standards, whether it is appropriate to issue multiple prescriptions and how often to see their patients when doing so.

“Can a prescriber lawfully issue multiple prescriptions for Schedule II drugs to be filled sequentially. . . ?”

Sec. 1306.14 Labeling of substances and filling of prescriptions.

(e) Where a prescription that has been prepared in accordance with section 1306.12(b) contains instructions from the prescribing practitioner indicating that the

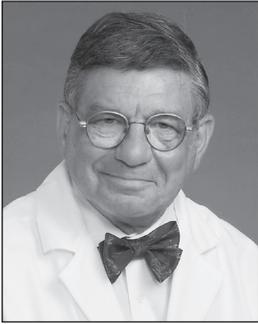
prescription shall not be filled until a certain date, no pharmacist may fill the prescription before that date.

Dated: November 7, 2007.

On Being a Patient

Walter M. Roufail, MD

Former President, NCMB



Dr Roufail

“Physicians are the worst patients” is a cliché so often repeated that nobody, to my knowledge, ever tried to find the motivations behind such reprehensible behavior.

Some time ago, I woke up at three in the morning with abdominal pain that I diagnosed as biliary colic that evolved into pancreatitis. Having some hydrocodone left over from a previ-

ous broken neck related to another stupid endeavor at the age of 70, I took one and within three hours the pain was tolerable.

Believe it or not, I did go to my primary care physician, who also happens to be a gastroenterologist. He is a rare breed and, mercifully, is at least 20 years younger than I. I was informed that I was jaundiced, had a high WBC count, and had to be admitted forthwith to the hospital.

My first encounter with the “System” was waiting for almost an hour in the Admissions Office until my room was ready. After all, the pain was now a six on the pain scale, down from the eight/nine it had been, and any man could endure that. After arriving at a rather spacious room (after all, I was on the faculty), I was finally resting on my bed (more to come about this). Then a variety of nurses and other persons of different titles showed up and asked me if I was well-treated and comfortable. I heartily agreed with the first proposition but could not have anything done about the second until the “doctors gave the orders.”

I am vague about the arrival of all those juvenile persons in green outfits eager to take care of an older faculty member. The pain had edged up. After a few tries at starting an IV, they hooked me to one of those marvels of modern technology, ie, the morphine pump. I started pumping with vigor. Soon the pain started subsiding, my consciousness became clouded, and I wondered whether I would ever regain it. To tell you the truth, I did not care.

Back to the beds. I am convinced the engineers who conceived them had spent a four-year fellowship at Auschwitz or in the Gulag. The minor tortures were the inability to reach a glass of water, get to the phone, the urinal, or the flat white disk that would ask you to call

if you were in distress if you were conscious enough to know who you wanted to call. I admit that nurses responded promptly but then had to find the physician on call to give the “Order.” In my state of consciousness, I didn’t know if that took a few minutes or hours.

The major torture, however, was some kind of metal spine in the middle of the bed that, I assume, was devised to stabilize your movements unless, of course, you wanted to move. This was particularly humiliating if you did not know whether the urinal was on the right or the left and where it was hooked. Soon you returned to early infancy and the alarm sounded throughout the hospital that your IV was out-of-line. Then a few kind ladies, who had obviously dealt with the situation before, rearranged the bed to fit an elderly body. The discomfort was worth the restoration of my dignity and the urinal remained where it should be for the rest of my confinement.

After a few days of blissful starvation, I was allowed to be fed orally. A gentleman in white gloves (not really) arrived with a tray of food covered by a dome of an “ocean sickness” shade of green. The dome should have remained in place because the bowl of liquid beneath it was obviously a soup of starved chickens and discarded noodles. The solid bits on the dishes still remain a mystery to me. My wife insisted and helped, forcefully, in feeding me so I would regain my strength; but the seed of depression had already been implanted and I refused to look at any menu for about a month.

Thousands of patients go through all this sort of thing on our advice, direction, and order every day. What makes physicians so different and difficult? My first identifiable discovery was, for the lack of a better term, what I have called: impending catastrophes. Any unusual pain, shortness of breath, or slight elevation of temperature can certainly mean a heart attack, a mesenteric thrombosis, a pulmonary thrombosis, or an antibiotic-resistant infection. The second was that we are used to having everything done for us. Urinals should be where they are supposed to be, four health assistants ought to be sitting around your bed knitting and responding to your every wish, and when food is allowed, a Bordeaux ‘64 and a Chateaubriand will do. Is that asking too much? (Don’t answer that.)

“Thousands of patients go through all this sort of thing on our advice, direction, and order every day. What makes physicians so different and difficult?”

Dr Roufail is a professor of medicine at Wake Forest University School of Medicine.

Position Statements of the North Carolina Medical Board as of 12/31/2007

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

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

Termination of the Physician-Patient Relationship

The Board recognizes the physician's right to choose patients and to terminate the professional relationship with them when he or she believes it is best to do so. That being understood, the Board maintains that termination of the physician-patient relationship must be done in compliance with the physician's obligation to support continuity of care for the patient.

The decision to terminate the relationship must be made by the physician personally. Further, termination must be accompanied by appropriate written notice given by the physician to the patient or the patient's representative sufficiently far in advance (at least 30 days) to allow other medical care to be secured. 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 avail-

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

3. The physician should individualize the approach to physical examinations so that each patient's apprehension, fear, and embarrassment are diminished as much as possible. An explanation of the necessity of a complete physical examination, the components of that examination, and the purpose of disrobing may be necessary in order to minimize the patient's possible misunderstanding.
4. The physician and staff should exercise the same degree of professionalism and care when performing diagnostic procedures (eg, electro-cardiograms, electromyograms, endoscopic procedures, and radiological studies, etc), as well as during surgical procedures and postsurgical follow-up examinations when the patient is in varying stages of consciousness.
5. The physician should be on the alert for suggestive or flirtatious behavior or mannerisms on the part of the patient and should not permit a compromising situation to develop.

(Adopted May 1991) (Amended May 1993, May 1996, January 2001, February 2001, October 2002)

SEXUAL EXPLOITATION OF PATIENTS

It is the position of the North Carolina Medical Board that 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 phantasies, 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 autotransfusion in any form, to enhance athletic performance or muscle development for cosmetic, nontherapeutic reasons, in the absence of an established disease or deficiency state, is not a medically valid use of these medications.

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

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

(Adopted May 1998) (Amended July 1998, January 2001) (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 has been developed to clarify the Board's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

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

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

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

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

state or federal law is required.

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

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

Section II: Guidelines

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

Evaluation of the Patient—A medical history and physical examination must be obtained, evaluated, and documented in the medical record. The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or co-existing 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 phy-

sician 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.

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

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 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 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.

AAAHHC – 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:

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

Level II procedures – any surgical or special procedures:

- that require the administration of local or peripheral nerve block, minor conduction blockade, Bier block, minimal sedation, or conscious sedation; and
- 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:

- that require, or reasonably should require, the use of major conduction blockade, deep sedation/analgesia, or general anesthesia; and
- 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(e). The isolation order shall require practice restrictions, such as cessation or modification of some or all surgical or obstetrical procedures or dental procedures, to the extent necessary to prevent a significant risk of transmission of HIV or hepatitis B to patients. The isolation order shall prohibit the performance of procedures that cannot be modified to avoid a significant risk of transmission. If the State Health Director determines that there has been a significant risk of transmission of HIV or hepatitis B to a patient, the State Health Director shall notify the patient or assist the health care worker to notify the patient.

(h) The State Health Director shall request the assistance of one or more health care professionals to obtain information needed to periodically review the clinical condition and practice of the infected health care worker who performs or assists in surgical or obstetrical procedures or dental procedures.

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

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

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

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

(Adopted November 1992) (Amended May 1996; January 2005)

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

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

This duty is subordinate to the duty to maintain patient confidences. In other words, when the colleague is a patient or when matters concerning a colleague are brought to the physician's attention by a patient, the physician must give appropriate consideration to preserving the patient's confidences in deciding whether to report the colleague. (Adopted November 1998)

ADVERTISING AND PUBLICITY*

It is the position of the North Carolina Medical Board that physician advertising or publicity that is deceptive, false, or misleading is unprofessional conduct. The key issue is whether advertising and publicity, regardless of format or content, are true and not materially misleading.

Information conveyed may include:

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

Advertising and publicity that create unjustified medical expectations, that are accompanied by deceptive claims, or that imply exclusive or unique skills or remedies must be avoided. Similarly, a statement that a physician has cured or successfully treated a large number of patients suffering a particular ailment is deceptive if it implies a certainty of results and/or creates unjustified or misleading expectations. If patient photographs are used, they should be of the physician's own patients and demonstrate realistic outcomes.

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

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

(Adopted November 1999) (Amended March 2001) (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 phar-

macetrical 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)

CAPITAL PUNISHMENT

The North Carolina Medical Board takes the position that physician participation in capital punishment is a departure from the ethics of the medical profession within the meaning of N.C. Gen. Stat. § 90-14(a)(6). The North Carolina Medical Board adopts and endorses the provisions of AMA Code of Medical Ethics Opinion 2.06 printed below except to the extent that it is inconsistent with North Carolina state law.

The Board recognizes that N.C. Gen. Stat. § 15-190 requires the presence of "the surgeon or physician of the penitentiary" during the execution of condemned inmates. Therefore, the Board will not discipline licensees for merely being "present" during an execution in conformity with N.C. Gen. Stat. § 15-190. However, any physician who

engages in any verbal or physical activity, beyond the requirements of N.C. Gen. Stat. § 15-190, that facilitates the execution may be subject to disciplinary action by this Board.

Relevant Provisions of AMA Code of Medical Ethics Opinion 2.06

An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution: (1) testifying as to medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution; (2) certifying death, provided that the condemned has been declared dead by another person; (3) witnessing an execution in a totally nonprofessional capacity; (4) witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity; and (5) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.

(Adopted January 2007)

PHYSICIAN SUPERVISION OF OTHER LICENSED HEALTH CARE PRACTITIONERS

The physician who provides medical supervision of other licensed healthcare practitioners is expected to provide adequate oversight. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise the appropriate amount of supervision over a licensed healthcare practitioner which will ensure the maintenance of quality medical care and patient safety in accord with existing state and federal law and the rules and regulations of the North Carolina Medical Board. What constitutes an "appropriate amount of supervision" will depend on a variety of factors. Those factors include, but are not limited to:

- The number of supervisees under a physician's supervision
- The geographical distance between the supervising physician and the supervisee
- The supervisee's practice setting
- The medical specialty of the supervising physician and the supervisee
- The level of training of the supervisee
- The experience of the supervisee
- The frequency, quality, and type of ongoing education of the supervisee
- The amount of time the supervising physician and the supervisee have worked together
- The quality of the written collaborative practice agreement, supervisory arrangement, protocol or other written guidelines intended for the guidance of the supervisee
- The supervisee's scope of practice consistent with the supervisee's education, national certification and/or collaborative practice agreement

(Adopted July 2007)

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

August - September - October 2007

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

REVOICATIONS

SEBHAT, Berhan, MD

Location: Durham, NC (Durham Co) | DOB: 10/22/1966
 License #: 2001-01395 | Specialty: IM (as reported by physician)
 Medical Ed: Medical College of Ohio (1998)
 Cause: In March 2007, Dr Sebhat violated his Consent Order of October 2006 by refusing to provide a urine sample in order to determine if he had consumed alcohol. He also failed to enter a monitoring contract with the NCPHP as required by the Consent Order.
 Action: 10/12/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/15/2007: Dr Sebhat's North Carolina medical license is revoked.

See Consent Orders:

BREWER, Thomas Edmund, Jr, MD

SUSPENSIONS

FEDAK, Jason R., Physician Assistant

Location: Wilmington, NC (New Hanover Co) | DOB: 4/10/1970
 License #: 0001-03737
 PA Education: Bronx Lebanon Hospital Center (2002)
 Cause: In June 2006, Mr Fedak signed a Consent Order with the Connecticut Board accepting a reprimand based on allegations he prescribed controlled and other medications to a family member who was not his patient.
 Action: 9/05/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/17/2007: Mr Fedak's North Carolina PA license is suspended for 30 days, suspension being stayed.

MAUSKAR, Anant Nilkanth, MD

Location: Houston, TX | DOB: 9/13/1932
 License #: 0000-18680 | Specialty: FP/IM (as reported by physician)
 Medical Ed: BJ Medical College, Poona, India (1957)
 Cause: The Texas Board suspended Dr Mauskar's Texas medical license, staying the suspension and placing him on probation on terms and conditions.
 Action: 9/25/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/16/2007: Dr Mauskar's

North Carolina medical license is suspended indefinitely, suspension being stayed provided he complies with conditions in the Texas Order.

See Consent Orders:

AUGUSTUS, Carl Trent, MD
BLISS, Laura Katherine, MD
FANN, Benjamin Bradley, MD
FIELDS, Jason Baker, MD
GREGORY (formerly Blemings), Ginger Dobbins, Physician Assistant
GUSTILO-ASHBY, Arlan Marcus, MD
LOWE, James Edward, Jr, MD
MANUSOV, Eron Grant, MD
RATHBURN, Stephen Don, MD

SUMMARY SUSPENSIONS

NONE

CONSENT ORDERS

ANDERSON, Robert Michael, MD

Location: Salisbury, NC (Mecklenburg Co) | DOB: 1/31/1962
 License #: 0096-00441 | Specialty: EM (as reported by physician)
 Medical Ed: Tulane University (1988)
 Cause: Under Consent Order, the Louisiana Board put Dr Anderson on probation for three years in March 2006 based on information he suffers from chemical dependency. His North Carolina license has been inactive since 2002.
 Action: 9/05/2007. Consent Order executed: Dr Anderson's license is placed on probation for three years, retroactive to March 2006; he shall comply with the Louisiana Consent Order.

ARCHAMBAULT, Mark Elno, Physician Assistant

Location: Winston-Salem, NC (Forsyth Co) | DOB: 12/28/1971
 License #: 0010-01083
 PA Education: Lock Haven University of Pennsylvania (1998)
 Cause: Mr Archambault has not practiced clinically since 2001. He has been instructing students in a PA program.
 Action: 10/09/2007. Consent Order executed for Limited Administrative License: Mr Archambault is granted a limited administrative license as a PA; he may not engage in clinical practice.

AUGUSTUS, Carl Trent, MD

Location: Charlotte, NC (Mecklenburg Co) | DOB: 1/22/1962
 License #: 0096-01218 | Specialty: IM (as reported by physician)
 Medical Ed: Medical University of South Carolina (1989)
 Cause: Without admitting fraudulent behavior, Dr Augustus recognizes the Board has evidence that could cause it to conclude he was guilty of unprofessional conduct in relation to handling of a check for \$170,009.04 sent to him in error by Blue Cross/Shield in 2005. The Board maintains he deposited the check and spent its proceeds. He contends an employee endorsed the check in error. He failed to return the funds to the bank and was sued as a result, a default judgment being rendered against him with an award to the bank of \$510,027.12.
 Action: 10/17/2007. Consent Order executed: Dr Augustus' license is indefinitely suspended, suspension being stayed and Dr Augustus being placed on probation; he shall reimburse the bank, plus attorney's fee and interest, in 12 payments over three years; must comply with other conditions.

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 Coll of Osteo, Kansas City (1989)
 Cause: To amend Dr Barber's Consent Order of 8/17/2006.
 Action: 10/28/2007: Consent Order amended: His Consent Order is amended to require he keep a log of controlled substance prescriptions, he attend a CME course on prescribing, and he and maintain pain management contracts with patients.

BLAKELEY, Dean DeWayne, MD

Location: Raleigh, NC (Wake Co) | DOB: 10/17/1961
 License #: 0000-35588 | Specialty: IM (as reported by physician)
 Medical Ed: University of Missouri, Columbia (1988)
 Cause: After reviewing some of Dr Blakeley's records, the Board ordered him to undergo assessment at the Center for Personalized Education for Physicians. Results indicated he should improve his knowledge in several areas.
 Action: 10/24/2007. Consent Order executed: Dr Blakeley is ordered to undergo remedial education in keeping with the recommendations of the CPEP; he must practice in a supervised environment; he shall not treat chronic pain; must comply with other conditions.

BLISS, Laura Katherine, MD

Location: Mebane, NC (Alamance Co) | DOB: 4/25/1958
 License #: 0095-00018 | Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina (1989)
 Cause: Dr Bliss prescribed Xanax® for a coworker and asked the coworker to share the pills with her. This was done. Her employer asked her to go to the NCPHP and it was their recommendation she be assessed. Assessment found no evidence of substance abuse but recommended treatment for alcohol dependence. Dr Bliss surrendered her license on 6/01/2007.
 Action: 10/17/2007. Consent Order executed: Dr Bliss' North Carolina medical license is indefinitely suspended effective 6/01/2007.

BREWER, Thomas Edmund, Jr, MD

Location: Denton, NC (Davidson Co) | DOB: 11/04/1956
 License #: 0000-28141 | Specialty: GP/EM (as reported by physician)
 Medical Ed: Wake Forest University School of Medicine (1983)
 Cause: In February 2006, Dr Brewer prescribed a controlled substance to four persons on four occasions knowing they did not require the medication and knowing that one patient, a pharmacist using a false name, would fill the prescriptions for himself and that the other three persons were not aware of the prescriptions being written in their names. Dr Brewer's medical license expired at the end of February 2006, but he conducted a physical examination and assessment of a patient in August 2007.
 Action: 10/03/2007. Consent Order executed: Dr Brewer's North Carolina medical license is revoked.

COHEN, Max William, MD

Location: Greensboro, NC (Guilford Co) | DOB: 10/15/1968
 License #: 2002-00507 | Specialty: OS/OSS (as reported by physician)
 Medical Ed: Medical College of Virginia (1996)
 Cause: Dr Cohen's failed to inform a patient in a timely way about the potential existence of sponge fragments left from a 2005 procedure prior to a 2006 procedure and to disclose the removal of those fragments in the 2006 procedure in the operative note. He also failed to perform a 2006 procedure on another patient at the correct interspace level. He has taken steps to prevent recurrence of those kinds of surgical issues, has expressed remorse, and apologized. He

has no previous record with the Board.
 Action: 10/19/2007. Consent Order executed: Dr Cohen is reprimanded and is placed on probation for one year; he must attend a CME course on ethics.

CORLEY, Charles Austin, MD

Location: Kennesaw, GA | DOB: 10/02/1967
 License #: 0099-00023 | Specialty: PD (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1993)
 Cause: In April 2007, the Georgia Board, via Consent Order, found Dr Corley was charged in Georgia with child molestation, enticing a child, and sexual battery of a minor. In the Consent Order, Dr Corley agreed not to practice in Georgia until the criminal charges are resolved and to comply with other requirements.
 Action: 10/17/2007. Interim Consent Order executed: Dr Corley shall not practice in North Carolina without prior written permission from the North Carolina Board; he shall notify the Board of the resolution of the charges against him within 20 days of that resolution; must comply with other requirements.

COX, Benjamin Gould, Jr, MD

Location: Menifee, CA | DOB: 11/27/1931
 License #: 2007-01629 | NS (as reported by physician)
 Medical Ed: New York Medical College (1959)
 Cause: On application for a license. Dr Cox has not performed neurosurgery since 1980.
 Action: 9/26/2007. Non-Disciplinary Consent Order executed: Dr Cox is issued a North Carolina medical license; he shall not perform or assist in neurosurgical procedures; must comply with other conditions.

DOBSON, Burt William, MD

Location: Fayetteville, NC (Cumberland Co) | DOB: 7/30/1967
 License #: 2007-01685 | Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (2002)
 Cause: On application for a license. While holding an RTL, Dr Dobson wrote prescriptions for controlled substances to a patient for whom he kept no chart. He could not justify the prescriptions and denied knowing the patient. He later admitted he did know the patient and did write prescriptions, but said the patient secretly got a prescription pad he had pre-signed. In February 2005, Dr Dobson entered a Consent Order with the Board admitting his conduct, accepting a reprimand, and agreeing not to apply for a full license until after April 2005. He has not practiced since December 2004.
 Action: 10/09/2007. Consent Order and Reentry Agreement executed: Dr Dobson is issued a North Carolina medical license; he shall have a physician colleague observe his practice for one year and report on his skills to the Board on a quarterly basis.

FANN, Benjamin Bradley, MD

Location: Asheville, NC (Buncombe Co) | DOB: 8/04/1954
 License #: 0000-33034 | Specialty: GYN (as reported by physician)
 Medical Ed: University of Colorado (1979)
 Cause: Dr Fann delivered a patient's child by caesarean section at Park Ridge Hospital. The child was then transferred to another hospital. Dr Fann's care of the mother was reviewed by Park Ridge and, based on that review, his privileges were summarily suspended for delay in responding to pages. In reviewing the issues, the Medical Board found he had met acceptable standards in responding to pages, but that his care of the patient departed from acceptable standards for other reasons. He failed to inform his obstetric patients of his loss of privileges and continued to take new obstetric patients. He did participate in a recommended NCPHP program and says he believed the hospital would restore his privileges before his patients delivered. However, several of his patients who had never been informed of his situation had to be delivered by another physician.
 Action: 8/15/2007. Consent Order executed: Dr Fann's North Carolina medical license is suspended for 18 months beginning 10/01/2007; suspension is stayed except for the period from 12/01/2007 to 12/31/2007; he will be on probation on terms and conditions for the duration of the period of probation; he shall maintain and abide by a contract with the NCPHP and permit random inspections of his office by Board investigators; he shall not practice obstetrics until approved by the Board following his satisfactory completion of specific requirements; must comply with other conditions.

FIELDS, Jason Baker, MD

Location: Wilmington, NC (New Hanover Co) | DOB: 5/24/1969
 License #: 0099-00833 | Specialty: PD (as reported by physician)
 Medical Ed: East Tennessee State University (1996)
 Cause: Dr Fields is methamphetamine dependent. At the Board's request, he inactivated his North Carolina medical license in 2006. At that time, he was already a participant in the NCPHP and had undergone inpatient treatment. His license was reactivated in March 2007. In April 2007, he surrendered his license after testing positive for methamphetamine.

Action: 10/05/2007. Consent Order executed: Dr Fields' North Carolina medical license is indefinitely suspended.

GREGORY (formerly Blemings), Ginger Dobbins, Physician Assistant

Location: Fuquay Varina, NC (Wake Co) | DOB: 8/30/1963
 License #: 0001-01410

PA Education: Bowman Gray School of Medicine (1991)

Cause: Ms Gregory has a substance abuse history with the Board. She tested positive for alcohol on several occasions, particularly on the EtG test, and was evaluated by Talbott Recovery in April 2006. Talbott recommended she have 30 days of inpatient relapse treatment. She denies she is drinking and the NCPHP believes she is not unsafe to practice in her current setting. She voluntarily placed her license on inactive status in October 2007.

Action: 10/17/2007. Consent Order executed: Ms Gregory's PA license is reactivated and she is placed on indefinite suspension, suspension being stayed on strict conditions related to substance abuse.

GUSTILO-ASHBY, Arlan Marcus, MD

Location: Cleveland, OH | DOB: 5/17/1967
 License #: 2001-00884 | Specialty: OB/GYN (as reported by physician)
 Medical Ed: Mayo Medical School (1996)

Cause: In 2006, Dr Gustilo-Ashby agreed to a Consent Order with the Ohio Board based on a finding that he had sexual contact with a patient in 2003/2004 and on results of assessments that found he had psychosexual disorder and adjustment disorder. He underwent a two-week inpatient treatment, medication management, and intensive outpatient treatment. He agreed that his license should be suspended, that he should provide reports to the Ohio Board on his treatment, and that specific conditions should apply to future reinstatement.

Action: 9/10/2007. Consent Order executed: Dr Gustilo-Ashby's North Carolina medical license is suspended indefinitely; he shall comply with the terms of his agreement with the Ohio Board.

HAMBLETON, Scott Lewis, MD

Location: Hattiesburg, MS | DOB: 4/15/1963
 License #: 2000-00444 | Specialty: FP/EM (as reported by physician)
 Medical Ed: University of Tennessee, Memphis (1994)

Cause: On application for license reinstatement. Dr Hambleton surrendered his license on 2/13/2002 following his arrest for attempting to obtain a controlled substance by fraud. On 12/10/2002, he entered a Consent Order with the Board reinstating his license under condition that he maintain an NCPHP contract, abstain from use of mind- or mood-altering substances and alcohol, and comply with other conditions. In 2004, Dr Hambleton admitted to use of hydrocodone. He surrendered his license on 3/18/2004. In June, 2004, he entered a Consent Order with the Board indefinitely suspending his license. He then underwent 90 days of inpatient treatment and is in a monitoring contract with the Mississippi PHP. He plans to practice in Mississippi.

Action: 8/15/2007. Consent Order executed: Dr Hambleton is issued a license to expire on the date shown on the license [2/15/2008]; he shall maintain and abide by his contract with the MPHP; must comply with other conditions.

HOWARD, Cleve W., MD

Location: Charlotte, NC (Mecklenburg Co) | DOB: 8/14/1941
 License #: 2007-01559 | Specialty: OPH/PD (as reported by physician)
 Medical Ed: University of Kansas School of Medicine (1967)

Cause: On application for a Retired Limited Volunteer License. In 2001, Dr Howard was fined by the Florida Board and ordered to attend five hours of risk management courses and deliver a lecture on wrong-side surgery. This action resulted from his placing a surgical tube in the wrong location in 1999. He intends to perform eye examinations in an indigent clinic.

Action: 9/13/2007. Consent Order executed: Dr Howard is issued a Retired Limited Volunteer License.

KHAYATA, Mazan, MD

Location: Tempe, AZ | DOB: 2/01/1960

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

Medical Ed: Cornell University Medical College (1984)

Cause: In May 2006, the Arizona Board issued Dr Khayata a letter of reprimand based on its finding he deviated from the standard of care by failing to properly evaluate a patient prior to beginning a surgical procedure.

Action: 9/21/2007. Consent Order executed: Dr Khayata is reprimanded.

LOWE, James Edward, Jr, MD

Location: Fayetteville, NC (Cumberland Co) | DOB: 12/05/1950

License #: 0000-37887 | Specialty: PS/HS (as reported by physician)

Medical Ed: Meharry Medical College (1975)

Cause: It appears Dr Lowe failed to adequately record information in the records of six patients and billed for certain surgical procedures not supported by the records. The Board also has evidence from which it could conclude Dr Lowe departed from the standard of care in diagnosis and surgical judgment in one case. It has no evidence any surgeries resulted in bad outcomes.

Action: 10/17/2007. Consent Order executed: Dr Lowe's North Carolina medical license is suspended indefinitely effective 12/01/2007; he may reapply for a license in three months from the date of this Consent Order.

MacDONALD, Carolyn, MD

Location: Pittsboro, NC (Chatham Co) | DOB: 11/29/1955

License #: 0095-00650 | Specialty: PhysMed/Rehab (as reported by physician)

Medical Ed: Eastern Virginia (1980)

Cause: From 2003 to 2005, Dr MacDonald, while at Progressive Rehabilitation and Pain Management, resigned prescription blanks and left them with an unlicensed employee in her absence. She says she required the employee call her to obtain permission to complete a resigned prescription. She abruptly closed her practice in December 2005 without notifying patients. She says her conduct was the result of having the administrative duties at Progressive Rehabilitation placed on her involuntarily. She did not attend to these duties properly due to inexperience and the demands of family illness. She has arranged to take training in organizational skills and administration. Her patient records indicate her patient care was satisfactory.

Action: 10/17/2007. Consent Order executed: Dr MacDonald is reprimanded; she shall comply the Board's Position Statement on the treatment of pain and shall maintain and abide by a contract with the NCPHP; must comply with other requirements.

MANUSOV, Eron Grant, MD

Location: West End, NC (Moore Co) | DOB: 5/23/1958

License #: 0098-00625 | Specialty: FP/SM (as reported by physician)

Medical Ed: Uniformed Services University (1984)

Cause: In May 2005, Dr Manusov began a sexual affair with an employee who was also wife of one of his patients. During July and August following, Dr Manusov's PA provided care for and wrote a prescription for the patient. At no time did Dr Manusov tell the patient about the affair nor did he end the physician-patient relationship. The patient's wife was divorced from the patient and married Dr Manusov.

Action: 10/17/2007. Consent Order executed: Dr Manusov's North Carolina medical license is suspended for one year; suspension is stayed as of 11/17/2007 and Dr Manusov is placed on probation for one year; he must attend CME courses on boundary issues, ethics, and prescribing; must comply with other conditions.

McMANUS, Shea Eamonn, MD

Location: Wilmington, NC (New Hanover Co) | DOB: 11/04/1965

License #: 0097-01056 | Specialty: IM (as reported by physician)

Medical Ed: Tulane University School of Medicine (1994)

Cause: Dr McManus has a history of alcohol and substance abuse. Beginning in August 2006, he underwent 14 weeks of inpatient treatment for a relapse. He admitted this to the Board in December 2006. He has since entered a contract with the NCPHP. The Board suspended his license in February 2007 and he seeks reinstatement.

Action: 10/05/2007. Consent Order executed: Dr McManus is issued a license to expire on the date shown on the license [4/05/2008]; he must abide by strict requirements related to alcohol and substance abuse.

MERCIER, Randall Robert, MD

Location: Pinhurst, NC (Moore Co) | DOB: 12/06/1953

License #: 0000-26898 | Specialty: IM/SM (as reported by physician)
 Medical Ed: Tulane University School of Medicine (1980)
 Cause: On application for reinstatement of license. Dr Mercier formed an emotional relationship with a patient that went beyond professional boundaries while he continued to treat her and prescribe for her. In September or October 2005, he abruptly left his practice suffering from bipolar disorder. In October 2006, the Board summarily suspended his license. On 11/17/2006, he entered a Consent Order with the Board indefinitely suspending his license. He is an NCPHP participant and has been under treatment since April 2006. He is stable and compliant with his treatment.
 Action: 8/14/2007. Consent Order executed: Dr Mercier is issued a North Carolina medical license; he shall maintain and abide by a contract with the NCPHP; he shall practice no more than 30 hours a week; must comply with other conditions.

NORTHROP, Dennis Ray, MD

Location: Lexington, KY | DOB: 9/12/1953
 License #: 0000-29635 | Specialty: AN (as reported by physician)
 Medical Ed: University of Oklahoma (1981)
 Cause: The Kentucky Board indefinitely restricted Dr Northrip's Kentucky medical license based on his record of abuse of alcohol and controlled substances.
 Action: 10/04/2007. Consent Order executed: Dr Northrip's North Carolina medical license is restricted indefinitely; he must abide by the terms of his Agreed Orders with the Kentucky Board; he must inform the North Carolina Board before returning to practice in North Carolina and will not begin such practice without written permission from the Board.

PITOVSKI, Dimitri Zivko, MD

Location: Advance, NC (Forsyth Co) | DOB: 8/06/1959
 License #: 2007-01377 | Specialty: OTO/ALI (as reported by physician)
 Medical Ed: Skopje University School of Medicine, Republic of Macedonia (1986)
 Cause: Dr Pitovski's North Carolina medical license expired in October 2006. He has been CEO of Allergy Centers of America since 2005 and his role is purely administrative. He does not plan to practice clinical medicine.
 Action: 8/07/2007. Consent Order executed: Dr Pitovski is granted a limited administrative license; he may not practice clinical medicine; this Consent Order does not limit his ability to employ physicians with full and unrestricted North Carolina licenses.

RATHBURN, Stephen Don, MD

Location: Asheville, NC (Buncombe Co) | DOB: 7/26/1958
 License #: 2002-01516 | Specialty: AN (as reported by physician)
 Medical Ed: Northeastern Ohio Universities (1982)
 Cause: Dr Rathburn diverted a controlled substance to his own use on at least two occasions. He surrendered his license in April 2007 and is in a five-year contract with the NCPHP.
 Action: 10/30/2007. Consent Order executed: Dr Rathburn's North Carolina medical license is indefinitely suspended.

SHANTON, Gregory Damon, Physician Assistant

Location: Newport, NC (Carteret Co) | DOB: 2/17/1963
 License #: 0001-01943
 PA Education: Alderson-Broadus (1992)
 Cause: Mr Shanton has abused alcohol and controlled substances and suffers from depression. He underwent inpatient treatment for depression in early 2007 and has received outpatient treatment since that time. The Board summarily suspended his PA license in April 2007 and indefinitely suspended his license by Consent Order in July 2007. He has entered a contract with the NCPHP and is compliant with it.
 Action: 9/27/2007. Consent Order executed: Mr Shanton is issued a PA license to expire on the date shown on the license; he must abide by strict requirements related to alcohol and substance abuse.

SLEEPER, Arthur, MD

Location: Martinsville, VA | DOB: 9/15/1944
 License #: 0094-01493 | Specialty: ONC/IM (as reported by physician)
 Medical Ed: University of Miami (1987)
 Cause: In November 2006, the Virginia Board issued an Order that reprimanded Dr Sleeper and placed terms and conditions on his license for his engaging in a romantic relationship with a patient. As of July 2007, he had fully complied with the terms and conditions of the Virginia Order. His Virginia license was fully restored.
 Action: 8/14/2007. Consent Order executed: Dr Sleeper is reprimanded.

SWANGER, Russell David, DO

Location: Whiteville, NC (Columbus Co) | DOB: 7/17/1961
 License #: 2007-01654 | Specialty: OB/GYN (as reported by physician)
 Medical Ed: Univ of Health Sciences Coll of Osteopathic Medicine, Kansas City (1989)
 Cause: On application for a medical license. Dr Swanger was reprimanded by the Georgia Board and required to fulfill certain terms as a result of a malpractice settlement related to complications during delivery of a baby resulting in delayed development of the child. He completed the terms required by Georgia.
 Action: 10/04/2007. Consent Order executed: Dr Swanger is issued a North Carolina medical license subject to a reprimand.

TOMPKINS, Kenneth James, MD

Location: Virginia Beach, VA | DOB: 9/22/1956
 License #: 0097-01625 | Specialty: D (as reported by physician)
 Medical Ed: Jefferson Medical College (1982)
 Cause: In September 2006, the Virginia Board found Dr Tompkins had prescribed to a person not his patient and violated the law and the rules of the Board in treating three persons who were his employees. He also prescribed weight-reduction medication without performing an appropriate history and physical, without prescribing and recording a diet and exercise program, and without recording monthly BP and pulse. Further, he prescribed other drugs to patients without documenting them. He also failed to report on a hospital staff application that he had been convicted for impaired driving in 1999.
 Action: 9/06/2007. Consent Order executed: Dr Tompkins is reprimanded.

WARE, Leslie Ann, Physician Assistant

Location: Wadesboro, NC (Anson Co) | DOB: 5/03/1968
 License #: 0001-03472
 PA Education: University of Nebraska Medical Center (1999)
 Cause: Ms Ware wrote prescriptions for several family members during 2006 and 2007. She did not keep a patient chart documenting a history and examination for either person.
 Action: 9/13/2007. Consent Order executed: Ms Ware is reprimanded; she shall comply with the Board's position statements on prescribing.

WHITLOCK, Gary Thomas, MD

Location: Jacksonville, NC (Onslow Co) | DOB: 7/15/1948
 License #: 0000-24331 | Specialty: EM/ADDM (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1978)
 Cause: Dr Whitlock has a history of substance abuse and medical conditions at times requiring controlled substances for relief of pain. He has a contract with the NCPHP and has undergone inpatient treatment. The NCPHP reports he is compliant with his contract.
 Action: 10/12/2007. Consent Order executed: Dr Whitlock is issued a license to expire on the date shown on the license [4/12/2008]; he must abide by strict requirements related to alcohol and substance abuse.

WOOD, John Brian Thomas, MD

Location: Elizabeth City, NC (Pasquotank Co) | DOB: 8/26/1956
 License #: 0000-39141 | Specialty: OTH (as reported by physician)
 Medical Ed: Pennsylvania State University (1985)
 Cause: Dr Wood prescribed non-controlled drugs to himself and family members.
 Action: 8/09/2007. Consent Order executed: Dr Wood is reprimanded.

WURSTER, Samuel Howard, MD

Location: Chicago, IL | DOB: 7/25/1962
 License #: 0097-00814 | Specialty: PS (as reported by physician)
 Medical Ed: University of Kansas (1989)
 Cause: While medical director of Premier Clinics, Dr Wurster failed to take reasonable and necessary steps to ensure patients were appropriately evaluated, treated as necessary, and prescribed medication. He failed to ensure staff of the clinics was appropriately trained, qualified, and supervised. He also authorized Triangle Pharmacy to deliver a prescription medication to the clinics and permitting the clinics to sell or administer the medication to patients without an appropriate history and physical and without a prescription. Dr Wurster has had no other complaints filed against him.
 Action: 8/15/2007. Consent Order executed: Dr Wurster is reprimanded; he shall not supervise laser hair removal services in North Carolina or any other state as medical director of any enterprise; he has not renewed his North Carolina license and should he ever apply for reinstatement these issues and his admissions here may be considered

by the Board.

MISCELLANEOUS ACTIONS

BUZZANELL, Charles Anton, MD

Location: Asheville, NC (Buncombe Co) | DOB: 9/23/1956
 License #: 0098-00481 | Specialty: AN (as reported by physician)
 Medical Ed: Georgetown University School of Medicine (1984)
 Cause: Motion by Dr Buzzanell's attorney to amend Dr Buzzanell's public file to reflect deposition testimony by Drs Buzzanell, Rholl, and Rauck relevant to the issues involved in the Charges and Consent Orders (of 9/16/2003, amended 1/15/2004 and 8/03/2005—and terminated on completion of all terms).
 Action: 10/17/2007. Order issued to amend the public file to reflect the findings presented in the motion.

CHEN, Chih-Cheng, MD

Location: Wilmington, NC (New Hanover Co) | DOB: 10/30/1941
 License #: 0000-25004 | Specialty: N (as reported by physician)
 Medical Ed: Taipei Medical College (1969)
 Cause: Inappropriate treatment of tremors led to issuance of a private letter of concern to Dr Chen from the Board in 2005. The Board conducted a further review of patient charts involving his treatment of pain in 2006 with Marcaine injections, and determined those treatments were without scientific or evidence-based rationale. Expert review also held his treatment was below acceptable standards.
 Action: 9/14/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 8/15-16/2007: Dr Chen is reprimanded; he shall no longer administer the nerve-block injections he had been employing and shall improve his charting to acceptable Medicare standards.

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL

DUBEY, Subu, MD

Location: River Forest, IL | DOB: 2/21/1961
 License #: 0094-01175 | Specialty: IM (as reported by physician)
 Medical Ed: Northwestern University (1987)
 Cause: Application for reinstatement of license. He was convicted of a felony (obstruction of criminal investigations relating to federal health care offenses) in 2002 in federal court. As a result, his North Carolina license was revoked.
 Action: 8/03/2007. Letter issued denying Dr Dubey's application for reinstatement of his North Carolina medical license. [He may request a hearing on this denial if he acts within 10 days.]

DUBEY, Subu, MD

Location: River Forest, IL | DOB: 2/21/1961
 License #: 0094-01175 | Specialty: IM (as reported by physician)
 Medical Ed: Northwestern University (1987)
 Cause: Appeal of the Board's denial of his previous application for reinstatement of license. He was convicted of a felony in 2002 in federal court. As a result, his North Carolina license was revoked.
 Action: 10/22/2007. Findings of Fact, Conclusions of Law, and Order of Discipline issued following hearing on 10/17/2007: The previous denial of Dr Dubey's application for licensure was proper and shall remain in effect.

SURRENDERS

GUICE, Richard Eric, MD

Location: Greensboro, NC (Guilford Co) | DOB: 10/09/1963
 License #: 0000-34022 | Specialty: OB/GYN (as reported by physician)
 Medical Ed: Medical College of Georgia (1989)
 Action: 9/14/2007. Voluntary surrender of North Carolina medical license.

JUSTICE, Brenda Jean, Physician Assistant

Location: Benson, NC (Johnston Co) | DOB: 10/02/1970
 License #: 0001-01923
 PA Education: Alderson-Broadus (1992)
 Action: 9/28/2007. Voluntary surrender of North Carolina PA license.

OLIVER, Joseph Andrew, III, MD

Location: Rockwell, NC (Rowan Co) | DOB: 9/11/1956
 License #: 0095-01366 | Specialty: FP (as reported by physician)
 Medical Ed: St George's Medical School, Granada (1992)

Action: 10/12/2007. Voluntary surrender of North Carolina medical license.

SARMIENTO, Pete Matibag, MD

Location: High Point, NC (Guilford Co) | DOB: 7/03/1965
 License #: 0097-00136 | Specialty: IM (as reported by physician)
 Medical Ed: Far Eastern University, Philippines (1990)
 Action: 8/24/2007. Voluntary surrender of North Carolina medical license.

STROTHER, Eric Furman, MD

Location: Durham, NC (Durham Co) | DOB: 12/03/1964
 License #: 0099-01620 | Specialty: AN (as reported by physician)
 Medical Ed: University of Texas Southeastern Medical School (1994)
 Action: 8/31/2007. Voluntary surrender of North Carolina medical license.

TOMPKINS, Kenneth James, MD

Location: Virginia Beach, VA | DOB: 9/22/1956
 License #: 0097-01625 | Specialty: D (as reported by physician)
 Medical Ed: Jefferson Medical College (1982)
 Action: 10/22/2007. Voluntary surrender of North Carolina medical license.

WRIGHT, Georgianna Aust, Physician Assistant

Location: Hickory, NC (Catawba Co) | DOB: 5/02/1977
 License #: 0001-03832
 PA Education: Alderson Broadus College (2003)
 Action: 8/23/2007. Voluntary surrender of North Carolina PA license.

PUBLIC LETTERS OF CONCERN

ASAJU, Sunday Olanrewaju, MD

Location: Utica, NY | DOB: 2/10/1952
 License #: 0000-34550 | Specialty: OB/GYN (as reported by physician)
 Medical Ed: University of Illinois (1986)
 Cause: Dr Asaju was placed on probation for a year by the New York Board on a finding that he had been negligent in his level of care on several occasions.
 Action: 10/03/2007. Public Letter of Concern issued: The Board admonishes Dr Asaju and cautions that any repetition of such practice may lead to formal disciplinary proceedings.

CLAYTON, Kimberly Lavita, MD

Location: Brooksville, FL | DOB: 9/03/1967
 License #: 2000-01099 | Specialty: GS (as reported by physician)
 Medical Ed: Case Western Reserve University (1993)
 Cause: In reviewing a malpractice payment, the Board was concerned about Dr Clayton's failure to communicate effectively with a patient's referring physician and, as a result, her performing a procedure at an incorrect site.
 Action: 10/22/2007. Public Letter of Concern issued: The Board admonishes Dr Clayton and cautions that any repetition of such practice may lead to formal disciplinary proceedings.

FUCHS, Herbert Edgar, MD

Location: Durham, NC (Durham Co) | DOB: 1/05/1958
 License #: 0000-39594 | Specialty: NS/PNS (as reported by physician)
 Medical Ed: Duke University School of Medicine (1984)
 Cause: Under Dr Fuchs' supervision, procedures were performed on a patient in May 2003 at L4-L5 that should have been performed at L5-S1. He was the patient's attending physician and the physician in charge of the patient during the procedure.
 Action: 10/17/2007. Public Letter of Concern issued: The Board is concerned about any allegations involving quality of care and cautions Dr Fuchs that repetition of similar facts and circumstances may lead to additional disciplinary proceedings; and Dr Fuchs' cooperation with the Board and remedial steps he and his staff have implemented are noted.

GROSSMAN, Clifford Norman, MD

Location: Miami, FL | DOB: 08/14/1966
 License #: 0095-00361 | Specialty: DR (as reported by physician)
 Medical Ed: Emory University (1993)
 Cause: Dr Grossman was reprimanded by the Georgia Board, fined, and required to take CME in ethics because of his changing of a treating physician's request regarding an MRI. This action delayed diagnosis and resulted in patient injury.
 Action: 9/01/2007. Public Letter of Concern issued: The Board admonishes Dr Grossman and cautions that any repetition of such an incident may lead to formal disciplinary proceedings.

HUBERMAN, Richard Allen, MD

Location: Kinston, NC (Lenoir Co) | DOB: 2/24/1947
 License #: 0000-18526 | Specialty: ORS (as reported by physician)
 Medical Ed: New York University (1972)
 Cause: Dr Huberman performed a surgical exision of a heel spur on the wrong foot of a patient in 2003.
 Action: 10/30/2007. Public Letter of Concern issued: The Board is concerned when there are allegations involving quality of care and cautions Dr Huberman that a repetition of such an incident may lead to additional disciplinary proceedings; the Board is pleased he has taken steps to ensure avoidance of such wrong-site surgery in future.

JACKSON, Richard Thomas, MD

Location: Winston-Salem, NC (Forsyth Co) | DOB: 7/01/1948
 License #: 2005-00510 | Specialty: N (as reported by physician)
 Medical Ed: Albany Medical College (1974)
 Cause: Dr Jackson prescribed medications for himself and his family.
 Action: 9/27/2007. Public Letter of Concern issued: The Board invites Dr Jackson to review its Position Statements on "Self-Treatment and Treatment of Family Member. . ." and its other Position Statements; it also encourages Dr Jackson to refrain from such prescribing in future except as noted in the Position Statement; it also cautions him that repetition of this incident may lead to formal disciplinary proceedings.

JOSLIN, Richard Grant, MD

Location: Carolina Beach, NC (New Hanover Co) | DOB: 4/14/1948
 License #: 0000-21665 | Specialty: FP (as reported by physician)
 Medical Ed: Medical College of Virginia (1974)
 Cause: Based on information derived from a malpractice case involving Dr Joslin, the Board is concerned that his evaluation of a patient did not adequately address the possibility the patient's headache was due to a more serious cause.
 Action: 8/17/2007. Public Letter of Concern issued: The North Carolina Medical Board admonishes Dr Joslin and cautions him that a repetition of such an incident may lead to formal disciplinary proceedings.

LAND, Eurgia Charles, MD

Location: Greenville, NC (Pitt Co) | DOB: 10/27/1949
 License #: 0000-22135 | Specialty: IM (as reported by physician)
 Medical Ed: Howard University (1975)
 Cause: Regarding Dr Land's supervising David M. Hinds, PA, for three years without Mr Hinds having filed an Intent to Practice Form with the Board.
 Action: 8/17/2007. Public Letter of Concern issued: The North Carolina Medical Board cautions Dr Land that a repetition of such an incident may lead to formal disciplinary proceedings; Dr Land is also required to complete an approved CME course without one year.

MacKENZIE, Karen Marie, MD

Location: Port Charlotte, FL | DOB: 3/28/1968
 License #: 2003-00650 | Specialty: GS (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1998)
 Cause: In reviewing a malpractice payment made on Dr MacKenzie's behalf, the Board was concerned about her peri-operative care of a surgical patient. She did not adequately document her discussion with the patient of risks and benefits and did not seek consultation on his co-existent medical problems. She also performed the operation while he was anticoagulated.
 Action: 10/09/2007. Public Letter of Concern issued: The Board admonishes Dr MacKenzie and cautions her that a repetition of such an incident may lead to formal disciplinary proceedings.

SIMMONS, Leo Benjamin, MD

Location: Wilmington, DE | DOB: 11/28/1944
 License #: 0000-39479 | Specialty: GS (as reported by physician)
 Medical Ed: Medical University of South Carolina (1970)
 Cause: Dr Simmons reliance on an erroneous MRA report without personally reviewing films and the apparent inadequate preoperative patient evaluation contributed to wrong-side surgery being performed.
 Action: 9/17/2007. Public Letter of Concern issued: The Board admonishes Dr Simmons and cautions that a repetition of such an incident may lead to formal disciplinary proceedings.

SWEET, Raymond Charles, MD

Location: Columbia, SC | DOB: 2/13/1947
 License #: 0000-33156 | Specialty: NS (as reported by physician)
 Medical Ed: Medical College of Virginia (1973)

Cause: Based on information in a malpractice claim and other data, the Board is concerned Dr Sweet misidentified the location of a tumor, which subsequently required a second surgery to remove the tumor.
 Action: 8/03/2007. Public Letter of Concern issued: The North Carolina Medical Board admonishes Dr Sweet and cautions him that a repetition of such an incident may lead to formal disciplinary proceedings.

WENN, Timothy Peter, MD

Location: Salisbury, NC (Rowan Co) | DOB: 5/26/1951
 License #: 0000-27103 | Specialty: EM/IM (as reported by physician)
 Medical Ed: Wayne State University (1980)
 Cause: Review of a malpractice claim and the corresponding medical record led to concern that Dr Wenn's evaluation of the patient did not adequately address the possibility that the patient's knee pain was related to vascular leg injury.
 Action: 10/03/2007. Public letter of Concern issued: The Board admonishes Dr Wenn and cautions that a repetition of such a practice may lead to formal disciplinary proceedings.

COURT APPEALS/STAYS

NONE

CONSENT ORDERS LIFTED

CARLSON, James Lenhart, 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: 10/12/2007. Order issued lifting Consent Order of 2/13/2003.

ENGLISH, Thaddeus David, Physician Assistant

Location: Elizabeth City, NC (Pasquotank Co) | DOB: 8/01/1972
 License #: 0001-03217
 PA Education: Lock Haven University of Pennsylvania (2000)
 Action: 10/23/2007. Order issued lifting Consent Order of 5/20/2004.

FARRELL, Edwin Gayle, MD

Location: Wilmington, NC (New Hanover Co) | DOB: 3/13/1945
 License #: 0000-17345 | Specialty: PD/AM (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1971)
 Action: 10/23/2007. Order issued lifting Consent Orders of 4/07/2005 and 10/23/2006.

HALL, Charles Daniel, MD

Location: Supply, NC (Brunswick Co) | DOB: 5/25/1964
 License #: 0094-01205 | Specialty: N (as reported by physician)
 Medical Ed: Duke University School of Medicine (1990)
 Action: 8/21/2007. Order issued lifting Consent Order of 8/18/2005.

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, Netherlands (1981)
 Action: 10/11/2007. Order issued lifting Consent Orders of 4/13/2006 and 3/16/2007.

SMITH, David Lewis, Physician Assistant

Location: Raleigh, NC (Wake Co) | DOB: 9/19/1951
 License #: 0001-01503
 PA Education: Alderson Broaddus College (1992)
 Action: 8/13/2007. Order issued lifting Consent Order of 10/11/2004.

TAUB, Harry Evan, MD

Location: Fletcher, NC (Henderson Co) | DOB: 11/24/1970
 License #: 2006-00491 | Specialty: ChP/P (as reported by physician)
 Medical Ed: Dartmouth (2001)
 Action: 10/29/2007. Order issued lifting Consent Orders of 1/22/2004 and 4/28/2006.

WHITE, Steven William, Physician Assistant

Location: Fayetteville, NC (Cumberland Co) | DOB: 12/19/1962
 License #: 0001-02116
 PA Education: Midwestern University (1996)
 Action: 8/01/2007. Order issued lifting Consent Order of 12/03/2003 and amendments to it.

TEMPORARY/DATED LICENSES:

ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES

AARONS, Mark G., MD

Location: Rockingham, NC (Richmond Co) | DOB: 5/07/1958

License #: 0000-31233 | Specialty: NEP/IM (as reported by physician)
 Medical Ed: Baylor College of Medicine (1984)
 Action: 9/20/2007. Full and unrestricted license issued.

FARRELL, Edwin Gayle, MD

Location: Wilmington, NC (New Hanover Co) | DOB: 3/13/1945
 License #: 0000-17345 | Specialty: PD/AM (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1971)
 Action: 9/20/2007. Full and unrestricted license issued.

ROSNER, Michael John, MD

Location: Hendersonville, NC (Henderson Co) | DOB: 12/04/1946
 License #: 0090-01548 | Specialty: NS/NS-Critical Care (as reported by physician)

Medical Ed: Virginia Commonwealth University School of Medicine (1972)
 Action: 9/20/2007. Temporary/dated license issued to expire 1/31/2008.

WADDELL, Roger Dale, MD

Location: Aberdeen, NC (Moore Co) | DOB: 11/17/1954
 License #: 0000-30105 | Specialty: NA
 Medical Ed: University of Colorado School of Medicine (1981)
 Action: 9/20/2007. Full and unrestricted license issued.

WILLIAMS, Dwight Morrison, MD

Location: Roanoke Rapids, NC (Halifax Co) | DOB: 2/15/1952
 License #: 0000-33577 | Specialty: OB/GYN (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1982)
 Action: 9/20/2007. Temporary/dated license issued to expire 3/31/2008.

See Consent Orders:

HAMBLETON, Scott Lewis, MD
McMANUS, Shea Eamonn, MD
SHANTON, Gregory Damon, Physician Assistant
WHITLOCK, Gary Thomas, MD

DISMISSALS**PADUA, Federico Pasudag, MD**

Location: San Antonio, TX | DOB: 12/24/1968
 License #: 0000-22029 | Specialty: FP/GM (as reported by physician)
 Medical Ed: Southwestern, Philippines (1972)
 Action: 8/03/2007. Notice of Dismissal issued: Charges and Allegations against Dr Padua dated 4/13/2007 are dismissed without prejudice.

REENTRY AGREEMENTS**ARANDA, Conrado Pena, MD**

Location: Brevard, NC (Transylvania Co) | DOB: 5/24/1939
 License #: 2007-01637 | Specialty: IM/Pulmonary Disease
 Medical Ed: Faculty of Med and Surg, Univ of Santo Tomas, Philippines (1962)
 Cause: Dr Aranda is retired and has not practiced since 2000. He has not maintained his CME.
 Action: 9/28/2007. Reentry Agreement for Retired Limited Volunteer License executed: Dr Aranda shall have a physician colleague observe his first year of volunteer practice and report to the Board on his skills at the end of that period.

BADER, Joanne Wilson, Physician Assistant

Location: Cincinnati, OH | DOB: 5/30/1953
 License #: 0010-01022
 PA Education: Duke University (1988)
 Cause: Ms Bader has not practiced as a PA since 2001.
 Action: 9/05/2007. Reentry Agreement executed: Ms Bader is issued a PA license; her supervising physician shall observe her practice for one year and shall report on her skills to the Board quarterly; she shall meet her CME requirements and meet with members of the Board on request.

CORRY, Beverly Elizabeth, MD

Location: Goldsboro, NC (Wayne Co) | DOB: 12/14/1947
 License #: 0000-23017 | Specialty: PD/PD-UR (as reported by physician)
 Medical Ed: University of California, San Francisco (1975)
 Cause: Dr Corry has not practiced clinical medicine since March 2004. Her CME is current.
 Action: 9/10/2007. Reentry Agreement executed: Dr Corry is issued a North Carolina medical license; she shall undertake a mini-residency for a period of three months at ECU School of Medicine; Dr Dale Newton shall report to the Board on her skills at the close of the residency; she must meet with members of the Board on

request.

EDGERTON, Ann Killian, Physician Assistant

Location: Charlotte, NC (Mecklenburg Co) | DOB: 9/06/1955
 License #: 0001-00356
 PA Education: Wake Forest University (1979)
 Cause: Ms Edgerton has not practiced as a PA since 1985 but has maintained her CME and has passed the PANC examination.
 Action: 10/09/2007. Reentry Agreement executed: Ms Edgerton is issued a PA license; her practice shall be observed by her supervising physician for one year with quarterly reports to the Board on her skills; she must meet with members of the Board on request.

JOHNSON, Theresa Ann, Physician Assistant

Location: Linden, NC (Cumberland Co) | DOB: 6/22/1962
 License #: 0010-01038
 PA Education: Baylor College of Medicine (1984)
 Cause: Ms Johnson has not practiced as a full-time PA since August 2004.
 Action: 9/26/2007. Reentry Agreement executed: Ms Johnson is issued a North Carolina PA license; her supervising physician shall observe her practice for six months and shall then report on her skills to the Board; she shall meet with members of the Board on request.

KRAMER, Olga Maria, Physician Assistant

Location: Charlotte, NC (Mecklenburg Co) | DOB: 3/22/1962
 License #: 0010-00995
 PA Education: Lake Erie College PA Program (1984)
 Cause: Ms Kramer has not practiced since 1996. All of her CME requirements are being brought up to date.
 Action: 8/01/2007. Reentry Agreement executed: Ms Kramer is issued a PA license; her supervising physician shall observe her practice for the first year and report quarterly to the Board on her skills; must meet with members of the Board on request.

PRIESTAE, Amy Christine, Physician Assistant

Location: Raleigh, NC (Wake Co) | DOB: 4/17/1967
 License #: 0010-01021
 PA Education: Wake Forest University (1992)
 Cause: Ms Priestaf has not practiced as a full-time PA since 1998.
 Action: 9/05/2007. Reentry Agreement executed: Ms Priestaf is issued a PA license; she must arrange to meet with her supervising physician on a weekly basis for the first six months of practice; the physician observing her must report to the Board on her skills on a quarterly basis for one year; she must meet with members of the Board on request.

QUINN, Jane A., MD

Location: Huntersville, NC (Mecklenburg Co) | DOB: 6/27/1957
 License #: 0000-39322 | Specialty: IM (as reported by physician)
 Medical Ed: Medical College of Wisconsin (1983)
 Cause: Dr Quinn has not practiced clinical medicine since late 2003 and voluntarily made her North Carolina license inactive in late 2006. Her CME is current and she is licensed in Maryland and New York.
 Action: 9/13/2007. Reentry Agreement executed: Dr Quinn is issued a medical license; she must arrange for a physician colleague to observe her practice for six months and report on her skills to the Board in writing; must meet with members of the Board when requested.

SEWARD, Paul North, MD

Location: Raleigh, NC (Wake Co) | DOB: 6/14/1943
 License #: 2007-01769 | Specialty: EM/PD (as reported by physician)
 Medical Ed: Harvard University (1968)
 Cause: Dr Seward has not practiced clinical medicine since July 2004. His CME is current.
 Action: 10/30/2007. Reentry Agreement executed: Dr Seward is issued a medical license; he must arrange for a physician colleague to observe his practice for six months and report on his skills to the Board in writing; must meet with members of the Board when requested.

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.

**Project Lazarus in Wilkes County:
An Innovative Approach to Overdose Deaths**

In the next number of the *Forum*, we will publish "Project Lazarus: Overdose Prevention and Responsible Pain Management" by Nabarun Dasgupta, MPH; Fred Wells Brason, II; and Su Albert, MD.

There are over 900 opioid overdose deaths in North Carolina each year, most of which are preventable. Wilkes County has a rate of accidental opioid poisoning (ie, overdose) deaths nearly five times greater than the national average and three times higher than the North Carolina average. Those who are dying are a mix of non-medical opioid users and legitimate pain patients.

Concerns with prescription opioid overdoses in the state extend back at least four decades, however, and recent changes in attitudes about pain management raise the issue again. Additionally, each year the state suffers millions of dollars in medical costs and lost productivity as a result of opioid overdose.

The innovative response to this challenge in Wilkes County includes Project Lazarus, a planned pilot program for the prescription and distribution of intranasal naloxone, an antidote for opioid-induced respiratory depression, to those at risk for opioid overdose. The goal is to promote appropriate pain management while reducing the adverse consequences of improper drug use.

Project Lazarus is the first program of its kind in the South, the first prescription naloxone program to target pharmaceutical opioids, and the first time naloxone has been incorporated into pain management. The results of the pilot study will inform decisions on expanding the program to other areas. Hopefully, prescription naloxone will reduce apprehension about prescribing opioids, leading to more appropriate pain management and fewer preventable opioid poisonings.

To present information about the program as quickly as possible, we have already placed the full article, detailing all aspects of the program and its background, on the NCMB Web site at ncmedboard.org. Watch for the hard copy in the *Forum* in April. The site also presents other materials on the issue.

**North Carolina Medical Board Meeting Calendar,
Examinations**

Meeting Dates: February 20-21, 2008; March 26-28, 2008; April 23-24, 2008;
May 21-23, 2008; June 18-29, 2008

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 Boards' 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.

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