MINUTES

North Carolina Medical Board

January 24-27, 2001

1201 Front Street, Suite 100
Raleigh, North Carolina

Minutes of the Open Sessions of the North Carolina Medical Board Meeting January 24-17, 2001.

The January 24-17, 2001, meeting of the North Carolina Medical Board was held at the Board's Office, 1201 Front Street, Suite 100, Raleigh, NC 27609. The meeting was called to order at 6:00 p.m., Wednesday, January 24, 2001, by Elizabeth P. Kanof, MD, President. Board members in attendance were: Walter J. Pories, MD, Vice President; John T. Dees, MD; Secretary/Treasurer; George C. Barrett, MD; Kenneth H. Chambers, MD; John W. Foust, MD; E. K. Fretwell, PhD; Charles L. Garrett, MD; Stephen M. Herring, MD; Robin N. Hunter-Buskey, PA-C; Mr. Paul Saperstein; and Mr. Aloysius P. Walsh.

Staff members present were: Mr. Andrew W. Watry, Executive Director; Ms. Helen Diane Meelheim, Deputy Director; Mr. R. David Henderson, Board Attorney; Mr. William H. Breeze, Jr., Board Attorney; Ms. Wanda Long, Legal Assistant; Lynne Edwards, Legal Assistant; Mr. John W. Jargstorf, Investigative Director; Mr. Don R. Pittman, Investigative Field Supervisor; Mr. Edmond Kirby-Smith, Investigator; Ms. Donna Mahony, Investigator; Mr. Fred Tucker, Investigator; Mrs. Therese Dembroski, Investigator; Ms. Barbara Brame, Investigator; Ms. Edith Moore, Investigator; Mr. Jason Ward, Investigator; Mrs. Jenny Olmstead, Senior Investigative Coordinator; Ms. Michelle Lee, Investigative Coordinator/Malpractice Coordinator; Ms. Myriam Hopson, Investigative Coordinator; Mr. Dale Breaden, Director of Communications and Public Affairs; Ms. Shannon Kingston, Public Affairs Assistant; Mrs. Joy D. Cooke, Licensing Director; Mr. Jeff A. Peake, Licensing Assistant; Ms. Erin Gough, PA/NP Coordinator; Mr. James Campbell, Licensing Assistant; Tammy O'Hare, Licensing Assistant; Mrs. Janice Fowler, Operations Assistant; Mr. Peter Celentano, Controller; Ms. Sonya Darnell, Operations Assistant; Ms. Ann Z. Norris, Verification Secretary; Gary Townsend, MD, JD, Medical Coordinator; Ms. Judie Clark, Complaint Department Director; Mrs. Sharon Squibb-Denslow, Complaint Department Assistant; Ms. Sherry Hyder, Complaint Department Assistant; Mr. Jeffery T. Denton, Administrative Assistant/Board Secretary; Mr. Scott A. Clark, Operations Assistant; Ms. Deborah Aycock, Receptionist; and Ms. Rebecca L. Manning, Information Specialist.

MISCELLANEOUS

Audit Report

Lynwood Jackson, CPA, Lynch & Howard

Mr. Jackson reviewed the North Carolina Medical Board "Report On Audit," year ending October 31, 2000, in detail. The report in part stated "In our opinion, the financial statements referred to present fairly, in all material respects, the financial position of the North Carolina Medical Board as of October 31, 2000 and October 31, 1999, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles."

Motion: (JF, KC) A motion passed to approve the Audit Report as presented.

New Board Members – Charles L. Garrett, MD and E.K. Fretwell, PhD

Dr. Garrett replaced Dr. Henry and Dr. Fretwell replaced Mrs. Walston.

Evaluation of Statement of Economic Interest

In accordance with Section 4 of Executive Order No. 127, the Medical Board, Dr. E. K. Fretwell, and Dr. Charles Leroy Garrett, Jr., received copies of letters from the Board of Ethics citing the following: (1) Dr. Garrett had no actual conflict of interest but potential for conflict of interest. "As such, he should not vote or participate on any matters which come

before the Board concerning himself, and/or employees of Coastal Pathology Associates, PA.," and (2) Dr. Fretwell had no actual conflict of interest or the potential for conflict of interest.

Drug Addiction Treatment Act of 2000; A Discussion (January 25, 2001)

The Children's Health Act of 2000 (H.R. 4365) was signed by President Clinton on October 17, 2000. That Act sets forth the "Drug Addiction Treatment Act of 2000" (DATA). This new legislation is of particular interest to state medical boards because it provides for significant changes in the oversight of medical treatment of opiate addiction. For the first time in almost a century, the medical therapy of opiate addiction with opioid medications will be permitted in office-based setting under certain restrictions. The Federation of State Medical Boards (FSMB) is proposing to develop model policy guidelines through a Working Group composed of state medical board members, addiction treatment specialists and others such as, physicians specializing in addiction medicine, pharmacists, state and federal regulatory agencies, etc.

The North Carolina Physicians Health Program (NCPHP), Drs Wilkerson and Pendergast, were invited to speak to the Board regarding this new legislation. Dr. Pendergast expressed that his main concern is "who will be treating these patients." He indicated that DATA's physician criteria needs to require more rigorous training requirements. Under one option the physician would only need to take eight hours of classroom training. This is not enough. Dr. Wilkerson is afraid of "pill pushing clinics." He continued that Buprenorphine has been widely used in Europe, is safer than Methadone with less overdoses, but it can still be abused.

Dr. Barrett, current President of the FSMB, stated that he was delighted to see Dr. Kanof doing this as a proactive approach. He was asked by the FSMB to attend the second public hearing on Buprenorphine in Washington. He found it interesting that the two groups making presentations were on "the dangers of drugs" and those afraid of just open door clinics. One thing was clear that doctors do not like drug addicts in their offices. He does not see a ground swell of physicians opening their offices to this and it may not be as big a problem as thought unless it is the physician that financially needs the patient. Dr. Barrett would like concerns in writing from NCPHP.

Dr. Garrett stated that despite of the problem let's not lose site of the good news that the quicker we can get rid of methadone the better. As a medical examiner he has seen a good many deaths from methadone; it is poorly understood and easily diverted. Methadone is a dangerous drug especially with experimenters.

EMS Legislative Initiatives

Mr. Drexel Pratt and Mr. Ed Browning of the Office of Emergency Medical Services met with the Board to discuss EMS legislative initiatives. Ms. Melanie Phelps of the Medical Society was also present.

The proposed legislation was reviewed. Mr. Pratt explained that this is only a proposal and they want to build a consensus first prior to proceeding. He continued that the proposed changes relates to the EMS section at the federal level. They have developed a vision document for all states in moving EMS more into a community healthy based environment. They want to be consistent with other states. They do not want to get away from the medical direction/oversight, but want to strengthen it. He explained that it was not the intent to mention scope on the web site. He continued that in North Carolina EMS has two

components. The personnel and system structure is under the offices of the Medical Care Commission (MCC) and advanced life support (ALS) areas give the Medical Board the authority for rule making. They see themselves with two rule making bodies and the intent is to get all EMS rules under one rulemaking body. They do want medical oversight. Their preference would be an independent commission of EMS however the political atmosphere is not much support to get new commissions on the block. They did not know scope would be an issue. They want to work with the Medical Board to determine if it is possible to get under one agency and still have medical oversight by the Board. They feel it is time to enhance the system and do not want a more fragmented system than they have now. They are open to any suggestions from the Medical Board.

Mr. Browning stated that medications used to be in the Medical Board's rules and over the years it took a significant amount of time to add or delete medications from the formulary. They want to ensure that in the Medical Board's statute it allows the MCC to adopt rules for the skills and medications in accordance with the formulary maintained by the Medical Board. In that way the Medical Board would still be responsible for medications used by EMS.

Dr. Pories believes it is a deeper issue than controlling the formulary, it involves the scope of practice of what the personnel inside an ambulance can do. As a surgeon he is reluctant to give up the Medical Board's current position. An advisory committee is just that – advisory in nature.

Mr. Pratt noted that it is now cumbersome to assure consistency with ALS personnel and non ALS personnel where discipline of ALS personnel is done at one place and discipline of non ALS personnel is done at another.

Mr. Browning stated that since June 2000 the Medical Board has been through 22-25 background checks on ALS EMS personnel for review at the EMS Committee. There are a couple under consideration for some action at this time. Whereas 50 Basic level EMS personnel have been reviewed during this same timeframe. It has been a cumbersome process at best in trying to get stuff through the Medical Board. There are situations that have taken months to work through the review process.

Ms. Phelps asked Mr. Pratt to compare the MCC and the Medical Board's review process. Mr. Pratt stated that MCC delegates the review to the agency with the agency providing a report back to the MCC. At the agency level the process usually works fairly quickly once through the appeals process.

Mr. Browning stated there is some disparity in the background checks that the Medical Board does. Under the current system if an applicant has a speeding ticket that application goes through a process. They do not do routine background checks of basic level personnel. It was the EMS Committee's decision to do the background checks which may hold up an application for 2-3.

Dr. Kanof asked which of the following can remain with the Board: scope, discipline, drugs?

Dr. Pories stated that the scope of medical acts has to remain with the Medical Board

Ms. Meelheim commented that the Medical Board only looks at applications of those individuals with identified problems in the past. These applicants undergo a background check.

Ms. Hunter-Buskey asked about the reference to practice settings of EMS personnel. Mr. Pratt stated that the intent is to get away from the mind-set of EMS personnel only being in a transport mode. They want to allow all paramedics to ride in automobiles and work with a lower level service to provide transportation. It does not make sense to take a paramedic out of the community just to transport. They do not want an independent practice but could supplement public service such as immunizations in the community. They do not condone hiring paramedics to work in emergency departments.

Dr. Kanof asked Mr. Pratt and Mr. Browning to go back to their lawyers and give the Medical Board an update at the February Board Meeting, and if a teleconference is needed prior to that due to legislative deadlines, to let the Medical Board know.

Research Task Force on Postgraduate Training Requirements for Physicians in North Carolina

Gene Orringer, MD, University of North Carolina School of Medicine
Peter J. Kragel, MD, East Carolina University School of Medicine
Cam Enarson, MD, Wake Forest University School of Medicine
Lloyd Michener, MD, Duke University School of Medicine
Dean Patton, MD, East Carolina University School of Medicine
Don Smith, NC AHEC Program, UNC-CH

Walter Pories, MD, Chair
Elizabeth Kanof, MD, President, NCMB
George Barrett, MD, Board Member (President, Federation of State Medical Boards)
Robin Hunter-Buskey, PAC, Board Member
John Foust, MD, Board Member
E. K. Fretwell, Ph.D., Board Member

Postgraduate Training Requirement: The Postgraduate Training Task Force met for the first and last time on January 24, 2001. Dr. Barrett was asked to speak to the Federation of State Medical Board's (FSMB) initiatives in this area. He stated that medicine is not less complex now and the role of medical boards is to protect the public. The Federation recognizes that there are many financial reasons to permit moonlighting and it is frequently done in a setting that good skill is needed, and this is the reason that three years is recommended.

There was general consensus that moonlighting helps the underserved areas of the State and helps to support the competition of residency recruiting (part of what they offer is the moonlighting aspects). Dr. Enarson read the new ACGME moonlighting requirements.

Mr. Watry stated that moonlighting is not the problem. The problem is cutting them loose after one year of postgraduate training. Dr. Pories agreed that the problem is the physician who is no longer in training and wants a license after one year. He continued that moonlighting is a matter of public health and believes what would happen in Eastern North Carolina would be a marked reduction in available health care. Mr. Watry interjected that the real problem the Board has are not the ones coming through our medical schools, but the ones that merely come in for a full license after they have stopped postgraduate training after one year.

There ensued a brief discussion on the possibilities of a restricted license after one year in a program, temporary licenses and resident training licenses. Dr. Barrett stated he would find out what was going on in Florida and distribute the information.

Seven Year Rule: The seven year requirement is generally accepted throughout the country. It means that to successfully complete the USMLE track, all components have to be completed within seven years. The MD/PhD candidates have unique problems with this requirement.

Dr. Orringer reiterated that he directs the M.D./Ph.D. Program at UNC. He continued that last year UNC had eight M.D./Ph.D. students, and that these are the brightest of students and it is an extremely competitive program. Dr. Michener stated that there is a growing national shortage of trained MD/PhD researchers and that the Board should do whatever it can to promote this group (nurture not impede).

Mr. Watry explained that this seven year limit occurred as an evolution of SPEX prior to the MD/PhD programs and is not "cast in stone." He indicated the Board will make reasonable accommodations.

Faculty Limited License: A brief discussion ensued regarding Faculty Limited Licenses which are requested by the deans. The consensus was that these licenses are useful but only on a limited basis.

Continuing Medical Education (CME): CME was discussed. There has been some confusion on what practice-relevant CME entails. Mr. Smith stated that the AHEC programs are deeply involved in CME and that AHEC applauds the work of the Medical Board in this area. A challenge of AHEC is to provide and help educate physicians on what practice-relevant means. Mr. Smith stated that grand rounds are broadcast to 19-20 sites in Eastern North Carolina. He continued that AHEC's are working on web-based education using videoconferencing between AHEC's now with personal computers.

Background Checks: A short discussion ensued regarding criminal background checks for medical school applicants to disclose prior alcohol and/or drug use. Dr. Enarson stated that faculty and residents get background checks, and that the school follows up on "yes" answers on applications.

House Officer Education: It was noted that more and better courses on ethics and professionalism are needed, and that perhaps the AHEC's could be more active in this regard. Dr. Enarson announced that Wake Forest had developed a CD ROM module that deals with opening a practice, finances, hiring, firing, etc.

Ophthalmology/Optometry Joint SubCommittee

This first meeting of the Ophthalmology/Optometry Joint SubCommittee was called to order at 2:00 p.m., Wednesday, December 14, 2000, at the office of the Medical Board. Present were: John W. Foust, MD, Chair; Elizabeth P. Kanof, MD; M. Scott Edwards, OD; David B. Baxter, OD; Cynthia Hampton, MD; W. Banks Anderson, MD; Michael F. Clark, OD; William B. Rafferty, OD; William G. Hendrix, OD, Optometry Board; Johnny M. Loper, JD, Counsel, Optometry Board; John D. Robinson, OD, Executive Director, Optometry Board; Michael S. Edwards, North Carolina Medical Society; W. Alan Skipper, North Carolina Medical Society; Michael Levitt, AAO; Aloysius P. Walsh, Board Member, North Carolina Medical Board; Andrew W. Watry, Executive Director, North Carolina Medical Board; H. Diane Meelheim,

Deputy Director, North Carolina Medical Board; James A. Wilson, Board Attorney, North Carolina Medical Board; William H. Breeze, Board Attorney, North Carolina Medical Board; and Jeffery T. Denton, Recorder, North Carolina Medical Board.

Dr. Foust began the meeting with the following opening remarks: "The primary item on our agenda today will be organization and prioritizing our agenda for the future.

I have been asked to chair this first meeting and before we get started I would like to use the chair's prerogative to make some remarks to set the tenor of this and future meetings. Before that let's each introduce ourselves.

(round-table introductions)

As we begin this meeting if there is any element of distrust among us I hope what I will say will dispel it rather than solidify it.

In 1957 I went on active duty with the Air Force, having been deferred during the Korean War to begin medical school and to begin postgraduate training in my specialty of OTO. I was assigned to Clark Air Base in the Philippine Islands. When I arrived at Clark I was surprised by two things, one immediate and one over time.

The first was the fact that I would be working in an Eye, Ear, Nose and Throat Clinic. It consisted of myself, the OTO, Major Sidrys, a Board Ophthalmologist, Lt. Toscano, an optometrist, and a Filipino occultist. My surprise here was due to the fact that my specialty was not more than 10 years out from being separated from ophthalmology and was still struggling to create its own identity.

The second surprise which developed over time was the realization, unlike what I had been led to believe during my education, that optometrists were also professionals.

Lt. Toscano acknowledged that his background was not the extensive medical education that Maj. Sidrys had received in medical school and ophthalmology residency. However, Lt. Toscano's performance documented that his optometry education was thorough.

I saw the two of them work together as a team in a professional manner – no backbiting or turf battles. Now I admit the military is a different environment from private practice and 1957 is different from 2000.

The health delivery system in the 21st century will become more and more a team system. The days of the solo practitioner doing it all are fading fast. In the past we have seen orthopedists and podiatrists struggle and in my own specialty we have seen struggles with the audiologists wanting to become the portal of entry for hearing problems.

I could go on and on but the point I wish to make is, in my opinion, the patient is better served when a team of professionals are working together and parenthetically I would add a successful team needs a leader.

I have been thoroughly criticized in the past for mentioning "turf". As medical funding becomes more and more limited and as more and more providers compete for these dollars, and as more and more patients demand more and more care the economic problems will grow. My point here is this; I would like to acknowledge and hope you would concur that

there are some economic issues underlying the matter before us. I would, however, having acknowledged this like to move on to the more important issue underlying this conflict that of the scientific training.

The Medical Board of North Carolina was established in order to properly regulate the practice of medicine and surgery for the benefit and protection of the people of North Carolina. The optometrist Practice Act says about the same thing but with some restrictions on the scope of practice, which is what brings us together.

The Medical Board licenses MD's, DO's and PA's and in collaboration with the Nursing Board NP's and soon with the Pharmacy Board CPP's. In the latter two specific requirements for training and experience are established and through collaboration of the two boards privileges are granted. This is what we hope to accomplish by developing a collaborative agreement between ophthalmologist and optometrist.

Richards in an article in the Annals of Health Law in 1999 said "Because medicine is a profession, because practicing medicine poses risks to the public, and because of physicians' specific connection to the historical public health issues of epidemic disease control and sanitation issues, the regulation of medical practice falls squarely within the traditional boundaries of the state police power.'

Our Medical Board was established in 1859. By the beginning of the 20th Century the state's authority to pass legislation in this area was firmly established. In 1910 Justice Day of the Supreme Court in Watson vs Maryland described the foundation and rational behind the states' regulatory authority as follows: "It is too well settled to require discussion at this day that the police of the States extends to the regulation of certain trades and callings, particularly those which closely concern the public health. There is perhaps no profession more properly open to such regulation than that which embraces the practitioners of medicine. Dealing, as its followers do, with the lives and health of the people, and requiring for its successful practice general education and technical skill, as well as good character, it is obviously one of those vocations where the power of the State may be exerted to see that only properly qualified persons shall undertake its responsible and difficult duties."

Further, in a case ***Louisiana Medical Board vs Fife*** in 1927 it was the decision of the Louisiana Court that "No person has a natural or absolute right to practice medicine or surgery. It is a right granted upon condition. And, although a state cannot prohibit the practice of medicine and surgery, and would hardly undertake to do such a thing, still it is well established that, under its police power, it may regulate, within reasonable bounds, for the protection of the public health, the practice of either, by defining the qualifications which one must possess before being admitted to practice the same, and, to make these regulations effective, to require the one intending to engage in the practice, to possess, before engaging therein, a certificate from the proper authority showing that he possesses the required qualifications."

I thank you for hearing me out. As I said at the beginning I would like what I had to say would help dispel any distrust that we might have and allow us to proceed in a constructive manner for the task before us."

Dr. Foust then stated that what this group has is a big task ahead. It was proposed that the Medical Board and the Optometry Board in collaboration with the Ophthalmology Society and the Medical Society try to work out a collaborative agreement for certain CPT Codes for

the optometrist in their scope of practice. He went on to explain how the Medical Board and the Pharmacy Board recently worked out a collaborative agreement that will go into effect in 2001. A copy of these rules were distributed to the group here today. He emphasized that if a collaborative agreement is to be reached by the group here today, there will have to be some specific rules on training and experience.

Dr. Anderson stated that he has a problem with defining in terms of CPT Codes since they are changeable and may not be the same from year to year. Instead, he would like for this subcommittee to address procedures, not CPT Codes. There was general agreement with this concept. Any reference to CPT Codes is to be understood as the procedure as currently understood.

It was reiterated that the following motion passed at the September Medical Board Meeting: "that a collaborative practice committee be established between the NCMB and the Board of Optometry based on the Clinical Pharmacist Practitioner (CPP) model to develop methodology to address implementation of the five CPT codes approved by the NCMB on June 21, 2000." The five CPT codes are as follows:

11900 (Injection, intralesional; up to and including seven lesions)
68200 (Subconjunctival Injection)
92235 (Fluorescein angiography [includes multiframe imaging] with interpretation and report)
92230 (Fluorescein angioscopy with interpretation and report)
92240 (Indocyanine-green angiography [includes multiframe imaging] with interpretation and report).

Dr. Edwards noted that the above codes were approved in June and rescinded in September and agreed that these should be the topic of the subcommittee's discussion.

Dr. Hampton suggested that the subcommittee come up with a mission statement to further identify the role of the subcommittee, do's and don'ts, etc. Especially, in relation to the law and, rules and regulations.

Ms. Meelheim read the definition of Optometry in statute § 90-114 to the subcommittee. Dr. Edwards stated that the Medical Board motion from the September Medical Board Meeting is in itself a type of mission statement.

Dr. Kanof proposed the following as the mission statement for this group: That this subcommittee attempt to develop the training and experience prerequisites needed by optometrist to perform the above list of procedures.

Mr. Loper stated that the agreement among all of those parties was that it was a contract entered by the court but agreed to among the parties and that contract was entered to avoid further litigation. What we accomplished is that (in general) in the event the Optometry Board were going to take the position that certain acts or procedures were within the scope of practice of optometrists operating in the State, that rather than going back to court optometry would come to the Medical Board and say "we believe that optometrists are entitled to perform (a particular procedure) and the Optometry Board would take the Medical Board's temperature on that, and if we could agree then we would simply amend this agreement or otherwise designate it in writing. If we could not agree then the Medical Board could not have automatic veto power to say that the Optometry Board couldn't do this. The

Optometry Board could either issue some sort of proclamation indicating that, in its opinion, it was appropriate for optometrist to perform those particular procedures. If the Medical Board disagreed with that its options were still open. They could do what they did in 1994. They could go to court. They could ask the court for an injunction to stop that from happening in the short term and then litigate it in the long term. But the agreement does not give the Medical Board, the Medical Society or anyone else veto power absent some sort of agreement or judicial determination to say that optometrist cannot perform a certain function. It is simply an agreement among the parties to discuss first, to see if you can reach an agreement, and then if you can't all options are still open. Mr. Breeze agreed that this what "more or less it says." Mr. Loper continued "that since that date there have been at least two or three occasions where procedures have been added." For example, rust rings and finger sticks were originally found not to be within the scope of practice of optometry. The optometrists made a presentation. The Medical Board agreed that it was appropriate to do so, so one or two of those codes moved from the "not optometry codes" to "yes, there is at least one procedure within that CPT Code that can be appropriately performed by optometrists."

Dr. Hampton stated that one problem she has with Dr. Kanof's proposed mission statement is that it pre-assumes that the subcommittee will develop criteria and it is going to happen. She continued that we are coming to the table very willing and open to talk about it but with the understanding that if it cannot be done safely and how to put the proper training in place so that optometrist can safely do these procedures that we have not then failed the mission.

Dr. Foust stated that one of the first things this group is going to have to decide is are we willing to proceed to discuss this whole area leading up to the final question of "what is the training." He stated he had made an attempt with his opening remarks to get to the point of discussion. He is hearing an attitude of "let's don't go there." He wants to know if there is any common ground the two groups can agree on. He indicated that this group here today is here to look at certain procedures that the optometrist would like to add and for the group to decide what sort of training and experience the optometrist would have to have to be qualified to do that procedure safely. Keeping the welfare of the patient in mind.

Dr. Anderson asked if this meant optometrist would be doing these procedures independently? Dr. Foust said that if we can agree on what the training and qualifications have to be then maybe they would be able to do that. Dr. Anderson interjected that the training and qualifications differed depending on the setting.

Dr. Clark emphasized there are statutes already in place. He believes the statute is clear in saying optometrist can medically treat conditions of the eye. He believes the real issue here is injection, where the differing opinions are. Their position as an optometry group is that if you can utilize medication, you can do it topically, you can do it orally, you can do it with injections, you can do it transdermally. It's medically treating a condition. The optometrists feel very strongly that they have the statute in their favor to medically treat conditions of the eye. The contention here is <u>other than surgery</u>. Are injections surgery? He gave several examples where lay people such as diabetics give themselves injections daily. He likes the idea of using the CPP concept as a template for where we are going. He agrees with the collaborative nature of it. We are all behind the well being of the patient. He believes the challenge for this group will be whatever you want to call it – turf, power, who supervises who, who has the authority to be on top in a situation like this. He stated that "our challenge here is to us knowledge, the issues of patient care, to use the experiences that the physician members have on this, to try to work out protocols to implement these codes. He

understands that the group's purpose was to try to establish opportunities to implement these codes.

Dr. Anderson stated that in some places nurses do fluorescein angiograms but they are trained and under the direct supervision and the responsibility of the physician involved. To say an optometrist can't do an injection of fluorescein or for ICG begs the question. The question is what setting, what role and what supervision is involved. The level of training and expertise to do this in different settings is totally different.

Dr. Edwards stated that the Optometry Board had put together a sort of statement of purpose from their belief of today's meeting goals. He assured the group that optometrists have no intention of going outside their scope of practice. He emphasized that optometrists are "not some kind of wildcats or loose cannons with needles and injections running around the state." In addition they are very concerned about any kind of agreements. They are here today because of an agreement. The Optometry Board has already put certain things in place as far as public safety. The Optometrist Board requires any optometrist doing Fluorescein angiography to have ACLS certification. Dr. Edwards read the following to the group:

"Over the past year and a half the Board of Optometry has been in discussions with the Board of Medicine concerning the use of injections by properly trained and certified optometrists in the diagnosis and treatment of conditions of the eye and its adnexa.

Prior to the amending of the optometry laws of North Carolina by the North Carolina General Assembly in 1997, optometrists were required by the Rules and Regulations of the North Carolina State Board of Optometry to communicate and collaborate with a licensed physician when using pharmaceutical agents, other than those agents that were topically applied, in the diagnosis, treatment and management of ocular disease. The 1997 General Assembly removed this requirement. Today properly trained and certified optometrists are allowed a prescriptive authority that is no longer limited as to the type of drug or the mode of administration in the diagnosis, treatment and/or management of ocular disease.

The discussions with the Medical Board have been complicated by an agreement entered into by the two Boards, the North Carolina Optometric Society, the North Carolina Medical Society, the North Carolina Society of eye Physicians and Surgeons and others that ended litigation between the parties some six years ago. There are those who argue that only by consent of all parties to the original agreement can the codes that appeared in the Agreement be allowed to optometrists. It is our contention that the ultimate decision rests with the respective Boards, i.e. the Board of Optometry as to the scope of optometry and the Board of Medicine as to what constitutes the unauthorized practice of medicine.

At no time during our discussions has the Medical Board declared that the administration of drugs through the means of injection constitutes surgery. The discussions have primarily centered upon the education and training of optometrists and on patient safety. The Board of Optometry welcomes input from the Medical Board and from the medical community at large as to the minimum criteria that should be imposed upon those optometrists who choose to utilize injections in their practice of optometry.

Patient safety is of as much concern to the Board of Optometry as it is to the Board of Medicine. In this regard, the Board of Optometry has already adopted a policy that would require all optometrists who propose to do any type of injection to maintain a current CPR

certificate and for those who propose to perform IV injections for the purpose of angiography to have a current ACLS certificate.

The Medical Board has adopted for its own purposes a position statement defining surgery in the context of laser surgery. Based in part upon statements made during the course of the negotiations by the then President of the Medical Board, the Board of Optometry finds no reason to challenge the Medical Board's position in this regard. We would also note that the North Carolina Society of Eye Physicians and Surgeons through their attorney at a later meeting agreed that the policy statement referred to above should remain unchanged.

In conclusion it is the purpose and intent of the Board of Optometry that its representatives participate in this joint effort with the Board of Medicine to the end that reasonable requirements be established whereby properly educated and trained optometrists in North Carolina are certified by the Board of Optometry to administer appropriate pharmaceutical agents by means of injection in the diagnosis, treatment and management of eye diseases. That in so doing they would not be engaging in the unauthorized practice of medicine."

Dr. Hampton stated that in the latter half of the above statement of purpose the Board of Optometry is claiming sole board authority and as she understands it that is not the situation in the State of North Carolina. She asked, "Does not the Board of Medicine win if there is a discrepancy between what one board considers their scope and another board considers their scope?" Ms. Meelheim pointed out that the Board of Optometry is an exclusion in the Medical Practice Act. She went on to read excerpts from the Optometry Act explaining that optometrist can prescribe and treat except for "surgery" which is part of the Medical Practice Act. She suggested that the discussion might be "what is not a surgical procedure."

Dr. Hampton agreed with Dr. Clark regarding the gray area and injections. She stated, "If no injection is surgery then what we are doing here is a moot point. Where do we draw the line?"

Dr. Clark suggested the two areas for discussion are (1) scope of practice and (2) standard of care. He believes it is important for any practitioner to follow the guidelines of both. He agrees that there are plenty of things well within his scope of practice (optometry) that are outside of reasonable standard of care based on his inexperience with certain things (certain retinal conditions, corneal conditions, etc.).

Mr. Loper stated that one of the things we are doing here today is trying to avoid litigation an all or nothing for either party. Nowhere does it say all injections are surgery or no injections are surgery. If they were to litigate this and the court said all injections are surgery then the Optometry Board loses and no protocol is needed. If the court came back the other way and said, "No injections are surgery," then the Medical Board loses and no organization outside of the Optometry Board would have any say-so in what optometrists did in terms of injections. He continued that in this regard the Medical Board has charged this subcommittee with the purpose of discussing the five different procedures to see, that it does not come down to an "all or nothing" resolution, but that the subcommittee consider some type of agreement on protocols for some or all of these five procedures in terms of training, education, experience, setting, etc. If an agreement is not reached then we are back at where we started – Optometry Board Pronouncement, Medical Board agreement/disagreement, etc.

Dr. Hampton said she understood Judge Barnett's statement in 1994 was that the Board of Medicine was the law in the land when it came to this type of dispute, and that's why the consent agreement came to the table. Mr. Loper explained that there was no final ruling from Judge Barnett. Mr. Breeze interjected that the litigation was settled. Mr. Breeze felt that the 1994 dispute came about mainly due to lack of communication between the parties involved.

Dr. Hampton stated, "some injection procedures are not the practice of medicine…but some injection procedures are." She feels strongly that the issues here are not all black and white. Mr. Breeze suggested that some may be medical but may fit some exception like a home-remedy or defined by custom (nurses doing finger sticks, etc.).

Dr. Foust stated that before any of this came about the Medical Board's Policy Committee had been tasked to give a definition of surgery. During this process the question, are injections surgery, was discussed. The Policy Committee decided that injections were not a part of surgery. He does consider some procedures "non-standard injections" (needle biopsy of the liver, etc.). However, the Policy Committee did define what surgery is and it is the movement or cutting out of tissue. Anytime tissue is involved with a needle he believes it would fall within this gray area.

Dr. Hampton agreed there is a gray area and explained that is why going to the Optometry Statutes is appropriate. Dr. Clark suggested that "the procedure is not defined by what is in the syringe…a procedure is a procedure." He does not think the classification of surgical or non-surgical procedure is a function of how serious the condition is. Dr. Hampton disagreed with this philosophy. Dr. Clark continued with "surgery does not define severity."

Dr. Foust pushed forward by stating that the thing that brought us here today was a recommendation to look at this in a method the Medical Board has found successful; working with the Nursing Board in matters concerning Nurse Practitioners, dealing with the Pharmacy Board in matters concerning Clinical Pharmacist Practitioners (CPP), etc. The Medical Board has specified in collaboration with the two boards what training and experience the pharmacists have to have and what training and experience the nurse practitioners have to have. The Nursing Board initially approves the nurse practitioner for a nursing license and then forwards it to the Medical Board. The same will be true with the CPP's, which the Pharmacy Board will also approve. He understands that today this group is looking into a possible way for things to be worked out for certain procedures to be done in a collaborative effort.

There appeared to be some confusion as to how the CPP rules would apply to the discussion regarding the above procedures. It was explained that it was not necessarily the content of the CPP rules but how the rules came about through a collaborative effort between the Pharmacy Board and the Medical Board sitting down around the table and jointly deciding on what qualifications (training, experience, etc) the CPP should have.

Dr. Rafferty emphasized "if we are going to find common grounds to move forward, to reach a solution for the matter that is before the Board today, I think we have to assume that there are some standards for these procedures or codes as you wish to call them. Not MD standards and not OD standards but standards for these procedures that medicine would like to see enacted for safe guarding the public. That we work collaboratively in some way to come up with some standards for these procedures that are on the table today. If we can come up with something of that sort I think then we can all reflect on whether those

standards are going to be acceptable. I would like to see some day in all of our professions that it is not the MD, the OD, it's a standard for what procedures we are doing. It may happen way down the road. To me right now just reflecting on this particular issue at this particular time, if we could establish some standards for that I think we might be able to move forward a little bit…if it is the MD initial behind it to do it, then we are probably at an impasse. If it's a certain degree of the ACLS, or whatever standards you want to put behind this, then we might be able to have some common grounds."

Dr. Hampton answered by saying that the ophthalmologists have looked at residency programs in this State and the training of the typical ophthalmology resident in doing these procedures in question to come up with some sort of a benchmark for what kind of standards. She thinks it is important to demonstrate a need for this – where is the need and how to meet that need. She continued, how far are we willing to compromise the standard as it currently exists?

Dr. Rafferty thinks it would be appropriate to take it to standards for the procedures rather than need which would lead back to the turf battle argument. Because there is a certain extensive background that the ophthalmology resident goes through for not just to do Fluorescein but is in training for surgery and other things, Dr. Rafferty does not think that is what he was talking about. He emphasized that if the standard is the attainment of the MD degree then the group will not find any common ground to move forward on.

Dr. Hampton countered that she was talking about how many of these procedures the ophthalmology resident has done, and/or interpreted by the time they come out of a residency. Can this be matched with additional optometry residency? She continued, that if this can't be matched then it needs to be demonstrated that there is a need to lower the standard.

Dr. Kanof stated that since the ophthalmologist have acknowledged that nurses do the Fluorescein injections we need to know how the nurses are trained, and the standards by which they are trained.

Dr. Anderson said that first of all they must be a registered nurse. The nurses are trained as a physician's apprentice in terms of working in the photography area with the other nurses who are doing that. Dr. Anderson stated he would have to come back with the details of that training and certification. Dr. Anderson did not know exactly how many in-training procedures a nurse performed before certification. He did say that once trained there is not a physician in the room when a nurse does these procedures.

Dr. Anderson confirmed that not all Fluorescein angiographies end up in laser surgery and stated that probably 20 angiograms are done for every 1 that results in laser surgery.

Dr. Foust observed that the conversation was "going around in circles again." He emphasized that today the group needs to get organized and set some agendas. He stated that the basic question for those people around the table today "is there any room to try to develop a collaborative agreement on these procedures?"

Mr. Loper suggested that each side come up with a list of protocols for procedures for requirements for education, training and experience, or a list of talking points. A week before the next meeting both sides should exchange the list by fax, and then come back to the meeting better prepared.

Dr. Foust agreed with Mr. Loper but added that when he was in a general surgery residency with Dr. Nathan Womack. Dr. Womack once said to him "I could take any person who is smart enough to get out of college and teach him in about 12 months, maybe 15, how to do every surgical procedure but I need another 4 years to teach him when not to do it!" Dr. Foust believes that at some point the discussion will have to center around "when not to do these procedures."

Dr. Edwards said this would be fine, however, one of the optometrists' problems and the real reason the optometrists are meeting today is that the agreement states that "before we go out here and unilaterally do something ourselves that we will come and communicate with this Board. We have been doing that now for over two years. We also need to be thinking along the lines of how much longer does this communication need to go on. We have already heard from specialists. We don't need to be doing this 4, 5, 6 months from now. We just need to bring this to closure sometime."

Dr. Clark agrees that if the group gets one procedure done it might make it simpler to do the others.

Dr. Hampton stated that there does not need to be too much of a rush on this since "we are setting precedent, not only for North Carolina but what may happen in the rest of the U.S." She believes a time limit should not play a role in this.

Dr. Edwards emphasized that he did not see the precedent since there are 21 other states that allow optometrist to do some form of injection. He also stated that there were really only three procedures on the table.

Dr. Kanof summarized that all had expressed a willingness to try to arrive at a meeting of the minds. She recommended that the group follow Mr. Loper's suggestion and try to deal with one specific procedure to see if an agreement can be reached.

Motion: (Kanof, Clark) That the optometrists and the ophthalmologists (in separate groups) list their perceptions of the qualifications for optometrists (training prerequisites, experience, interpretation, setting and training for "when not to do it") for Fluorescein Angiography and exchange these written perceptions with each group at least a week prior to the next meeting.

There was a general consensus that all are willing to continue at this point to see if something can be worked out collaboratively between the Medical Board and the Optometry Board.

Dr. Foust asked who would chair the next meeting? Dr. Edwards expressed that there should be a chair from both boards and that all of the meetings may not be at the Medical Board offices. Dr. Kanof made a motion to the effect that an optometrist chair the next meeting and that it be held at the Optometry Board. Dr. Edwards declined acting as chair until the third meeting by stating the optometrist would be glad to meet at the Medical Board for the next subcommittee meeting.

The document exchange will take place on January 15, 2001 by each side forwarding their document to the Medical Board in electronic form that morning. The Medical Board will then forward the documents to the other side.

The next meeting of the Ophthalmology/Optometry Joint SubCommittee will be held at the Medical Board's Office on **Thursday, January 25, 2001 at 5:00 p.m.** over dinner.

The meeting adjourned at 4:20, Wednesday, December 14, 2000.

MINUTE APPROVAL

Motion: A motion passed that the October 18 & 19, 2000; November 15-18, 2000; December 13 & 14, 2000; and January 13, 2001, Board Minutes be approved as submitted.

EXECUTIVE DIRECTOR'S REPORT

Andrew W. Watry, Executive Director, presented the following information:

- **Legislative Issues:**

Office Based Surgery: I forwarded you a draft from the North Carolina Medical Society of proposed legislation to regulate office based surgery. This legislation confers authority for the Board to set standards for general anesthesia and parenteral sedation. A copy of this draft legislation has been furnished to all Board Members. It further provides for a permitting process to use general anesthesia or parenteral sedation. As part of this permitting process the Board shall establish education, training and equipment standards and provides for onsite examination and inspection of physician offices by qualified representatives of the Board. Through the Board's Policy Committee we are attempting to evaluate options in use in other states and to identify costs for determining what it would take to set up a program as suggested by this legislation.

Discussion: Dr. Barrett stressed that this is in contrast to the Board's goal of licensing. Dr. Herring believes it can be done similarly to how the dentist have done it. Even though this is a priority for the Medical Society, Mr. Watry wants to be sure the Medical Board has had a chance to discuss this issue before proceeding. Dr. Barrett stated that he respects the Medical Society's view but "we need our own view." He continued that it is important for the Medical Board to be in dialogue with the Medical Society because we both are involved in protecting patients but that the Medical Board should follow what it believes to be best. Ms. Hunter-Buskey wants more information, particularly what other states are doing. Dr. Kanof believes the questions is is it appropriate for the Medical Board to get involved in the office inspection process and that oversight seems to be the main issue. Dr. Foust stated that the Medical Board has the authority to regulate physicians but no authority to regulate facilities.

Update: (January 25, 2001) Ms. Meelheim stated that overnight she had received responses from 25 other medical boards. The Dental Board in North Carolina has , as of October 2000, 3,000 plus licensees. Their current process has two arms: anesthesia (130 dentist) and sedation (85 dentist). Their office inspectors consist of dentist who have held their permit for five years. They audit 20% annually.

VA, SC, NY, IL, NH and CO are currently working on rules and procedures for facility surveys. IL and NH have delegated the responsibility to inspect to their public health department, facility services.

RI, FL, CA and TX have regulations for doing inspections and certification. They outsource the inspections. FL has not implemented yet. RI has not implemented yet but is ready to do so. (Ms. Phelps added that NJ writes their own regulation.)

AL, OK, IO, ARE, AK, MN, LA, GA, MT, and KS have no regulations nor any in the works.

Dr. Kanof tabled further discussion until a chart could be prepared comparing the list of the other states.

Emergency Medical Services (EMS): We have met with Drexal Pratt and Ed Browning of the Office of Emergency Medical Services (OEMS), Department of Human Resources, to talk about their legislative proposal to consolidate EMS regulation under that office. We provide oversight over the regulation of paramedics, EMT-D (defibrillators) and EMT-I (intermediate) jointly with that office. We relayed no position for the Board. We did suggest that if they propose to take the Board out of the process that they consider adding a Board Member to their advisory council and they agreed to pursue this. The existing law does not give the Board a strong mandate in this area. Further, it makes sense for any profession to be regulated in one agency instead of having a split of regulatory functions between two agencies and the State Office of Emergency Medical Services has the necessary expertise to regulate this area effectively. The OEMS certifies the basic level EMT and drafts all of the rules governing training programs and the regulation of ambulance services. The reality is that OEMS screens the applications and brings only the problem ones to our attention. Also, OEMS drafts rule changes and we sign off on them. OEMS also maintains the database of licensees and issues certificates on our behalf. Thus, the proposed change would likely not have a practical impact on the Board. This proposed regulatory change has been under discussion for several years and it is apparently materializing this year. OEMS personnel have indicated support for our suggestion that a Medical Board Member be placed on their advisory council. The Board can thus maintain involvement in medical issues that relate to the regulation of these professions.

Advanced Practice Nurses: There have also been indications for a few years that the North Carolina Nurses Association (NCNA) would propose a bill to consolidate the regulation of advanced practice nurses under the Board of Nursing. Our information is they will have a bill to do that this year. As of today we still have not seen a copy of the draft legislation but Sindy Barker, the Executive Director of NCNA, has indicated that a draft will be presented in a special meeting to advise Medical Board Members of this legislative initiative. This meeting is scheduled for Tuesday, January 23, 2001, at 12 Noon at the Board of Nursing. We will have representatives of the Board at this meeting, but all Board Members who have an interest are welcome to attend. I am advised that she is updating the NCMS as well.

Criminal Record Check: The Nursing Board is sponsoring legislation which specifically provides for criminal record checks for nurses through fingerprint records. I have done some background research in this area. The Mortuary Sciences Board does criminal background checks through this mechanism. This was done several years ago in response to a rather embarrassing situation involving a mortician with a criminal background. The Mortuary Sciences Board vectored into this process without specific statutory authorization. They did it by getting advice from the Attorney General. Their statute, like ours, provides that you can deny a license for several reasons, including conviction of a crime or of committing a crime involving moral turpitude. The Attorney General reasoned that if that is a basis for denial the board has authority to do these criminal background checks. We do not have a criminal

record check per se which involves fingerprinting. We do ask the DEA to review all of our applications and a DEA check can establish criminal history as it relates to DEA registration. The criminal record check proposed by the Nursing Board, involving fingerprints is far more thorough. There has been discussion at this Board about the pros and cons of fingerprint checks. It is reasonable to assume that in the legislative process there may be some questions about other boards and fingerprint checks when this legislation surfaces. The nursing bill makes no mention of boards other than nursing, but that could certainly change in the legislative process.

Medical Practice Act: In regard to the Board's legislative proposals, we are meeting with representatives of the NCMS to convey the Board's legislative issues. These issues carry forward from House Bill 1049 from prior legislative sessions.

- **Office Automation:** We are developing program enhancements in the areas of complaints, investigation, licensing, and legal. The underlying program efforts which provide for a stable platform of licensing and registration information are complete. These enhanced programming initiatives will provide for smoother workflow, better management of information about applicants and case load, reduction in paperwork, and more timely and expeditious processing of workflow.

  We have been contacted by a neighbor state, South Carolina, where staff expressed an interest in our custom designed licensing program. Rebecca Manning visited the board giving an impressive representation of our system.

- **Problem Physicians:** The Board has endorsed compiling its own version of a publication listing various categories of problem physicians, identifying the issues and typical Board responses. The Board set up a special committee involving Dr. Wilkerson and others for the purpose of starting work on this project. Contacts have been made and we should start shortly.

- **Outside Meetings:** Your Board President has established an ambitious and exciting schedule for meeting with various medical societies and hospital groups. Ten such presentations have been scheduled between now and April 10th. We are advising Board Members of presentations in their respective localities. If you need a comprehensive list of these events, please let me know.

PUBLIC AFFAIRS/COMMUNICATIONS PROGRAM REPORT

Dale Breaden, Communications Director, presented the following information:

Forum

The fourth number of the *Forum* for 2000 was published in mid-January. Among other items, the fourth number features the Board's position statements, an excellent speech given by Dr Stewart Rogers at UNC's White Coat Ceremony, another essay by Dr Pories, our first cartoon (courtesy of Dr Pories), an opinion piece on medical errors, strong articles by Dr Kanof and Mr Watry, and a lengthy letter and response on the optometrist-ophthalmologist debate.
We hope to have the searchable data base for all *Forum* articles completed soon.
The two articles on prescribing that appeared in the third number of the *Forum* for 2000 were reprinted in the January 2001 number of *The Medicolegal Ob/Gyn Newsletter*.

Web Page

I will not repeat here our earlier descriptions of our Web site and its contents. I should stress, however, that each section is regularly reviewed and brought up to date as needed. I should also note that we are regularly receiving congratulations from the media and the public on the Web site, its ease of use, and the extent of its coverage.

As you know, the Board's full public record file is now available on line via DocSearch (previously called DocFinder). This is a major advance and enhances the value of the Web site dramatically. (It was announced on WRAL-TV, noted on other television stations and in the major press. It is also touted in the current *Forum*). We owe a debt to Ms Meelheim and the Operations Department for making this advance possible! Also, we have added a section called "QuickCheck," which lists in alpha order and with identifiers every person who has a public file with the Board. Further, it is now possible to pull up a list of physicians in particular specialties by city or town in the "Physician Locator" section. These data resources serve the public and the media well and save a significant amount of staff time in responding to inquiries.

Most recently, Shannon Kingston has completely updated the MPA and the Rules of the Board (Administrative Code) on the Web site. This was done with the close cooperation of the Legal Department to assure accuracy. In their new form, they can be readily modified as future changes occur.

Shannon Kingston's creative and technical skill has been invaluable in steadily improving the Web site. And she and I are always open to your comments and suggestions on further improvements.

Informational Brochure/CME Guide

The brochure was published in late October and a copy was sent to all Board members. It will be given to interviewees, members of the public seeking information, applicants, and the media. (The first printing run was done on white instead of the natural paper specified, and was, therefore, a gift from the printer. A second run, on the proper paper, was printed quickly and is now being distributed.) The brochure's text is also available on the Web site.

As you know, the brief guide on the CME rule was published in *Forum* #3 and is available on our Web site and as a printed document. It is given to each interviewee, and we have sent copies to each component of the Medical Society, to the Old North, the AHECs, the state specialty societies, and the deans of the medical schools. It will also appear in *Forum* #1, 2001. Since its publication, the number of questions we receive about the rule has fallen noticeably. To be of further assistance, we hope to have a simple CME Record Form on the Web site soon.

Broadcast Activities/Audio-Video

As I have reported before, Ms Corey Root, producer at the NC Agency for Public Telecommunications, and I hope to enhance cooperation between the Board and the Agency. The Agency recently initiated a new health series that may give us an opportunity to work with it on health related programming sometime in the next year. A notice concerning the series and the Agency's programming appeared in the previous *Forum* and is reprinted in the current number.

We have now produced audio versions (on CD and cassette) of our videos on sexual misconduct and ethics. We trust these audio presentations by Dr Schneidman and Dr Pellegrino will widen the market for their messages. Both CDs and cassettes will be inexpensive and easier to use than the videos we have made available over the past several years. We also would like to make Dr Pellegrino's talk on medical board responsibility available to all our Board members, some of whom have had no opportunity to hear it.

PA/NP Materials

Shannon Kingston and Erin Gough are preparing several articles for the *Forum* relating to PA/NP licensing and registration. Shannon has also developed a PA/NP section of the Web site. As you know, she attends meetings of the PA/NP Committee to facilitate her efforts in this area.

Presentations to Public and Professional Groups
Over the past year, the following presentations have been made or scheduled and reported to Public Affairs.

Andrew Watry
2000
Davidson Co Medical Society--February 29
UNC/CH third year medical students--March 13
Wake Forest U School of Medicine (MAAP program)--November 2

Diane Meelheim
2000
UNC School of Public Health students--February 22
Duke University School of Nursing/NP students (Fayetteville)--February 24
Wake Forest University PA Program--March 13
Duke PA Program--April 27
UNC School of Nursing, FNP students--May 23
ECU School of Allied Health, PA Students--June 29
AHEC Meeting, Greensboro--October 17
2001
NC Medical Staff Coordinators, Fayetteville--March 2
NCCME Meeting, Pinehurst--March 23

James Wilson
2000
UNC School of Law, Presentation to students on Health Law--January 24
ECU Medical School, Fourth Year Students on Health Law--March 6
NC Society of Healthcare Attorneys, Telehealth--October 6
ECU School of Medicine Health Law Forum, Medical Errors--September 13
Wake Forest U School of Medicine (MAAP program)--November 2

Don Pittman
2000
Opioid use in a Regulated Environment, Pardue Pharmaceuticals program--November 20

Mr VonSeggen
2000
Cape Fear PA Regional Meeting, Wilmington--February 22
East Carolina University PA Program--February 22
Wake Forest University Conference on Inappropriate Patient Relationships--February 25
Wake Forest University PA Program--March 13
NC Medical Group Managers Spring Meeting--March 31
"Job Powwow" session on Regulatory Issues in Job-Seeking, Winston-Salem--April 1
Forsyth Co Med Society, retired physicians, re: Volunteer Licenses, Wake Forest U--April 5

Dr Kanof
2000
Womack Army Hospital-- November 2
2001
Greater Greensboro Medical Society--January 11
Wake Forest University Hospital--January 18
Onslow Memorial Hospital--February 1
Alamance Regional Hospital--February 5
High Point Medical Society--February 8
Caldwell Memorial Hospital--February 20
Cumberland County Medical Society--February 27
Wayne County Medical Society--March 1
Union Regional Medical Center--March 6
Nash County Medical Society--April 10
Raleigh Community Hospital--September 6

Ms Walston
2000
Garden and Discussion Club, Wilson--September
Tuesday Book Club, Wilson--October
Greater Wilson Rotary Club--November

Shannon Kingston handles the scheduling of presentations. She is contacting civic, church, professional, and other groups to determine their interest in having speakers from the Board. She and I would appreciate it if members of the Board who have the appropriate contacts would speak with their local civic groups/clubs to determine if they would be interested in presentations on the work of the Board. Shannon will be happy to make the arrangements once the initial contact is made.

Board Action Report
The detailed bimonthly disciplinary report system continues to function well, making disciplinary information available to all health care institutions and media in the area of subject licensees' practices and to organizations and agencies with statewide responsibilities. A full year of reports appears on our Web site. This use of the Web site, combined with our new e-mail facility, has now made it possible to reduce the number of print copies of the report needed for mailing. A cumulative report also appears in the *Forum*, and special notices concerning revocations, summary suspensions, suspensions, and surrenders are sent out when the information is received by Public Affairs. We have also introduced a system for directly informing other state boards of revocations, suspensions, summary suspensions, and surrenders involving their licensees. Shannon does this by checking the AMA data base to determine other states in which the licensees are licensed and then contacting those state boards. Thanks to the Internet, media throughout the state, not just in counties where subject practitioners live, can now receive full listings of Board actions on a regular basis.
Our thanks, as always, go to the Legal Department and to Jenny Olmstead for reviewing each Board Action Report prior to its release.
[I should note that we do not actively distribute Charges and Allegations when they are filed by the Board. However, they are public record documents and we make them available as soon as they become effective to anyone who requests or has requested them. Charges and Allegations are promptly placed on the Web site as documents in DocSearch.]

Annual Board Action News Release

The Board Action report for 2000 will soon be prepared for release.

News Clippings
We continue to make the regular weekly packet of clippings from the Internet available to you on disk. Shannon also began sending them by e-mail during September. This approach will make it possible to do away with distribution by disk in time. (Some items, of course, are not available electronically and hard copy must be sent. This includes materials from our own NC clipping service and the FSMB's clippings from Bacon. The latter, as you have noticed, are sent to us by the FSMB in a rather scrambled form, often poorly copied and hard to read.) I should note that the electronic items are received here in a form that is triple spaced, with items running directly into one another. Shannon restructures these into an easily readable form for your convenience.
Shannon has now fully organized our clippings archive for 1999 and 2000. Previous years are being assembled as quickly as possible.

800 Number
This telephone number remains extremely active, a useful public service.

ATTORNEY'S REPORT

A motion passed to close the session to prevent the disclosure of information that is confidential pursuant to sections 90-8, 90-14, 90-16, 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and to preserve attorney/client privilege.

The Legal Department reported on 62 cases. A written report was presented for the Board's review. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

EXECUTED CASES

ANDRINGA, Richard Cornell MD
Consent Order executed 1/8/2001

BRETT, John Montgomery MD
Notice of Charges and Allegations executed 1/8/2001

BRINTON, Lewis Floyd MD
Order of Summary Suspend executed 11/17/2000

DECLERCK, Paul A. MD
Consent Order executed 1/9/2001

DENTON, Beecher Tate III PA
Consent Order executed 12/14/2000

DORLON, Robert Edwin Jr. MD

Order to terminate Consent Order executed 1/8/2001

GUALTEROS, Oscar Mauricio MD
Consent Order executed 11/14/2000

HENDRICKS, David Martin MD
Consent Order executed 1/8/2001

KILGORE, Larry Charles MD
Consent Order executed 11/14/2000

KYZER, David Dee MD
Order executed 12/1/2000

LESTER, Allan John MD
Order of Dismissal executed 1/9/2001

MCCLELLAND, Scott Richard DO
Consent Order executed 11/21/2000

MELTON, Katherine Rose MD
Order executed 8/10/2000

PEACE, James Harmon Jr. MD
Consent Order executed 11/14/2000

RUDISILL, Elbert Andrew Jr. MD
Order to terminate Consent Order executed 12/14/2000

WORIAX, Eric PA
Consent Order executed 11/14/2000

ZABENKO, Robert Tracy DO
Consent Order executed 1/8/2001

HEARINGS

HAMILTON, James Greene, MD
01/2001 BOARD ACTION: Accept MD's request to continue

LITTLE, Douglas Jonathan, MD
01/2001 BOARD ACTION: Accept proposed Consent Order

POLICY COMMITTEE REPORT

John Foust, MD, Chair; Elizabeth Kanof, MD; Stephen Herring, MD; Walter Pories, MD, Aloysius Walsh

The Policy Committee was called to order at 2:05 p.m., Wednesday, January 24, 2001, at the office of the Board. Present were: John W. Foust, MD, Chair; Stephen M. Herring, MD; Elizabeth P. Kanof, MD; Walter J. Pories, MD; Aloysius P. Walsh; Andrew W. Watry, Executive

Director; Gary Townsend, MD, JD, Medical Coordinator; Dale G Breaden, Director, Public Affairs (PC Staff); and Jeffery T. Denton, Board Recorder (PC Staff).

NB: ***Recommendation to Board***=Committee's request for Board consideration of item. ***Action***=Item related to the Committee's own work or deliberations.

Review of Minutes (Dr Foust)
The minutes of the December 13, 2000, Policy Committee were reviewed and accepted, a typographical error in the first line being corrected (changing October 13 to December 13).

Scope of Practice Subcommittee Update (Drs Herring and Pories)

Dr Herring noted that the Ophthalmology/Optometry Joint Subcommittee would be meeting for the second time at 5:00 p.m., Thursday, January 25, 2001.

Alternative Medicine Subcommittee Update (Drs Kanof and Walsh)

Dr Kanof announced that the next meeting of the Federation's committee on alternative medicine, the Committee to Develop Model Guidelines for the Use of Complimentary and Alternative Therapies in Medical Practice, had been changed from January to March 26. In addition, she announced that there is an upcoming one-day conference in Greensboro on alternative medicine.

Annual Review of Position Statements (Mr Breaden)

The annual review of position statements continued. The focus at this meeting was on the "Ophthalmologists: Care of Cataract Patients" position statement. Mr Breaden presented several drafts in accord with the Committee's previous comments. Dr Barrett suggested the Board may be getting very close to micromanaging care.

***Action*:** The drafts presented are referred for development to a subcommittee of the Policy Committee consisting of Drs Pories, Foust, and Herring.

MD/DO Advertising and Publicity (Dr Kanof)

At the November 2000 Board Meeting, the Dr Kanof passed the following North Carolina Medical Society resolution to the Policy Committee for consideration: "Resolved, that the North Carolina Medical Society request that the North Carolina Medical Board issue a position statement clarifying how physicians should properly designate their osteopathic or allopathic status in all commonly used media and specify the circumstances under which physicians may be disciplined for non-compliance with the Board's position."

Dr Kanof presented a proposed revision of the "Advertising and Publicity" position statement incorporating wording to address earned medical degrees. Several members expressed concerns about this issue.

***Action*:** Mr Watry and Dr Kanof will explore the subject further and bring it back to the next meeting for reconsideration.

Office-Based Surgery: Definition of Incidental Surgery (Drs Herring and Pories)

At the December committee meeting, it was decided that a joint subcommittee would be formed to look into defining "incidental surgery." It was to include representatives from the Medical Society, the MCC, and the Medical Board (Drs Herring and Pories).

Dr. Herring stated he had had some discussions and now is sure the Medical Board needs to define what "incidental surgery" is. Dr Pories read a draft of a definition he had prepared and said he would make a copy available for the Committee's study.

Regulating the Sale of Goods from Physician Offices (Dr Kanof)

The FSMB recommendations regarding regulating the sale of goods from physicians' offices was reviewed. The need for this or a formal position statement on the subject was questioned. Dr Barrett commented on when ophthalmologist were told to stop selling glasses out of their offices. No conclusion was reached.

Action: Dr Kanof would like the committee to review the AMA statement on this subject prior to making a decision.

Development of a Regulatory System for Office-based Surgery

Ms. Meelheim had nothing to report at this time regarding the estimated cost of planning or developing a regulatory system for office-based surgery.

Development of Guidelines for Problem Physicians: A Discussion

At the December 2000 committee meeting, it was decided that a workgroup consisting of Dr Herring, Mr Walsh, Ms Hunter-Buskey, Mr Watry, Drs Townsend, Wilkerson, and Pendergast, and a legal representative be established to discuss development of guidelines for problem physicians, and that Dr Charles Trado be invited to participate.

Dr Herring reports that he has obtained the past 2.5 years of Board materials and is going to categorize it with Mr Watry's outline from Georgia to list generic examples and how the Board handled each issue. He will then make up a checklist similar to what is now used to draft consent orders. Mr Watry indicated that Dr Wilkerson has indicated a desire to work on this issue with the Board.

There being no further time, the meeting adjourned at 3:10 p.m., Wednesday, January 24, 2001.

Thursday, January 25

The Committee met at 10:00 a.m. to conduct further business.

Revisions of Selected Position Statements

After discussion of each draft of the proposed revisions, the following actions were taken.

Action:

1. The proposed revision of the position statement on Access to Physician Records will be reconsidered in view of the recommendations made by the Medical Society. Mr Watry, Ms Meelheim, and Melanie Phelps, of the Medical Society, will prepare a new proposed revision for the Committee's consideration in March. They will also consider enhancing the footnotes in the position statement on Retention of Medical Records.

2. The new title for the position statement on the Availability of Physicians to Their Patients After Hours was approved for recommendation to the Board. (See below.)

AVAILABILITY OF PHYSICIANS TO THEIR PATIENTS AFTER HOURS

Q It is the position of the North Carolina Medical Board that once a physician-patient relationship is created, it is the duty of the physician to provide care whenever it is needed or to assure that proper physician backup is available to take care of the patient during or outside normal office hours. If the physician is not generally available outside normal office hours and does not have an arrangement whereby another physician is available at such times, this fact

must be clearly communicated to the patient, verbally and in writing, along with written instructions for securing care at such times.

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

(Adopted 7/93)
(Amended 5/96, January 2001)

3. The change of the word "valid" to "validated" in the position statement on Prescribing Legend or Controlled Substances was approved for recommendation to the Board. (See below.)

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 chronic 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 validated 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 5/98)
(Amended 7/98, January 2001)

4. In the position statement on the Retired Physician, eliminating the reference to maintaining CME effort and replacing it with a reference to the need to meet the Board's continuing medical education requirement was approved for recommendation to the Board. (See below.)

THE RETIRED PHYSICIAN

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

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

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

·practice within their areas of professional competence;
·prepare and keep medical records in accord with good professional practice; and
·~~maintain their competence through an active continuing medical education effort~~ meet the Board's continuing medical education requirement.

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

(Adopted January 1997)
(Amended January 2001)

5. In the position statement on Guidelines for Avoiding Misunderstandings During Physical Examinations, eliminating the words "it is advisable that" in the third line of item 2 in the statement and inserting the word "should" between party and be, thus reading "a third party should be present," was approved for recommendation to the Board. (See below.)

GUIDELINES FOR AVOIDING MISUNDERSTANDINGS
DURING PHYSICAL EXAMINATIONS

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

1.Sensitivity to patient dignity should be considered by the physician when undertaking a physical examination. The patient should be assured of adequate auditory and visual privacy

and should never be asked to disrobe in the presence of the physician. Examining rooms should be safe, clean, and well maintained, and should be equipped with appropriate furniture for examination and treatment. Gowns, sheets and/or other appropriate apparel should be made available to protect patient dignity and decrease embarrassment to the patient while a thorough and professional examination is conducted.

2. Whatever the sex of the patient, a third party should be readily available at all times during a physical examination, and ~~it is advisable that~~ a third party should be present when the physician performs an examination of the breast(s), genitalia, or rectum. When appropriate or when requested by the patient, the physician should have a third party present throughout the examination or at any given point during the examination.

3. The physician should individualize the approach to physical examinations so that each patient's apprehension, fear, and embarrassment are diminished as much as possible. An explanation of the necessity of a complete physical examination, the components of that examination, and the purpose of disrobing may be necessary in order to minimize the patient's possible misunderstanding.

4. The physician and staff should exercise the same degree of professionalism and care when performing diagnostic procedures (e.g., 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)

6. In the position statement on Sexual Exploitation, addition of a line referring to the NC General Statutes, Chapter 90, Article 1F, was approved for recommendation to the Board. (See below.)

SEXUAL EXPLOITATION OF PATIENTS

It is the position of the North Carolina Medical Board that entering into a sexual relationship with a patient, consensual or otherwise, is unprofessional conduct and is grounds for the suspension or revocation of a physician's license. Such conduct is not tolerated. As a guide in defining sexual exploitation of a patient by a licensee, the Board will use the language of the North Carolina General Statutes, Chapter 90, Article 1F (Psychotherapy Patient/Client Sexual Exploitation Act), §90-21.41.

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

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

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

Inquiry on Microdermabrasion

After reviewing a letter asking if microdermabrasion would be included under the heading of surgery as defined by the Board, it was decided to seek more information before reaching a decision.

Action: Table this issue until March. Dr Kanof will gather more data to assist the Committee in reaching a decision.

The Committee adjourned at 11:30 a.m.

OPERATIONS COMMITTEE REPORT

Elizabeth Kanof, MD; Walter Pories, MD; John Dees, MD; Paul Saperstein

Chairman, Paul Saperstein, called the Executive Committee of the North Carolina Medical Board to order at 8:30 am. Members in attendance were Liz Kanof, MD, President; Walter J. Pories, Vice President; John Dees, MD, Secretary/ Treasurer; Andy Watry, Executive Director; Peter Celentano, Controller; Diane Meelheim, Assistant Executive Director. (Mr. Saperstein participated by telephone.)

January financials were discussed in detail. Mr. Saperstein noted that the Board continues in the black.

Personnel issues discussed included information regarding the final selection for the Director of the Legal Department. The committee is to meet with the candidate at 5 pm. Additionally, Mr. Allen Holcomb has been hired as a temporary worker to fill a vacant position in the Operations Department.

There are a number of new Board members who need an orientation to the Directors and Officers Insurance policy. This is to be given by Ms Meelheim when time permits.

Dr. Kanof presented a work sheet, which she endorsed as a method of conveying policy information between the Executive Committee. This will be discussed in more depth at a later meeting.

Mr. Watry presented information regarding a proposal from an outside legal firm who have agreed to handle cases for the Board on an hourly basis. The committee endorsed this method of moving these cases along more rapidly.

Motion: A motion passed to approve the report as presented.

EMERGENCY MEDICAL SERVICES (EMS) COMMITTEE REPORT

Walter Pories, MD; Aloysius Walsh; Robin Hunter-Buskey, PAC

A motion passed to close the session to prevent the disclosure of information that is confidential pursuant to sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes.

The EMS Committee reported on 7 investigative cases. A written report was presented for the Board's review. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

PHYSICIAN ASSISTANT COMMITTEE REPORT

Walter Pories, MD; Aloysius Walsh; Robin Hunter-Buskey, PAC

PA License Applications-

(***Indicates PA has not submitted Intent to Practice Forms)

Board Action: Issue full licenses

PHYSICIAN ASSISTANT	PRIMARY SUPERVISOR	PRACTICE CITY
Avery, Leanne	**Leader Jr**., David L.	Raleigh
Barbacci, Kristen Beth	***	
Biehl, Ethel Linda	***	
Clarke, Jay Lawrence	***	
Conti, Stacey Erin	***	
Garber Jr., John Cline	**Kryn**, Edward T.	Clayton
Malia, Kelly Sean	***	
Rainwater, Marvin Keith	**Wheeless**, Clifford	Louisburg
Sabulsky Jr., Richard Michael	**D'Amico**, Thomas	Durham
Sandhu, Urmila Joi	**Sweede**, Sharon S.	Black Mountain
Starr, Eric William	***	
Wolfe, Betty Jean	**Bullock**, Ann	Cherokee

PA License Application for Committee Review-

A motion passed to close the session to investigate, examine, or determine the character and other qualifications of applicants for professional licenses or certificates while meeting with respect to individual applicants for such licenses or certificates.

> The Board reviewed one licensure application. A written report was presented for the Board's review. The Board adopted the committee's recommendation to approve the written report. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

PA Intent to Practice Forms Acknowledged-

PHYSICIAN ASSISTANT	PRIMARY SUPERVISOR	PRACTICE CITY
Anderson , April	**Pippin** , Richard Lee	Farmville
Araghi , Sayeh S.	**Chao** , Albert Chung-Kuang	Hope Mills
Arcand , Scott Anthony	**Seroska** , Phillip John	Whiteville
Baker , David Bryant	**Dickerson** , Michael	Smithfield
Baker , David Charles	**Mohiuddin** , Masood	Morganton
Baxley , Janice Elalea	**Leone** , Peter Anthony	Raleigh

Beaman Jr, Carlton Reid	Wilson
Blelloch , Lawrence Andrew	Raleigh
Boyd , William Scott	Eden
Boyte , Sabrina Ann	Swansboro
Bradshaw , Johnnie Mack	Charlotte
Bruning , Kevin	Charlotte
Burkey , Beth Ann	Sanford
Butler , Thomas Richard	Raleigh
Butts , Gary Paul	Yadkinville
Cassidy , John	Statesville
Chavis , Anthony Darnell	Raleigh
Chavis , Anthony Darnell	Raleigh
Cook , Ashly Leonard	Raleigh
Cook , Ashly Leonard	Raleigh
Culbreth , Daniel Andrew	Wilmington
Curry , Brenton	Rutherfordton
Deakle , Mary Stone	Winston-Salem
Donau , Charles Robert	Fayetteville
Dotson , Ruth	Boone
Dowdy , Karen Graue	Hendersonville
Evans , Molly	Louisburg
Fertig , Norman Richard	Greenville
Freas , Luther Wayne	Wilmington
Futch , William	Henderson
Futch , William	Morehead City
Gatewood , Tina Smith	Greensboro
Gatlin , Lois Jean Zeitlin	Hendersonville
Gerni , Kimberly	Angier
Gibson , Scott David	Fayetteville
Gudger , Marian Waddell	Statesville
Guiton , Todd Joseph	Raleigh
Hales , Edward William	Charlotte
Hinds , David McDonald	Wilson
Hoffmann , Martha Kingston	Asheville
Huber , Steven James	Morehead City
Jacobson , Kendra Lee	Cary
Johnson III, Walter	Durham
Karimi , Najeeb	Charlotte
Kelly Jr., Charles R.	Pinehurst
Kilburn , Emily	Charlotte
Kirch , Eric	Raleigh
Kovacs , Katharine Denues	Raleigh
Langley , Dawn Tracy	Lumberton
Laton , Gregory Vincent	Southern Pines
Lawhorn , Robert Lee	Charlotte
Leamy , Gregory Joseph	Raleigh
Leamy , Gregory Joseph	Raleigh
Ledford , Joel	Robbinsville
Lehman , Michael M.	Smithfield
Lewis , Jody	Burlington
Liepins , Andrew Patrick	Raleigh

Sigmon , James Gregg	Wilson
Oller , Dale William	Raleigh
Daniel , Terry Glen	Eden
Quick Jr., John Buster	Swansboro
Oliver Jr., Andrew Blaine	Charlotte
Callaway , Clifford Kay	Charlotte
Cheesborough , John Davidson	Sanford
Kelsch Jr., John Martin	Raleigh
Strickland , R. Todd	Yadkinville
Bellingham , Daniel Dwight	Statesville
Oller , Dale William	Raleigh
Palombaro , James Frank	Raleigh
Palombaro , James Frank	Raleigh
Oller , Dale William	Raleigh
Exposito , Andres Joseph	Wilmington
Finch Jr., George Carlton	Rutherfordton
Puma , Joseph Anthony	Winston-Salem
Henderson , Keith Francis	Fayetteville
Harter , Mark Richard	Boone
Whitaker , Gary Randall	Hendersonville
Gruenbaum , Ronald Salomon	Louisburg
Williams , Frances	Greenville
Durham , Stephen Bryan	Wilmington
Perren , Richard Stephen	Henderson
Lowry , Brian Patrick	Morehead City
Fernandez , Juan Humberto	Greensboro
Bodie , Barry Hoyt	Hendersonville
Reyes , Rodolfo Constantino	Angier
Lownes , Robert Lefonia	Fayetteville
Grimm , Ruby Ann	Statesville
Leader Jr., David Lindsay	Raleigh
Petrilli , Robert	Charlotte
Collins , Irance Reddix	Wilson
Tait , Jeffrey	Asheville
Lowry , Brian Patrick	Morehead City
Hicks , Marilyn Pack	Cary
Blazing , Michael August	Durham
Ekwonu , Tagbo John	Charlotte
Prince , Gus Donald	Pinehurst
White , Lena Katherine	Charlotte
Matthews , Charles Joseph	Raleigh
Glenn , Susan Annette	Raleigh
Grimm , Paul Jeffrey	Lumberton
Wolf , Harvey Hugh	Southern Pines
Cook , Joseph William	Charlotte
Palombaro , James Frank	Raleigh
Oller , Dale William	Raleigh
Johnson , Patricia June	Robbinsville
Dickerson , Michael	Smithfield
Strickland , James Donald	Burlington
Thompson , Lisa Welstein Horn	Raleigh

Lightner , Michelle L.	**Maxwell** , James Henry	Wade
Martin , Holly	**Koinis** , Thomas Frank	Oxford
Martinez , Jessica	**Naziri** , Wade	Greenville
Matthews , Renae	**Kimball** , Robert Roy	Statesville
McCrary , Barbara Stanley	**Hines** , Edward Lloyd	Burlington
McCrary , Barbara Stanley	**Smith** , Christopher Edmund	Burlington
McCrary , Barbara Stanley	**Miller** , Howard Edward	Burlington
McDaniel , Gary E.	**Leader Jr**., David Lindsay	Raleigh
McHatton , Timothy L.	**Pavelock** , Richard Micheal	Charlotte
McMillen , Peggy	**Proctor** , Camilla Allyn	Rocky Mount
McNamee , Sheila Marie	**Richardson** , David Lee	St. Pauls
Mendenhall , Tiffany	**Ransom** , James Laurence	Greensboro
Mock , Michele	**Broyles** , William Kevin	Durham
Moseley , Daniel Grace	**Thompson** , Lisa Welstein Horn	Raleigh
Moye , William Stewart	**Contogiannis** , Mary Ann	Greensboro
Mulligan , Terry	**Singh** , Satvir	Warsaw
Mulligan , Terry	**Kornegay** , Hervy Basil	Warsaw
Nelson , Zenith	**Leonardo** , James Michael	Greenville
Newman , Barbara Ann	**Salyers** , Martha Jane	Asheville
Oakley , Lisa Marie	**Pham** , Hiep Thanh	Fayetteville
Oles , James Richard	**Candela** , Stephen Joseph	Whiteville
Petrarca , Brian Donald	**Wentz** , Elliott Lee	Greensboro
Powell , Debra Diane	**Fletcher** , Sidney Marc	Charlotte
Quillen , Rocky C.	**Charania** , Amin Aziz	Concord
Reid , Aubrey James Bernard	**Dickerson** , Michael	Smithfield
Richards , Dick Alan	**Nickerson** , Lloyd Emery	Salisbury
Rodezno , Robert Vincent	**Rowlett III**, Joseph Peterson	New Bern
Schoonmaker , John	**Grimm** , Paul Jeffrey	Lumberton
Sheaffer , Luanne Gardner	**Maultsby** , James Alexander	Clinton
Sherman Jr., Robert	**Wolf** , Harvey Hugh	Southern Pines
Shock , Lisa Petronella	**Withrow** , Glenn Ashley	Chapel Hill
Spinner , Tricia	**Cox** , Craig Harness	Huntersville
Stuckey , Travis	**Mahar** , Matthew	Sylva
Stuckey , Travis	**Davis** , Todd Driscoll	Franklin
Sumerlin , Jeffrey Scott	**Lowry** , Brian Patrick	Morehead City
Swansiger , David Charles	**Thompson** , Forrest Leigh	Gastonia
Todd , Christy	**Dziedzic** , Stanley Frank	Fayetteville
Turbay , Monica Maria	**Tortora Jr**., Frank Louis	Cary
Vaughan Jr., William Thomas	**Wu** , Lawrence Reginald	Durham
Wallace , Connie Sue	**McMillan** , Edward Beman	Charlotte
Williams , Lynne Baheyeah	**Walsh** , Kim Marie	Burlington
Wolkofsky , Robyn	**Sigmon Jr**., Richard Lee	Charlotte
Wrigley , Kim	**Alexander** , James Ray	Asheville
Yates , Heather	**Harris** , Robert Mark	Sanford
Yeaman , Paul Ashley	**Wilson Jr**., Shelburne Duval	Linville
Young , Scott Allen	**Kepp** , Edward Allen	Albemarle

Public Agenda Items for Committee Discussion-

Information regarding National Commission for Certification of Anesthesiologist Assistants (from Mr. Watry).

Board Action: Accept as information

Response from Franklin Group, Inc., regarding their marketing solicitations to NC PAs.

Board Action: Discuss at February meeting.

NURSE PRACTITIONER COMMITTEE REPORT

Walter Pories, MD; Aloysius Walsh, Robin Hunter-Buskey, PAC

NP Initial Applications Recommended for Approval after Staff Review-

Board Action: Approve

NURSE PRACTITIONER	PRIMARY SUPERVISOR	PRACTICE CITY
Barnhardt, Debra Jean	**Clontz**, Ted H.	Charlotte
Beasley, Amanda Dillon	**Igwemezie**, Benjamin M.	High Point
Bishop, Elizabeth Howard	**Long**, Frank E.	Concord
Bridges, Robyn Robertson	**Dekle**, Larry C.	Wentworth
Brown, Diane Lynn	**Nascimento**, Luiz	Hamlet
Bullard, Sarah Grace	**Vogt**, Joel A.	Greensboro
Causey, Sherry R.	**Little**, Edwin P.	Kinston
Chance, Rosemarie Roberts	**McKie Jr**., James	Greensboro
Chance, Rosemarie Roberts	**Truesdale**, Gerald L.	Greensboro
Chauvigne, Brigitte	**Griffin**, John J.	Greensboro
Everette, Susan Keeter	**Park**, Frederick K.	Rocky Mount
Grainger, Susan Elaine	**Walker**, George K.	Kernersville
Haith, Karen Ann	**Morrisey**, Lemont	Burlington
Heatherington, Jill	**Frazer III**, Joe W.	Asheville
Kassmann, Barbara P.	**Fair**, Jeffrey H.	Chapel Hill
Kindler, Renee Michelle	**Rowson**, Jonathan D.	Maxton
Knott, Beverly Gail	**Imbus**, Harold R.	Kernersville
Lewis, Margaret Lynn	**Barber**, Anthony R.	Hickory
Likis, Frances Estes	**Sales**, Eileen F.	Gastonia
Lucas, Katherine Young	**Ciszek**, Thomas A.	Fayetteville
Lynch, Mary Alice	**Powell**, Bayard L.	Winston-Salem
McNutt, Kathleen Weaver	**Hart**, Robert E.	Hickory
Moody, Shinel LaLicia	**Allen**, Cyril A.	Raleigh
Parsons, Ann Lynette	**Nickens**, Larry C.	Goldsboro
Patterson, Stephanie Lorraine	**Covington**, Connell	Raleigh
Pearson, Deborah Lewis	**Spillane**, William F.	Winston-Salem
Phillips, Judy L.P.	**Harley**, Stewart J.	Asheville
Sands, Mary Karen	**Collins**, David D.	Winston-Salem
Sands, Mary Karen	**Semble**, Elliott L.	Winston-Salem
Shattuck, Lynn Redden	**Purrington**, Jacinda I.	Greensboro
Skergan, Natalie Naugle	**Martin**, Paul L.	Durham
Stein, Judy Lynn	**Guyton**, John R.	Durham

Wood, Kristine Lea	**Cline Jr**., Wayne A.	Salisbury

NP Subsequent Applications administratively approved-

Board Action: Approve

NURSE PRACTITIONER	PRIMARY SUPERVISOR	PRACTICE CITY
Abbott, Linda M.	**DiMartino**, Thomas C.	Edenton
Adriance, Robin J.	**Medina**, William D.	Hendersonville
Ballard, Marcia H.	**Leonard**, Thomas R.	Carthage
Ballard, Tracy M.	**Rowe**, William T.	Greensboro
Bauman, JoAnn G.	**Siegmann**, James R.	Ft. Bragg
Beasley, Teresa H.	**Sailer**, Kaaren S.	Charlotte
Beck, Samuel L.	**Fisher**, Ronald P.	Sylva
Benton, Jennifer D.	**Johnson**, Robert R.	Wilmington
Brown, Scott Michael	**Sigmon**, James G.	Wilson
Bush, Tara D.	**Janis**, Eric M.	Smithfield
Drake, Cathy A.	**Gessner**, Carl E.	Concord
Eure, K. JoAnn H.	**Williams**, Frances E.	Greenville
Hancock, Margaret K.	**Fernandez**, Juan H.	Greensboro
Hayes, Helen B.	**McMillan**, Edwin B.	Charlotte
House, Laura A.	**Zaiim**, Loghman	Cary
King, Gloria M.	**Gardner**, Donald N.	Mt. Airy
Lee, Carol A.	**Grimm**, Paul J.	Rowland
Marks, Michael B.	**Kimball**, Robert R.	Statesville
Matusik, Leonard J.	**Yancich**, Louis A.	N. Wilkesboro
McNeill, Ella M.C.	**Hall**, Myra J.D.	Raeford
Miller, Penny E.	**Williams**, Randall W.	Raleigh
Morrozoff Jr., William G.	**Hall**, Myra J.D.	Raeford
Moynahan, Mary T.	**Jenkins**, C. Mitchell	Manteo
Pearson, Tamera L.	**Glance**, Gregory L.	Asheville
Poole, Cathy M.	**Carter**, Jean W.	Raleigh
Rountree, Jane L.	**Wigand-Bolling**, Gwen	Dobson
Savinon, Carla E.	**Blue**, Tony O.	Wilmington
Spaulding, Rosemarie B.	**Shaftner**, Kimberly K.	Princeton
Stevens, Tanya B.	**Sowell**, James R.	Lenoir
Sugg, John B.	**Nasr**, Viviane	Raleigh
Taylor, Bobbie M.	**Kohn**, Harvey D.	Wagram
Trumble, Barbara G.	**Kornmayer**, John D.	Columbus
Voyles, Cynthia E.	**Shields**, Audrey W.	Cornelius
Werner, Margaret K.	**Haber**, Michele A.	Winston-Salem
Wilks, Kanzenner R.	**Haber**, Michele A.	Winston-Salem

PHYSICIAN ASSISTANT ADVISORY COUNCIL REPORT

Walter Pories, MD; Aloysius Walsh, Robin Hunter-Buskey, PAC

Present: Marc Katz, Justine Strand, Bill Dillard, Wade Marion, Debbie Hauser, Patricia Dieter, Wayne VonSeggen, Walter Pories, Elizabeth Kanof, Al Walsh, Diane Meelheim, Andy Watry.

The meeting was called to order at 4:05 pm by Wayne VonSeggen. A listing of the members, associate members, and ex officio members was circulated for correction of addresses and contact information.

It was announced that the Board had appointed Dr. Frank Leak and Wayne VonSeggen as ex officio members for a term of two years. The Board has yet to enact specific terms of office for the remainder of the Council. It was recommended that Lanny Parker, President Elect of the NCAPA be considered for appointment to the Council if the Board approves.

The proposed Bylaws for the PAAC were reviewed. Article 4.2 was amended to read: *"Meetings with the Full Board. The Council will request to meet with the full Board at least once per year, or as requested by the Board."* The motion to amend was passed. A motion to approve the Bylaws as amended was made, seconded, discussed, and approved.

After considerable discussion on the subject of the electronic medical record and physician cosignature of PA notes in an electronic medical record, a motion was made, seconded, and approved to request that the Board ask the Board staff to look into problems regarding the electronic medical record especially regarding PA-Physician countersignature issues.

Board staff requested feedback regarding on-line reregistration for PAs. Several PAs had positive comments, although there are some alignment issues on the form itself which may need attention. Board staff says that up to 60% of licensees are reregistering on-line, which is much higher than expected.

There had been a question from Glenn Pierce regarding looking into streamlining the licensure of PAs wishing to work in volunteer settings. He wondered whether a possible solution could be to model a potential change for volunteer licensure to be expeditiously processed like PAs in disaster settings. It was generally felt that our current requirements are suitable, but this will be a topic of discussion at the next meeting.

The next meeting will be March 13, 2001 at 4:00pm at the NCMB office in Raleigh. Agenda Items planned include: 1) Terms of Members, 2) Nomination & Election of Officers, 3) Review of Board Staff report on Electronic Countersignature, 4) Temporary Licensure after 1-1-2002. 5) Alternatives to 100% Countersignature of PA Notes. The Council was charged with investigating possible options related to this issue and bring some ideas to present to the next meeting.

The PAAC was adjourned at 5:40pm.

LICENSING COMMITTEE REPORT

Kenneth Chambers, MD; Robin Hunter-Buskey, PAC; E.K. Fretwell

Board Agents

Catchline: Mrs. Walston and Dr. Henry have expressed an interest in serving as Agents of the Board. The committee recommended Mrs. Walston and Dr. Henry be appointed as Agents of the Board.

Board Action: Appoint Mrs. Walston and Dr. Henry Agents of the Board.

A motion passed to close the session to investigate, examine, or determine the character and other qualifications of applicants for professional licenses or certificates while meeting with respect to individual applicants for such licenses or certificates.

The Board reviewed 11 licensure applications. A written report was presented for the Board's review. The Board adopted the committee's recommendation to approve the written report. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

SPLIT BOARD LICENSURE INTERVIEWS

A motion passed to close the session to investigate, examine, or determine the character and other qualifications of applicants for professional licenses or certificates while meeting with respect to individual applicants for such licenses or certificates.

Ten licensure interviews were conducted. A written report was presented for the Board's review. The Board adopted the committee's recommendation to approve the written report. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session

APPLICANTS PRESENTED TO THE BOARD

Jon Michael Adleberg
Michael Bentley Adler
Arshad Naveed Ahsanuddin
Barbara Darnell Aldridge
Melissa Y Wang Allan
Joanne Bell Allen
Ron Russell Allison
Marvin Winston Ashford Jr
Broadus Zane Atkins
Brenda Gibbs Baker
Christopher Guy Ballinger
Henry Maynard Bellamy
Marc David Benevides
Mark Jonathan Bennett
Billy Wayne Berry Jr.
Ira Stephen Bloomfield
Robin Lynn Boyd-Kranis
Andrea Carol Bradford
Marcia Elizabeth Bromley
Igor Mark Bron
Stephanie Delores Brown
Richard Carson Butler
James Daniel Byrne
Felicia Chang
Humaira Khawaja Chaudhary
Arlene Ng Chua
Joanne Marie Clinch
Dudley Deshon Crawford
Johnita Lyon Darton
Daniel Dominique De Meyts
Edna Ekva Ekuban-Gordon
Sherif Magy Elmasry
Jonathan Eli Fischer
David Michael Flannagan
Elizabeth Helen Foley
Laurie Beilstein Frueh
Freddie Florante Casimiro Floro Fuentes
Edward Simon Garbacz
Kenneth Ngu Achiri Geh
Peter Michael Giftos
Neal Michael Goldberger
Rajitha Goli
Martha Ann Goodrich
William Howard Grant Jr.
Kathleen Louise Grove
Nabila Abdel Aziz Haikal
John Pierre Hakim
Marc Charles Hamburg
Kari Leah Hayes
Christy Louise Henry
Jo Ellen Hirsch
John Franklin Hoy
Michael Webb Hughes
James Ronald Humbert

David Scott Humphries
John Thomas Janousek
Matthew Bradley Jennings
Sue Joan Jue
Terry Wayne Kersey Jr.
Erika Christine Lambert
Beverly Caren Land
David Lee Lang
Catherine Ann Lawrence
Melissa Anderson Laxton
Francis Kiet Le
Robert Edward Murray LeBlanc
Peter Fisher Lebowitz
Kenneth Scott Lerrick
Robert Irwin Lesowitz
Kathryn Elizabeth Long
Bohdan Malyk
Mehul Vipul Mankad
Anthony James Manuel
Samuel Maurice Massoud
Lahar Raj Mehta
Lida Patricia Mesa
David Aaron Miller
William Gardner Montgomery
Stephen Christopher Mullins
Bilal Naeem
Girish Venugopalan Nair
Roland Ng
Cornelius Sunday Okonkwo
James Douglas Okun
Niccole Mambu Oswald
Jashvantkumar Gamgarambhai Patel
Manesh Raman Patel
Winston Campbell Patterson
Majorie Pearsall
Edwin Ariel Perez
Terry Lee Pieper
James Alexander Leader Pittman
Sunil Narsing Prasad
Dinesh Shiva Rao
Lisa LaVallee Ray
Kay Lynne Redman
Carey Ann Robar
Sara Lynn Rooker
Joyce Iris Ross
Timothy Starling Roush
Cheryl Anne Russo
John Mark Ryan
Richard Andrew Santa-Cruz
William Floyd Sayers
Karen Russell Schmidt
Narayanswami Chandra Sekharan
David Min Suk Seo
Robert Alexander Shaffer
Paul Flanagan Shea
Wendy Lyn Smith
Simone Sommer
Jerzy Antoni Sopala
Jill Elizabeth Spadia
Robert Edward Stambaugh
Iris Eileen Torres
Michael Edward Tschickardt
Daniel Chidi Uba
Ashfaq Uraizee
Carol Louise Venable
Gordana Vlahovic
Christopher Alan Wallace
Robert Edmond Walters Jr.
Elizabeth Mary Weaver
Joseph Scott Welch
Mark Alan Whiting
Richard Taylor Williams
James Elbert Winslow III
Kristi Elena Woods
John Joseph Wyland
Yu Zhu

LICENSES ISSUED BY ENDORSEMENT AND EXAM

Michael Bentley Adler
Arshad Naveed Ahsanuddin
Barbara Darnell Aldridge
Melissa Y Wang Allan
Joanne Bell Allen
Ron Russell Allison
Broadus Zane Atkins
Brenda Gibbs Baker
Christopher Guy Ballinger
Marc David Benevides
Billy Wayne Berry Jr.
Ira Stephen Bloomfield
Robin Lynn Boyd-Kranis
Andrea Carol Bradford
Marcia Elizabeth Bromley
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Gordana Vlahovic
Christopher Alan Wallace
Robert Edmond Walters Jr.
Elizabeth Mary Weaver
Joseph Scott Welch
Mark Alan Whiting
Richard Taylor Williams

James Elbert Winslow III
Kristi Elena Woods
Yu Zhu

INTERVIEW FORMS NOT YET RECEIVED
Girish Venugopalan Nair

REINSTATEMENTS (long process)
Stephen Christopher Mullins
Ashfaq Uraizee

REACTIVATIONS(short process)
Jon Michael Adleberg
Felicia Chang
David Scott Humphries
Majorie Pearsall
Simone Shulamith Sommer

FACULTY LIMITED LICENSE
Mark Jonathan Bennett
James Alexander Leader Pittman

NORTH CAROLINA PHYSICIANS HEALTH PROGRAM (NCPHP) COMMITTEE REPORT

Kenneth Chambers, MD; John Dees, MD; Stephen Herring, MD

A motion passed to close the session to prevent the disclosure of information that is confidential pursuant to section 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes.

The Board reviewed 26 cases involving participants in the NC Physicians Health Program. A written report was presented for the Board's review. The Board adopted the committee's recommendation to approve the written report. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

COMPLAINT COMMITTEE REPORT

John Dees, MD; Elizabeth Kanof, MD; Walter Pories, MD; Aloysius Walsh

The full Board reviewed and approved the complaint committee report noted below.

A motion passed to close the session to prevent the disclosure of information that is confidential pursuant to sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes.

The Complaint Committee reported on 43 complaint cases. A written report was presented for the Board's review. The Board adopted the committee's recommendation to approve the written report. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

INVESTIGATIVE COMMITTEE REPORT

Paul Saperstein; Stephen Herring, MD; Robin Hunter-Buskey, PA-C; John Foust, MD

A motion passed to close the session to prevent the disclosure of information that is confidential pursuant to sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes.

The Investigative Committee reported on two investigative cases. A written report was presented for the Board's review. The Board adopted the committee's recommendation to approve the written report. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

INFORMAL INTERVIEW REPORT

A motion passed to close the session to prevent the disclosure of information that is confidential pursuant to sections 90-8, 90-14, 90-16 and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes.

Thirty informal interviews were conducted. A written report was presented for the Board's review. The Board adopted the Split Boards' recommendations and approved the written report as modified. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

MALPRACTICE COMMITTEE REPORT

John Dees, MD; Elizabeth Kanof, MD; Walter Pories, MD; Aloysius Walsh

A motion passed to close the session to prevent the disclosure of information that is confidential pursuant to sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes.

The Malpractice Committee reported on 17 cases. A written report was presented for the Board's review. The Board adopted the committee's recommendation to approve the written report. The specifics of this report are not included as these actions are not public information.

Motion: A motion passed to approve the report as presented.

A motion passed to return to open session.

ADJOURNMENT

This meeting was adjourned on January 26, 2001.

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John T. Dees, MD
Secretary/Treasurer