MINUTES

North Carolina Medical Board

January 22-25, 2003

1201 Front Street, Suite 100
Raleigh, North Carolina

Minutes of the Open Sessions of the North Carolina Medical Board Meeting January 22-25, 2003.

The January 22-25, 2003, 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 8:09 a.m., Wednesday, January 22, 2003, by John T. Dees, MD, President. Board members in attendance were: Charles L. Garrett, MD, President Elect; Stephen M. Herring, MD, Secretary; Mr. Hari Gupta, Treasurer; E. K. Fretwell, PhD; Robin N. Hunter-Buskey, PA-C; H. Arthur McCulloch, MD; Robert C. Moffatt, MD; Michael E. Norins, MD; Walter J. Pories, MD; Edwin R. Swann, MD; and Mr. Aloysius P. Walsh.

Staff members present were: R. David Henderson, JD, Interim Executive Director/Operations Department Director; Thomas W. Mansfield, JD, Legal Department Director; Mary Wells, JD, Board Attorney; Brian Blankenship, JD, Board Attorney; Marcus Jimison, JD, Board Attorney; Ms. Wanda Long, Legal Assistant; Ms. Lynne Edwards, Legal Assistant; Mr. John W. Jargstorf, Investigative Director; Mr. Don R. Pittman, Investigative Field Supervisor; Mr. Edmond Kirby-Smith, Investigator; Ms. Kate Mahony, Investigator; Mr. Fred Tucker, Investigator; Mrs. Therese Dembroski, Investigator; Ms. Barbara Brame, Investigator; Ms. Edith Moore, Investigator; Mr. Jason Ward, Investigator; Ms. Jenny Olmstead, Senior Investigative 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; Ms. Kathleen Lopez, Licensing Assistant; Ms. Alexa Kapetanakis, PA/NP Coordinator; Ms. Michelle Lee, Licensing Assistant; Tammy O'Hare, Licensing Assistant; Ms. Annette Marcussen, Licensing Assistant; Gary Townsend, MD, JD, Medical Coordinator; Mitchell S. Collman, MD, Assistant Medical Coordinator; Ms. Judie B. Clark, Complaint Department Director; Mrs. Sharon Squibb-Denslow, Complaint Department Assistant; Ms. Sherry Hyder, Complaint Department Assistant; Ms. Patricia Paulson, Complaint Department Staff; Ms. Deborah Aycock, Operations Assistant/HR Coordinator; Ms. Rebecca L. Manning, Information Specialist; Mrs. Janice Fowler, Operations Assistant; Mr. Peter Celentano, Controller; Mr. David Shere, Receptionist; Mr. Donald Smelcer, Director, IT Department; Ms. Brandy Forward, Compliance Department Director; and Mr. Jeffery T. Denton, Executive Assistant/Board Secretary.

MISCELLANEOUS

Presidential Remarks

Dr. Dees commenced the meeting by reading the North Carolina Board of Ethics' "ethics awareness and conflict of interest reminder." He thanked the Board and staff for all that has been done and continues to be done through these last two months which have been very trying.

Dr. Dees announced that Dr. Garrett would be presiding over the hearing for Dr. Rosner, and that Drs Herring and Moffatt are both recused from the hearing.

Audit Report

Mr. Lynwood Jackson, CPA, Lynch & Howard

Mr. Jackson reviewed the North Carolina Medical Board Audit for fiscal year 2002.

Motion: (WP, RM) A motion passed to accept the Audit Report as presented.

Evaluation of Statement of Economic Interest

In accordance with Section 5 (b) of Executive Order Number One, Harlan A. McCulloch, MD, and Edwin R. Swann, MD received copies of letters from the Board of Ethics citing the following: (1) Dr. McCulloch had no actual conflict of interest but potential for conflict of interest. "Dr. McCulloch is a licensed physician and is under the jurisdiction of the NC Medical Board. As such, he should exercise the proper caution while performing his official duties," and (2) Dr. Swann had no actual conflict of interest but potential for conflict of interest. "Dr. Swann is a licensed physician and is under the jurisdiction of the NC Medical Board. As such, he should exercise the proper caution while performing his official duties."

FSMB Resolution – Delay Implementation of the Clinical Skills Assessment Exam

Daryl C. Osbahr, a medical student at UNC Chapel Hill, requested and was allowed time before the Board to present a proposed resolution to the Federation of State Medical Boards titled "Delay Implementation of the Clinical Skills Assessment Exam" which he would like to the Board to sponsor.

Dr. Dees stated he had received calls and contacts regarding this issue and that, the Chair after consultation with other Member of the Board has agreed to have a brief discussion from the public who wish to comment on the proposed resolution.

Elizabeth P. Kanof, MD: I am here to speak on behalf of the students. This is a licensing issue and therefore merits the attention and concern of the Board. If current trends continue 23% of all students will become our licensees. All four of our schools have taught and assessed clinical skills for 10 years. To use our future licensees with each an average of $100,000 in debt upon graduation, as a tool to force the less than 20% of medical schools which do not have clinical assessment courses to comply seems unfair to me. The debate has been active since last June. There have been no substantial changes on the part of the Federation to ease the student's concerns. The debate has triggered such issues as would USMLE III rather than II be the more appropriate time for testing clinical skills. I don't doubt that decades ago setting licensure standards motivated schools to upgrade their curriculums. At this point in time regarding this issue it might be resolved if the LCME and AOA would require all medical schools to vigorously and consistently assess clinical skills of all students as a requirement for graduation. I feel confident that if the Board would be willing to assume a leadership role by submitting a resolution to the April Meeting of the Federation that it is likely other states will cosponsor. Even if they don't, the issue would be thoroughly aired and discussed. I want you to be aware of the overwhelming testimony at the AMA last June and December in support of the students. It is disturbing that for the first time in years the President of the AMA is not invited to address the Federation.

Daryl C. Osbahr: In part he stated that UNC has a CPX exam that is offered right now. Eighty percent of medical schools are offering clinicals skills testing now. It is very important at the upcoming Federation meeting that this is addressed.

Peter V. Scoles, MD, Senior Vice President NBME, Philadelphia: He stated in part that the NBME was tasked to develop this test and it has taken 15 years to develop and test it. They have been asked to conduct studies which are now complete. The analysis information was released yesterday and will be public in 1.5 weeks. They found the test to be valid and it can be equated. They find it is a challenge for a significant number of medical students. In this test the standards that were used were those applied to the ECFMG students which is an accepted testing procedure.

Motion: (CG, MN) A motion passed not to adopt the proposed resolution submitted by Mr. Osbahr.

The Board discussed the issue. Dr. Garrett stated that there is a big difference in supporting the students than submitting a resolution on their behalf. He is glad we have supported the students and thinks there are still some problems with the clinical skills exam but does not believe it is the job of the Medical Board to support this resolution. Drs McCulloch and Moffatt spoke in favor of the resolution. Dr. Dees stated that he has thought about this a lot. He approves of a lot of the things this Board has already done but now the Medical Board is being asked to sponsor a resolution this is not their own resolution. He summed up things by stating "I assure you that whatever happens in Chicago (location of the upcoming Federation meeting) will probably not be the end of it.

Bylaws Amendment

The following Bylaws amendment was distributed to all Board Members at the December 18, 2002 Board Meeting in order to comply with the 30-day notice for amendment of the Bylaws.

BYLAWS
of the
NORTH CAROLINA MEDICAL BOARD

ARTICLE I
OFFICES

Section 1. Principal Office. The Board shall have a principal office in North Carolina.

Section 2. Other Offices. The Board may have other offices.

ARTICLE II
BOARD POWERS, COMMITTEES, AND COMPENSATION

Section 1. General Powers. The Board itself has all its general powers.

Section 2. Committees. The Board may designate one or more Committees. The President shall appoint Committee members. Committees have no powers other than: (a) to review matters and recommend actions to the Board, (b) to initiate or continue investigations or inquiries, including, in the committees' sole discretion, the use of Board process (subpoenas, orders, or the like) in furtherance thereof, (c) to empower staff, either generally or in a specific instance, to initiate or continue investigations or inquiries, including, in the committees' sole discretion, the use of Board orders to produce documents or things, (d) to employ experts to evaluate evidence in matter under investigation or inquiry, and (e) those powers authorized by the Board.

Section 3. Executive Committee. There shall be an Executive Committee comprised of the Officers of the Board, who are chosen in accordance with Article IV of these Bylaws, along with the Immediate Past President of the Board. In the event the Immediate Past President is not available to serve on the Executive Committee, the position on the Executive Committee reserved to the Immediate Past President shall be filled by a vote of a majority of the

total membership of the Board as to a candidate nominated to the Board by the Executive Committee.

Section 4. Compensation. The Board may pay per diem and expenses to the maximum extent permitted by law.

ARTICLE III
MEETINGS OF THE BOARD

Section 1. Regular Meetings. Regular meetings will occur as scheduled.

Section 2. Special or Emergency Meetings. Special or Emergency meetings of the Board may be called by the President or in the event of the unavailability of the President by the President-Elect.

Section 3. Notice of Meetings. Notices of meetings shall be given as required by law.

Section 4. Quorum. A quorum of the Board is a majority of the members.

Section 5. Manner of Acting. Except as otherwise provided herein, the Board acts by simple majority vote of the members present at a meeting at which there is a quorum.

Section 6. Participation by Conference Telephone. The Board may meet by electronic means to the maximum extent permitted by law.

ARTICLE IV
OFFICERS

Section 1. Officers of the Board. The officers of the Board shall consist of a President, a President-Elect, a Secretary, and a Treasurer. The offices of Secretary and Treasurer may be held by a single person.

Section 2. Election and Term. The officers of the Board shall be elected annually by the Board. Term of office is November 1st to October 31st. The Executive Committee shall nominate to the Board at its July meeting a slate of the candidates for the above offices for the coming term. The Board shall vote on the entire slate. The slate is approved when a majority of the total membership of the Board votes in favor of the slate. This process shall continue at the Board's July meeting until a slate is elected.

Section 3. Vacancies. In the event that the President fails to serve out his or her term as provided in this Article for whatever reason, then the President-Elect shall assume the office of President and hold the office of President for the remainder of the departed President's term. The President completing the term of the departed President shall be eligible to serve a full term as President after completing the term of the departed President. In the event an officer other than the President fails to serve out his or her term as provided in this Article for whatever

reason, the vacancy shall be filled by a vote of a majority of the total membership of the Board as to a candidate nominated to the Board by the Executive Committee.

Section 4. Removal. Any officer may be removed from office by a vote of a majority of the total membership of the Board at any time.

Section 5. President. The President shall be the principal executive officer of the Board. The President shall, when present, preside at all meetings of the Board. The President shall sign documents for the Board.

Section 6. President-Elect. The President-Elect shall, in the absence or disability of the President, have all the authority and perform the duties of the President.

Section 7. Secretary. The Secretary shall have the responsibility and authority to maintain and authenticate the records of the Board. The Secretary shall, in the absence or disability of the President and the President-Elect, have all the authority and perform the duties of the President.

Section 8. Treasurer. The Treasurer shall have charge and custody of all funds and securities belonging to the Board and shall keep, or cause to be kept, full and accurate records of the finances of the Board. The Treasurer shall, in the absence or disability of the President, President-Elect, and the Secretary, have all the authority and perform the duties of the President.

ARTICLE V
PROFESSIONAL STAFF

Section 1. Professional Staff. The Board shall employ a Professional Staff to assist it, in whatever lawful way it may prescribe, in the discharge of its duties under and to enforce the laws regulating the practice of medicine or surgery.

Section 2. Executive Director. The Board shall employ an Executive Director who shall lead and manage, hire and dismiss, the Professional Staff. The officers of the Board shall evaluate the Executive Director annually. ~~The Executive Director may be removed only by action of the Board taken after recommendation of the officers of the Board and the affirmative vote of two-thirds (2/3) of the total membership of the Board.~~

ARTICLE VI
GENERAL PROVISIONS

Section 1. Seal. The seal of the Board shall consist of two concentric circles between or within which is the name of the Board.

Section 2. Fiscal Year. The fiscal year of the Board shall be fixed by resolution of the Board of Directors.

Section 3. Amendments. Except as otherwise provided herein or by applicable law, these Bylaws may be amended or repealed and new bylaws may be adopted after a thirty (30) day notice by a vote of two-thirds (2/3) of the total membership of the Board.

Section 4. Rules of Order. To the extent that matters of procedure are not addressed in these Bylaws or in applicable sections of the North Carolina General Statutes or North Carolina Administrative Code, the Board shall follow parliamentary procedure as set forth in Rules of Order: An Authoritative, Simplified Guide to Parliamentary Procedure, by James E. Davis (Chicago Review Press, 1992).

Motion: (WP, EKF) A motion passed to adopt the Bylaws a amended above.

MINUTE APPROVAL

Motion: A motion passed that the December 18-19, 2002, Board Minutes be approved as amended.

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 and 143-318.11(a) 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.

Thomas Mansfield, Legal Director, presented his report.

PENDING CASES

A written report on 140 cases was presented for the Board's review. The specifics of this report are not included as these actions are not public information.

Motion: A motion was passed by the Board to approve the report as amended.

A motion passed to return to open session.

EXECUTED CASES

BREWER, Thomas Edmund Jr. MD
Consent Order executed 12/10/2002

HAMBLETON, Scott Lewis MD
Consent Order executed 12/10/2002

SAPPINGTON, John Shannon MD

Charge executed 12/19/2002

HEARINGS

ROSNER, Michael John MD
Henersonville, NC
DATE OF BIRTH: 12/04/1946
SPECIALTY: NS

BLB/DLE
CASE NUMBER: 2002-11226-001

HEARING: January 23-25, 2003

BOARD ACTION: Indefinite suspension. MD may not reapply for six months.

PUBLIC AFFAIRS/COMMUNICATIONS PROGRAM REPORT

Dale Breaden, Communications Director, presented his report regarding *Forum*, website hits, staff and Board presentation.

POLICY COMMITTEE REPORT

Charles Garrett, MD, Chair; Stephen Herring, MD; Aloysius Walsh; Michael Norins, MD; Arthur McCulloch, MD

The Policy Committee of the North Carolina Medical Board was called to order at 3:33 PM, Wednesday, December 18, 2002, at the office of the Board. Present were: Charles L. Garrett, MD, Chair; Stephen M. Herring, MD; Michael E. Norins, MD; Aloysius P. Walsh; and Arthur McCulloch, MD. Also attending were Walter Pories, MD, Board member; Michael Crowell, JD, Tharrington Smith, Attorneys at Law; Jane Pine Wood, JD, McDonald, Hopkins, Burke & Haber, Attorneys at Law; Julian D. Bobbitt, Jr, JD, Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan; Howard Kramer, JD, General Counsel, North Carolina Board of Nursing; Johnny M. Loper, JD, Womble, Carlyle, Sandridge & Rice; Melanie Phelps, JD, North Carolina Medical Society; Steve Keene, JD, North Carolina Medical Society; Thomas Mansfield, JD, Board Attorney, NCMB (PC Staff); Dale G Breaden, Director, Public Affairs, NCMB (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.

Minutes (Dr Garrett)

The October 2002 Policy Committee Meeting minutes were presented for information only, having been approved previously.

(Dr Herring presided for discussion of the following item, Dr Garrett being recused)

Purchased Laboratory Tests (Dr Herring and Mr Mansfield)

At the June 2002 Board meeting, a motion passed that the Board and Medical Society's attorneys jointly seek a private opinion from the AMA Council on Ethical and Judicial Affairs concerning this issue, asking them if it represents a violation of medical ethics.

Since then, further information has been received, including a policy developed by the North Carolina Society of Pathologists (NCSP). It was also reported that the president of

the North Carolina Medical Society is willing to put together a working group of the Society and Board members to review the issue. At the October 2002 Committee meeting, several guests spoke, including Keith Nance, MD, President, North Carolina Society of Pathologists; Laura Lomax, MD, President, North Carolina Dermatology Association; William S. Ketcham, MD, practicing dermatologist; John Bower, MD, practicing pathologist; and Michael Crowell, JD, of the Tharrington Smith Law Firm. No further Committee discussion of this item was called for at this meeting. However, the following comments were received from interested individuals attending the meeting.

Michael Crowell, JD, repeated his position of October that the Board should have a position statement on markups. He then introduced Jane Pine Wood, JD. Ms Wood indicated that she represents 85 groups in 35 states. She reviewed several issues: the incentive for the national pathology provider to get Medicare work; the element of quid pro quo; medical work in exchange for discounts; the physician's looking for the most cost effective provider and not necessarily the best quality provider; possible violation of anti-kickback law; the AMA's ethical opinion, adopted over 20 years ago, that physicians should not be purchasing services and putting a markup on those services; the need for more specific guidance for physicians in North Carolina; states that require direct billing; states that take a position that services can be marked up as long as the bill shows what that markup is. She expressed concern that North Carolina is unregulated in this regard and the Inspector General of HHS has said they could view a discount by a pathology provider to a physician as violation of the anti-kickback law. In her clients' jurisdictions, where by statute a markup for a handling fee is permitted, the fees are generally under $10, and are tied to the service. However, it is not uncommon for discounts to be offered on pathology services of up to 50%, with physicians adding a markup.

Dr Herring thanked the guests for coming. He indicated this information will be distributed to and addressed by the Committee at a future time.

(Dr Garrett resumed the chair.)

Alternative Medical Malpractice Payment Systems (Mr Keene and Mr Mansfield)

At the June 2002 Committee meeting, Dr Garrett said the Legal Department was going to look into alternative medical malpractice payment systems that allow the organization a physician works for to make malpractice settlement payments without identifying the physician. Mr Keene indicated he had read in the Federal Register about a proposed rule making that would close this particular loophole (if done by an organization for a physician, the name of the practitioner would still have to be reported).

At the August 2002, meeting Mr Keene said he had spoken to National Practitioner Data Bank (NPDB) officials, including Ms Cynthia Grubbs, to determine the status of rule making in this area. They indicated that the original notice of proposed rule making (NPRM) has been withdrawn, and that a revised NPRM is expected to be published within 6-12 months. He distributed the original December 1998 NPRM and the April 2000 status report indicating the rule was being withdrawn. There was nothing new to report at this meeting.

Action: This item will remain on the agenda until such rule making occurs. In the meantime, Mr Mansfield is to take a look at this question and consider getting an advisory opinion from the North Carolina AG in relation to the North Carolina reporting requirement.

Office Based Surgery: Consideration of NCMS Task Force Recommendations (Dr Garrett)

At the August 2002 Committee meeting, Dr Garrett stated that the Policy Committee received a charge from the president of the Board to consider the NCMS recommendations. At that time, with a heavy Committee agenda already in place for August, he felt it would not be appropriate to devote the majority of the meeting to the Task

Force material. Dr Garrett then inventoried the related material on hand at the time for review and study.

At the October 2002 Committee meeting, several amendments to the Task Force recommendations were proposed and were accepted for inclusion in the updated marked copy. All information received regarding the OBS Task Force Recommendations was referred to the Board's Legal Department. Mr Mansfield conducted a review of the material and created a working group that included all the attorneys of the several organizations and groups involved with the issue.

At this Committee meeting, Dr Garrett reported that the dermatologist have withdrawn their request to redefine "minor field block."

Mr Mansfield reported that the attorneys involved have had various telephone calls and meetings. After considering all input, he recommends adopting these recommended guidelines in the form of a position statement and states his view that such a course is lawful and appropriate. He suggests adding the following language with a footnote referencing the specific NC statute: "Nothing in this position statement affects the scope of activities subject to or exempted from the North Carolina health care facility licensure laws." He advised the Committee that the Board could be challenged in court on this issue, but he does not think the document is an attempt to regulate nurses or restrict the work of CRNA's. He does not think adoption of the recommendations in such a form would violate any laws--it would simply be a position statement intended to inform our licensees, not mandate what any other profession could do. It should not change anything in the physician/CRNA relationship.

Howard Kramer, JD, requested that a copy of the Board of Nursing letters of December 16 and July 17, 2002 to the Medical Board be included as part of the Policy Committee minutes. He disagrees with Mr Mansfield, stating that whether you call it a guideline or a position statement, if it carries with it potential disciplinary action by the Board against a licensee, it is a rule. He feels it is the word "collaboration" should replace the word "supervision."

Recommendation to Board: The Policy Committee recommends that the Office Based Surgery Task Force Report be adopted as now amended. Following which: (1) it be turned over to the Legal Department to be formatted as a position statement without change in content, and (2) it then be brought back to the full Board in January for consideration of the format.

[NOTE: The Board approved this recommendation at its meeting on December 19.]

Optometrists Performing Certain Injections (Dr Garrett and Mr Mansfield)

September 18, 2002, Dr Pories thanked the North Carolina Board of Optometry for notifying the Medical Board regarding optometrists treating and managing chalazia. Dr Garrett described chalazia in detail. There was a consensus that the NC Medical Board is concerned about non-physicians performing this procedure. On September 19, 2002, the Medical Board sent a letter to the Board of Optometry stating: "The Medical Board understands from your memorandum of August 13, 2002, to North Carolina Licensed Optometrists (a copy of which is attached) that your Board is preparing to issue 'privileges' to perform certain procedures requiring injections in the practice of Optometry." The Board has reviewed your memorandum and is concerned that the activities contemplated may constitute the unlicensed practice of medicine. The Medical Board wishes to advise your Board that it may take legal action in the event that optometrists perform acts that constitute the practice of medicine."

At this meeting Dr Garrett stated that it appears that the optometrists are going to begin training and certifying optometrists to do injections within the next 60-90 days. He believes it is going to happen even though they have been put on notice that that would be a violation of

the MPA and the Medical Board would take action. Since it seems inevitable, he requests that Mr Mansfield be authorized to enter into conversation with Mr Loper, who represents the Board of Optometry, to see if we can bring this issue before a judge and get a ruling before the optometrists go forward with the injections.

Mr Mansfield indicated he has spoken briefly with Mr Loper and they would like the opportunity to discuss this approach, to try to resolve differences, and to see if there is a way to get a ruling. This will take time and resources.

Mr Loper indicated he did not know if the optometrists' current course of action could be held off, but he will be happy to sit down with his clients and see if they will entertain a standstill until "litigation by agreement could occur." He indicated that in his experience it would be hard to get in front of a judge and get a decision in 60-90 days.

Mr Bobbitt, representing the North Carolina Society of Ophthalmologists, commended this approach, saying it keeps anyone from getting hurt.

Recommendation to Board: Mr Mansfield is authorized to confer with Mr Loper on this matter to see what can be done to facilitate the approach proposed.

Motion: A motion passed that Mr. Mansfield is authorized to confer with Mr. Loper on this matter to see what can be done to facilitate the approach proposed.

Disruptive Physicians (Drs Herring and Norins)

At the August 2002 Committee meeting it was noted that the state of Utah has been developing a policy statement on disruptive behavior among physicians, though it has not yet been adopted. Dr Garrett stated the Board has talked about this in the past and previously decided to follow the Georgia guidelines until staff was able to supply relevant North Carolina data and decide whether to pursue drafting North Carolina guidelines. Drs Herring and Norins were asked to review the Utah policy, the FSMB Report of the Special Committee on Professional Conduct and Ethics, the Georgia Problem Physician Guide, and any other relevant material to determine if North Carolina could benefit from a policy statement on disruptive physicians. Drs Herring and Norins separately provided their own versions of a possible position statement to the Committee, both agreeing that a statement is needed.

At the October 2002 Committee meeting, Drs Herring and Norins were asked to collaborate on a proposal prior to the December meeting. At this meeting, a revised version of a possible statement on the disruptive physician, combining the substance of their initial proposals, was distributed.

Action: Drs Herring and Norins are to collaborate further on their proposal for presentation at the February 2003 Committee meeting.

Possible Position Statement on Professionalism

At the October 2002 Committee meeting, Dr Kanof provided a draft of possible key elements for a position statement on professionalism. The Legal Department was to review this proposal with Mr Breaden for possible development of a draft position statement based on the results of that review for consideration at the December Committee meeting.

Mr Mansfield, Dr Townsend and Mr Breaden jointly provided the following comment: "While we understand the concerns that motivate this proposal, we believe it would be unwise to attempt a definition of professionalism when the Board now has broad flexibility in that area under the statute. Any effort to specifically define the elements of professionalism would inevitably place limits on the Board's options and would, in effect, place the Board in a box. Beyond that this particular proposal is unfocused and its several elements seem random in nature."

Action: Proposal is filed.

Possible Board Policy on Qualifications for Expert Review

At the October 2002 Committee meeting, Dr Kanof provided a draft of possible elements for development of a proposed Board policy regarding qualifications for expert review. This proposal was to be reviewed by the Executive director, Mr Mansfield, and Dr Townsend. Mr Breaden was to prepare a policy statement based on their review for consideration at the December Committee meeting.

Mr Mansfield, Dr Townsend and Mr Breaden jointly provided the following comment: "Rather than address this particular text, this subject might best be dealt with by asking Dr Townsend and those other staff who are involved in the selection of experts to note the qualifications and requirements they now set and then have the Committee review the material and raise any concerns or make any suggestions it might have. This process would allow development of a written policy based on identified needs, practical experience, and reasonable expectations."

Action: Proposal is tabled until the February Committee meeting. Those currently dealing with expert reviewers are to provide the guidelines they currently use for choosing expert reviewers for the Committee's consideration at that time.

Possible Board Policy on Medical Expert Witness

At the October 2002 Committee meeting,
Drs Kanof and Herring provided a draft of possible elements for development of a proposed Board policy regarding medical expert witnesses. This proposal was to be reviewed by the Executive Director, Mr Mansfield, and Dr Townsend. Mr Breaden was to prepare a policy statement based on their review for consideration at the December Committee meeting.

Mr Mansfield, Dr Townsend and Mr Breaden jointly provided the following comment: "It appears an effort to address this issue in such detail would have the potential to inhibit the board's freedom of action in dealing with the question of professionalism in the performance of physicians serving as expert witnesses. In this context, as in others, the Board speaks most clearly through its action in specific cases. If a Position Statement were felt to be needed in any case, it should probably consist of no more than a simple expression of the basic idea offered in the opening paragraph of the suggested statement: testimony should be truthful, unbiased, and objective. The more elaboration, the more chance of limiting the Board's options."

Mr Mansfield thinks we don't need a position statement at all since this matter is currently covered by three different entities: (1) societies set the standards, (2) courts decide who gets to testify, and (3) the MPA.

Action: Proposal is tabled until the February Committee meeting.

Board's Physician-Patient Relationship Statement (Mr Henderson)

The Board recently received a letter from Fred M. Carmichael, JD, of Sumrell, Sugg, Carmichael, Hicks & Hart, PA, who asked for comments and the position of the Board on several detailed questions regarding the establishment and/or termination of the physician-patient relationship described in specific situations noted in his correspondence.

Mr Henderson commented that he had already spoken with the North Carolina Medical Society, which is currently conducting a study of these issues. He also spoke with Mr Carmichael, who seemed to be satisfied with holding off a response from the Board until the Medical Society completes its study. The Medical Society has agreed to fold Mr Carmichael's questions into their study.

Action: This item will be tabled until the Medical Society completes its study and the Board has had the opportunity to review the results of that study. The Medical Society will also study the issue of specialty surgeons being required to take call for general surgery.

Agenda Item 5: Issue of Drug Approvals by Insurers

All materials requested from FSMB and Mr Keene having been received, this item is now deleted from the agenda.

There being no further business, the meeting adjourned at 5:10 PM, Wednesday, December 18, 2002. The next regular meeting of the Policy Committee is tentatively set at 3:30, Wednesday, February 19, 2003.

Motion: A motion passed to adopt the Policy Committee Report.

January 23, 2003

Office Based Procedures

At the January 23, 2003 Board Meeting Mr. Mansfield presented the previously adopted Office Based Surgery Task Force Report as reformatted for a Board Position Statement to the Full Board. It was carefully reviewed with minor changes being made for consistency purposes.

Motion: A motion passed that the below Position Statement of the North Carolina Medical Board on Office-Based Procedures be adopted as amended.

POSITION STATEMENT OF THE NORTH CAROLINA MEDICAL BOARD
ON
OFFICE-BASED PROCEDURES

PREFACE

THIS POSITION STATEMENT ON OFFICE-BASED PROCEDURES IS AN INTERPRETIVE STATEMENT THAT ATTEMPTS TO IDENTIFY AND EXPLAIN THE STANDARDS OF PRACTICE FOR OFFICE-BASED PROCEDURES IN NORTH CAROLINA. THE BOARD'S INTENTION IS TO ARTICULATE EXISTING PROFESSIONAL STANDARDS AND NOT TO PROMULGATE A NEW STANDARD.

THIS POSITION STATEMENT IS IN THE FORM OF GUIDELINES DESIGNED TO ASSURE PATIENT SAFETY AND IDENTIFY THE CRITERIA BY WHICH THE BOARD WILL ASSESS THE CONDUCT OF ITS LICENSEES IN CONSIDERING DISCIPLINARY ACTION ARISING OUT OF THE PERFORMANCE OF OFFICE-BASED PROCEDURES. THUS, IT IS EXPECTED THAT THE LICENSEE WHO FOLLOWS THE GUIDELINES SET FORTH BELOW WILL AVOID DISCIPLINARY ACTION BY THE BOARD. HOWEVER, THIS POSITION STATEMENT IS NOT INTENDED TO BE COMPREHENSIVE OR TO SET OUT EXHAUSTIVELY EVERY STANDARD THAT MIGHT APPLY IN EVERY CIRCUMSTANCE. THE SILENCE OF THE POSITION STATEMENT ON ANY PARTICULAR MATTER SHOULD NOT BE CONSTRUED AS THE LACK OF AN ENFORCEABLE STANDARD.

GENERAL GUIDELINES

THE PHYSICIAN'S PROFESSIONAL AND LEGAL OBLIGATION

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

procedural and anesthesia care delivered in the office setting, including compliance with all aspects of these guidelines.

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

EXEMPTIONS

These guidelines do not apply to Level I procedures.

WRITTEN POLICIES AND PROCEDURES

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

Emergency Procedure and Transfer Protocol

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

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

Infection Control

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

Performance Improvement

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

Performance improvement activities should include, but are not limited to, review of mortalities; the appropriateness and necessity of procedures performed; emergency transfers; reportable complications, and resultant outcomes (including all postoperative infections); analysis of patient satisfaction surveys and complaints; and identification of undesirable trends (such as diagnostic errors, unacceptable results, follow-up of abnormal test results, medication errors, and system

problems). Findings of the performance improvement program should be incorporated into the practice's educational activity.

Medical Records and Informed Consent

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

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

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

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

CREDENTIALING OF PHYSICIANS

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

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

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

- didactic course complemented by hands-on, observed experience; training is to be followed by a specified number of cases supervised by a practitioner already competent in the respective procedure, in accordance with professional society standards.

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

ACCREDITATION

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

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

PATIENT SELECTION

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

ASA Physical Status Classifications

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

Candidates for Level II Procedures

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

Candidates for Level III Procedures

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

SURGICAL OR SPECIAL PROCEDURE GUIDELINES

Patient Preparation

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

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

The physician performing the surgical or special procedure also should:

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

Discharge Criteria

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

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

Information to the Patient

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

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

6. designated treatment hospital in the event of emergency.

REPORTABLE COMPLICATIONS

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

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

EQUIPMENT MAINTENANCE

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

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

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

COMPLIANCE WITH RELEVANT HEALTH LAWS

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

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

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

Patient Rights

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

ENFORCEMENT

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

LEVEL II GUIDELINES

PERSONNEL

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

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

Surgical or Special Procedure Guidelines

Intraoperative Care and Monitoring

- The physician who performs Level II procedures that require conscious sedation in an office should ensure that monitoring is provided by a separate health care professional not otherwise involved in the surgical or special procedure. Monitoring should include, when clinically indicated for the patient:
  1. direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
  2. pulse oximetry should be performed continuously (an alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness);
  3. an electrocardiogram monitor should be used continuously on the patient;
  4. the patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes; and
  5. the body temperature of a pediatric patient should be measured continuously.
-

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

Postoperative Care and Monitoring

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

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

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

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

Equipment and Supplies

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

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

LEVEL III GUIDELINES

Personnel

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

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

Surgical or Special Procedure Guidelines

Intraoperative Monitoring

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

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

Postoperative Care and Monitoring

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

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

Recovery from a Level III procedure should be monitored by an ACLS certified (PALS or APLS certified when appropriate) health care professional using appropriate criteria for the level of

anesthesia. At least one health care professional who is ACLS certified should be immediately available during postoperative monitoring and until the patient meets discharge criteria. Each patient should meet discharge criteria prior to leaving the operating or recovery area.

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

Equipment and Supplies

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

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

DEFINITIONS

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

AAAHC – the Accreditation Association for Ambulatory Health Care

ABMS – the American Board of Medical Specialties

ACGME – the Accreditation Council for Graduate Medical Education

ACLS certified – a person who holds a current "ACLS Provider" credential certifying that they have successfully completed the national cognitive and skills evaluations in accordance with the

curriculum of the American Heart Association for the Advanced Cardiovascular Life Support Program.

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

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

Anesthesia provider – an anesthesiologist or CRNA.

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

AOA – the American Osteopathic Association

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

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

ASA – the American Society of Anesthesiologists

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

Board – the North Carolina Medical Board.

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

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

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

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

FDA – the Food and Drug Administration.

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

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

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

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

Immediately available – within the office.

JCAHO – the Joint Commission for the Accreditation of Health Organizations

Level I procedures – any surgical or special procedures:

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

Level II procedures – any surgical or special procedures:

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

Level III procedures – any surgical or special procedures:

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

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

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

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

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

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

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

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

OSHA – the Occupational Safety and Health Administration.

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

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

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

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

Reportable complications – untoward events occurring at any time within forty-eight (48) hours of any surgical or special procedure or the administration of anesthesia in an office setting including, but not limited to, any of the following: paralysis, nerve injury, malignant hyperthermia, seizures, myocardial infarction, pulmonary embolism, renal failure, significant cardiac events,

respiratory arrest, aspiration of gastric contents, cerebral vascular accident, transfusion reaction, pneumothorax, allergic reaction to anesthesia, unintended hospitalization for more than twenty-four (24) hours, or death.

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

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

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

EXECUTIVE COMMITTEE REPORT

John Dees, MD; Charles Garrett, MD; Stephen Herring, MD; Hari Gupta; Walter Pories, MD

Finance Committee

The Finance Committee meeting was held on Wednesday December 18, 2002, at 8:30 am and was called to order by the chairman, Hari Gupta. Board members in attendance were Robert C. Moffatt, MD, Michael E. Norins, MD. Members of the staff in attendance were R. David Henderson and Peter T. Celentano, CPA.

Real Estate

The meeting went into closed session so Mr. Gupta could update the committee on the plans to purchase property for the Board. The proposed floor plans were also reviewed.

Financials

Mr. Celentano, CPA, presented to the committee the October 2002 compiled financial statements. Dr. Norins raised a question about current cash management and the amount that we have currently on the Balance Sheet. This will be reviewed at the January 2003 Executive Committee meeting.

The departmental budgeting process was reviewed. Changes to the budget will be presented to the committee in January 2003.

The October 2002 Investment Summary was reviewed and accepted as presented.

Linwood A. Jackson, CPA, a partner in the CPA firm, Lynch & Howard, PA, CPA was introduced to the Finance Committee. Mr. Jackson ("Woody") presented a draft of the audited financial statements for the fiscal year ended October 31, 2002. Mr. Jackson will present the financial statements to the full Board in January 2003.

Executive Committee

The Executive Committee meeting was held on Wednesday December 18, 2002, at 9:30 am and was called to order by Charles L. Garrett, MD, Vice President. Board members in attendance were Stephen M. Herring, MD, Secretary, Mr. Hari Gupta, Treasurer, and Walter J.

Pories, MD, Past President. Members of the staff who attended were R. David Henderson and Peter T. Celentano, CPA.

Minutes

Minutes for the November 2002 meeting were presented and approved.

Financials

Mr. Gupta summarized the November 2002 financial statements and comments that were reviewed in the Finance Committee meeting.

Old Business

Real Estate: The meeting went into closed session so Mr. Gupta could update the Executive Committee on the plans to purchase property for the Board. The floor plans and the various phases of renovations were also discussed in detail. Dr. Pories inquired about the possibility of scanning our files into electron ic form in order to make room by archiving the paper files. Mr. Henderson stated that this was brought up in the last Directors' meeting and that the consensus from the Directors' was skepticism. Mr. Henderson and Dr. Pories agreed that this should be revisited later after the renovations are completed. Mr. Henderson updated the Executive Committee on the input from the directors. Dr. Garrett made a motion to accept the plans as modified. This motion was seconded and unanimously approved.

License Interview numbers: Dr. Garrett reviewed the statistics that were compiled by Mr. Celentano with regard to the number of licensing interviews done by members of the Board and agents of the Board. Dr. Pories made a motion that all Board Agents should be appointed for a two-year term, and that a training program should be established for all Board Agents who seek additional terms.

Dr. Pories made a motion that the provision in the By-Laws for terminating an Executive Director be removed. The motion was seconded and unanimously approved.

Task force update: Mr. Henderson and Dr. Garrett updated the Executive Committee on the issue of discounted lab fees.

The Executive Committee reviewed the policy of the Board in regards to teleconference licensing interviews. Dr. Garrett wished to know how many states require an interview.

Physician population growth: The Executive Committee was given a summary of physician growth versus total population growth within the state of North Carolina, which will be studied by Dr. Pories and summarized.

Insurance Policy: Mr. Henderson stated that he had reviewed the D & O policy that the Board currently has in place. Mr. Henderson requested that he be given more time to study the policy as currently written and he will report back at a later time.

OEMS appointment: Dr. Garrett stated that Dr. Elizabeth Kanof was reappointed to the OEMS Advisory Council for an additional four-year term, starting in December 2002. Dr. Kanof is currently serving on two appointments, the other being the OEMS Disciplinary Committee.

Holiday party: Mr. Henderson formally thanked the Board for the financial assistance in regards to our holiday party.

New Business

New Employees: Mr. Henderson reviewed the status of various personnel issues, including the hiring of five full-time employees on December 1, 2002. These employees filled positions that have turned over in recent months. Mr. Henderson discussed the possibility of a photo directory with biographical information being established. Mr. Henderson discussed the current staffing levels and the possibility of hiring another attorney to temporarily fill the current vacancy. The Director of Operations position remains open and will until a permanent Executive Director is hired.

ED Search: Mr. Henderson discussed various aspects of the search for a permanent Executive Director, including running classified ads in newspapers and on various websites, with information on our website. Dr. Garrett emphasized to the Executive Committee that a thorough search is being conducted.

Reimbursement for emergency meetings of the Board: Dr. Garrett made a motion that the amount to be billed by Board Members for emergency meetings of the Board should be standardized. The Board President and the Executive Director on a case-by-case basis will set the amount to be billed.

Fingerprinting: Mr. Henderson updated the Executive Committee on the temporary rule adopted December 1, 2002 which allows the Medical Board to conduct background checks using fingerprints. This fingerprinting requirement is set to go into effect on February 1, 2003. The website is being updated so all applicants will be made aware of the new requirements. The turn around time for a background check is estimated to be only two weeks. Therefore, except for resident training licenses, no temporary licenses will be issued without the completed background check. Resident training licenses will be issued without waiting for the completed background check once we have a clean set of fingerprints, a signed authorization, and the background check fee. The cost will be passed through to each applicant.

Agents of the Board: Dr. Garrett made a motion to appoint Dr. George Barrett and Dr. Elizabeth Kanof as agents of the Board for a two-year term.

Recording of the Board Meetings: Dr. Garrett made a motion to discontinue the recording of the Board Meetings. This practice was instituted in the last several months and has been deemed unnecessary.

Dr. Garrett and Dr. Herring stated that the new Boardroom needed to be up fitted with a more advanced microphone system. Dr. Herring also hoped that the HVAC system would be improved. Mr. Gupta stated that this was on the schedule of items to be done by the landlord999.

AED: Dr. Herring reminded the Committee that the AED should be tested on an annual basis and that he would be willing to do this. He also thought that it was important that the staff be trained in the use of such equipment.

CAVU Meeting: Mr. Gupta updated the Committee on the last meeting with our database software designer (CAVU). Mr. Gupta stated that all projects that are currently in process are being frozen and that we need to regain control of what modules still need to be completed.

New Equipment: Mr. Gupta updated the Committee on the plans to implement a schedule for replacing equipment in the office. The servers, laptops and other computer equipment need to be on a maintenance schedule, as most of this equipment has an estimated useful life of about three years.

ALLIED HEALTH COMMITTEE REPORT

Michael Norins, MD; Robin Hunter-Buskey, PAC; Arthur McCulloch, MD

DECEMBER 2002 ALLIED HEALTH COMMITTEE MINUTES

October 2002 Minutes

Approved

November 2002 Minutes

Approved

What does the approval letter mean to CPP's?

Deferred to February

Discussion regarding pharmacists mislabeling medication bottles, in which they refer to physician extenders as physicians

Deferred to February

*The committee will request Dr. Dees to correspond with the President of the NC Board of Pharmacy to discuss a meeting of the CPP Joint Subcommittee

Ideal PA, NP, CPP applications

Current and Ideal applications were distributed. The applications will be reviewed by the committee members and discussed at the next meeting.

NP Proposed Rule Change

Task: Ms. Kapetanakis will request a redacted copy of the nurse practitioner proposed rule change from the NC Board of Nursing.

NCCPA exam schedule follow up

Task: Ms. Kapetanakis will contact the NCCPA and gather information on the process/timing of the PANCE exam and the submittal of the PA application.

PAAC Appointees for 2003

Task: Ms. Kapetanakis will contact the PAAC subcommittee for choosing a physician member and will report back ASAP with their decision.

*** Full Board approved 2003 PAAC Member list (attached)

Disciplinary Process for Nurse Practitioners

Mr. Jimison gave an explanation to the continued portion of the Disciplinary processes for Nurse Practitioners that he has been working on. It was agreed that our Board would need to approve before the document is sent back to the Board of Nursing.

**Ms. Phelps and Mr. Jimison handed out the Draft of The Role of the NCMB in the oversight of Allied Professionals Chart.

**Dr. Norins suggests researching the issue of Nurse Midwives and their relationship to the Medical Board.

**Ms. Hunter Buskey would like to revisit the two Nurse Midwife complaints. Dr. Norins assures that the NP Joint Subcommittee will be reviewing them and taking appropriate actions.

Distributed Articles:

What are you Liable For? Scope of Practice Concerns When Clinicians Fill "Lesser" Positions

Issue Brief: The Role of Chart Co-Signature in Physician Supervision of Physician Assistants: What is Best for Patient Care?

APPLICANTS LICENSED

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

PHYSICIAN ASSISTANT	PRIMARY SUPERVISOR	PRACTICE CITY
Ake, Larry Wayne Jr.	***	
Bauer, Stacey Ann	***	
Blake, John Alden	***	
Galloway, Ayanna Saran	***	
Hawes, Annemarie Myers	***	
Kern, Elizabeth Marie	Redfearn, Allison	Lumberton
Layfield, Heather Jane	***	
Lias, Sherri Ann	Cook, Joseph	Charlotte
McDonald, Daniel Joseph	***	
Stumm, Robert Michael	***	
Ursin, James Bradford	Howard, Willard H III	Rutherfordton

Graduates to be licensed after we receive passing NCCPA scores –

Hilliard, Michelle Dawn	***

PA - Intent to Practice Forms Acknowledged

PHYSICIAN ASSISTANT	PRIMARY SUPERVISOR	PRACTICE CITY
Barney, Cherry Greene	Huffman, Elaine Woodard	Rockingham
Bennett, Barbara Ann M	Gibson, Robert Wylie Jr.	Winston-Salem
Calhoun, Anna Kathryn	Henderson, Robert Clark II	Winston-Salem
Coniglio, David Martin	Sullivan, Keith Michael	Durham
Donovan, Christina Marie	Brader, Alan Hayden	Raleigh
Evers, Susan Edith	Kolappa, Kalavathi	Washington
Faulkner, John Hume	McCaleb, Jane Harvey	Enfield

Gore, William Anthony	Harris, Diane Ennis	Clinton
Hinds, David McDonald	Artis, Karlus Cornelius	Goldsboro
Hinds, David McDonald	McCaleb, Jane Harvey	Halifax
Howard, Brenda Lee	Silberman, Harold Reiter	Durham
Hudak, Pamela Gainey	Thomas-Montilus, Sandhya Anne	Lumberton
Jamieson, Mark Stephen	Adelekun, Temidayo Adesoji	Kings Mountain
Jaynes, Elizabeth Suzanne	Murphy, Michael Durant	New Bern
Keller, Philip Arthur	Walker, Dana Sherrick	Kitty Hawk
Kittrell, Catherine Susan	Sullivan, Timothy Michael	Charlotte
Lamb, Douglas Lawrence	Bremnor, Judy Debra	Warsaw
Lawrence, Robert Evans	Butcher, David Lee	Washington
Lee, Stacey Michelle	Fowler, Fred Charles	Charlotte
Mashburn, Neil Teague	Flickinger, Marc William	Mt Airy
McDonald-Fletcher, Varnell	Liebelt, Ralph Arthur	Durham
McKittrick, Katherine Ann	Brown, Harry James	Cherokee
Melgar, Tammy Strickland	Baloch, Mohammad Haroon	Raleigh
Muolo, Charlotte Ann	Rhodes, Charles Winston W.	Mt Pleasant
Patton, Colleen Hill	Kishbaugh, David	Fayetteville
Peters, Tosheen Saba	Marfo, Magdalene	Monroe
Priest, Monica Eve	Brown, Harry James	Cherokee
Reeves, David Allen	Harris, Diane Ennis	Clinton
Reid, Aubrey James B	Winter, De Benjamin	Smithfield
Reid, Lynn Anderson	Zimmern, Samuel Hyams	Charlotte
Riehle, Tonya Mae	Woollen, Thomas Hayes Jr.	Charlotte
Saunders, Sarah Ann M	Berliner, Steven Harvey	Mebane
Saunders, Sarah Ann M	Bliss, Laura Katherine	Mebane
Saxon, Donald Paul	Del Do, Shari Ann	Fayetteville
Schulman, Eve Jasmine	Anagnos, Damon Philip	Chapel Hill
Schwartz, Adam David	Wu, Lawrence Reginald	Durham
Scoggins, Vince Rene	Hagberg, Robert David	Shelby
Sheaffer, Luanne Gardner	Harris, Diane Ennis	Clinton
Singh, Prachee	Hoffman, Stanley David	Gastonia
Smith, Tracey	Carley, Richard Scott	Supply
Smith, Tracey	Weinstein, Robert Harvey	Wilmington
Stanley, Glenn Martin	Perren, Richard Stephen	Henderson
Stanley, Glenn Martin	Winter, De Benjamin	Smithfield
Taylor, Allison Elizabeth	D'Alli, Richard Eugene	Durham
Thiebaud, Eugene Henry Jr.	Fink, James Thomas Jr.	Winston-Salem
Tignor, Gayle Ryan	Allgood, Sara Elizabeth	Charlotte
Troyon, Sharon Fawn	Harris, Diane Ennis	Clinton
Wilson, P. Darlene	Kenney, James Eugene	Henderson
Woodall, Emily Claire	Wolfe, Steven Frederick	Statesville
Wurst, Martine Elizabeth	Reynolds, Eugene II	Gastonia

NP – Initial Applications Recommended for Approval after Staff Review-

NURSE PRACTITIONER	PRIMARY SUPERVISOR	PRACTICE CITY
Ahearn, Nanci	Jones, Gregory L	Belhaven
Bellamy, Kendra	Stanges, Steven M	Asheville
Breedlove, Kristina	Tanaka, David T	Durham

Brinson, Stephenie	Blackwell, Samuel D	Apex
Brummett, Athena	Kraus, Eric M	Greensboro
Bunch, Amanda	Teixeira, Frederick	Washington
Burke, Catherine	Shapley-Quinn, Kathleen	Burlington
Chapman, Tracy	Dembski, John E	Morganton
Connelly, Kathy	Tackman, Anthony	Raleigh
Dean, Patricia	Everhart, C Hugh	Beaufort
Frederiksen, Julie	Resnikoff, Richard	Jacksonville
Grugan, Kimberly	Martin, John P	Asheville
Hession, Helen	Meehan, Joan N	Clayton
Jeffries, Angela	Dickerson, Jill	Wake Forest
Justice, Paul	Fleming, S Bryson III	Asheville
Knight, Traci	Cook, Steven H	Banner Elk
Knupp, Maria	Leonhardt, Gary G	Greenville
Lorenz, Kristina	Scott, Duncan II	Asheville
Melton, Tammy	Russell, Larry J	Hendersonville
Pusey, Tanya	Rutledge, Robert	Statesville
Rowe, Kathleen	Udekwu, Pascal	Raleigh
Scarborough, Tammy	Dunn, Laurie L	Raleigh
Trandel-Korenchuk, Darlene	Hughes, Christine L	Charlotte
Walters, Ashley	DiNome, Anthony J Jr.	Charlotte
Wolfe, Desi	Young, Thomas E	Raleigh
***Addition		
Behil, Theresa D	Barber, James B	Raleigh

NP - Subsequent Applications administratively approved-

NURSE PRACTITIONER	PRIMARY SUPERVISOR	PRACTICE CITY
Bigelow, Sharon	Hathorn, James W	Durham
Bishop, Elizabeth	Lane, Jennifer A	Charlotte
Bradley-Hawkins, Estena	McCaskill, Samuel G Jr.	Henderson
Burke, Diana	McKay, Cecilia S	Chapel Hill
Capp, Monica	Cannon, Marjory	Wake Forest
Davis, Barbara	Sinn, Leslye M	Durham
Donta, Robin	Mock, Elisabeth F	Monroe
Ellwood, Pamela	Mullen, Joseph P III	Shelby
Emmons, Deborah	Mijumbi, Olivia	Gastonia
English, Dianne	Stallings, Martin	Shelby
Fitch, Tiffany	Jung, Peter W	King
Flaugher, Carol	Marzbani, Siamak	Smithfield
Fogarty, Kelly	Shelton, Stuart D	Fayetteville
Gardner, Mary	Beamer, Mark E	Belhaven
Gibson, Teresa	Browder, David	Rocky Mount
Gilbert, Katie	Joyner, William L	Wilmington
Goodwin, Cynthia	Portner, Bruce	Winston-Salem
Grinar, Donald	Oak, Chang Y	Plymouth
Hutson-Moore, Tracy	Mynatt, Richard J	Wilmington
Jordan, Paula	Clayton, Christy L	Cary
Kelly, Loretta	Wall, Thomas C	Greensboro

King, Patricia	Fisher, John A	Goldsboro
Lawler, Kelly	Caserio, James J	Hendersonville
Lowe, Eleanor	Crane, Steven D	Hendersonville
Lowe, Eleanor	Sloss, Katherine	Bat Cave
Lowe, Karen S	Arvind, Moogali M	Greensboro
Mathis, Barbara	Lacaze, Mary E	Charlotte
Maxwell, Melissa	Sullivan, Timothy M	Charlotte
McCreary, Jennifer	Darrell, Thomas C	Fuquay-Varina
Meelheim, Helen	Dewyea, Victor	Fort Bragg
Pelletier, Janet	Polo, Cynthia	New Bern
Plentl, Maria	Halme, Jouko K	Raleigh
Robinson, Caroline	Chirico, Dianne M	Ft Bragg
Shanley, John Jr.	Pack, Winifred	Fayetteville
Skakey, Josette	Moss, David	Charlotte
Smith, Tabetha	Sloan, Randy M	Hampstead
Sollecito, Anne	Dessauer, Kati E	Cary
Spinks, Carroll	Dreiling, Dale T	Greensboro
Stump, Janice	DeGuehery, Lindsey E	Wilson
Viviano, Robin	Brown, Josephine J	Raleigh
Wagnon, Julianne	Haaksman, James A	Asheville
Whaley, Jimmy	Long, Ronald M	Goldsboro
Wilson, Susan E	Sen, Souvik	Chapel Hill
Woodruff, Laura	Brundle, Scott H	Raleigh

Clinical Pharmacist Practitioner Applications-

None

Motion: A motion passed to approve the report.

LICENSING COMMITTEE REPORT

Robert Moffatt, MD, Chair; E.K. Fretwell, PhD; Robin Hunter-Buskey, PAC; Edwin Swann, MD

License Interview CDs

There was some discussion regarding the motion from December 2002 meeting regarding the technical steps to proceed with scanning applications for the purpose of burning CDs for license interviews. The equipment has not been purchased for this task due to cost. An in-house inventory is planned to see if there are scanners available from other departments that are not being used. It was reported that extra laptops may be available for Board Members to keep at their office for interviewing purposes so they will not have to be carried back and forth from home to office.

Rules Development

Catchline: Status update to the Committee from Mr. Paris

Committee Recommendation: The License Committee chair will meet with Mr. Paris and Ms. Cooke to review the first draft before proceeding any further.

BOARD ACTION: The License Committee chair will meet with Mr. Paris and Ms. Cooke to review the first draft before proceeding any further.

Inactive Emeritus Retired License

Catchline: Update from the Legal Department regarding the License Committee's request to implement an "Inactive Emeritus Retired License" category.

Committee Recommendation: Based on Mrs. Wells legal opinion it is recommended to use the term "Inactive Retired" instead of "Inactive Emeritus."

BOARD ACTION: Based on Mrs. Wells legal opinion it is recommended to use the term "Inactive Retired" instead of "Inactive Emeritus."

Criminal Background Checks

Catchline: Update on implementation

Committee Recommendation: Accept as information - Process has been implemented – Effects all applications received on or after February 1, 2003.

BOARD ACTION: Accept as information - Process has been implemented – Effects all applications received on or after February 1, 2003.

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 2 license 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 because 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.

Seven 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 because these actions are not public information.

A motion passed to return to open session.

APPLICANTS PRESENTED TO THE BOARD

Dennis Joel Abraham	Terence Bielecki	Debra Ann Campbell
Felicity Adams Vanke	Ram Mohan Rao Bongu	Gregory Michael Carbone
Maha Alattar	Curtis Edward Bower	Rebecca Maya Carchman

Laura Chappell Cazier
Chanhthevy Sourisak Chai
Malcolm Lindsay Chaney
Jack Mabry Chapman Jr.
Martha Johnston Chesnutt
Bennett Bing Chin
Michael Jon Cicale
Wendy Georga Cipriani
Kevin Richard Clark
James Paul Conde
Michael Joseph Cooney
Davey Benjamin Daniel
Albert Clarke Darlington
Madhusudan Nemchand Dharawat
Twanna Belinda Dixon
Andrew John Dyksterhouse
Kimberly Paige Reynolds Edwards
Patrick Scott Edwards
Jennifer Taylor Ellis
John Edward Emmel
Alistair Robert Erskine
Linda Youngman Evans
Robert Evans Fines Jr.
Eduardo Mauricio Fraifeld
Michael Lawrence Friedland
Joseph William Galassi Jr.
Chandana Ganguli
Martin Johnson Gillespie
Melissa Danielle Gilmer-Scott
Denise Renee Gooch
Harriette Denice Green
John Lindsay Green
Dirk Hamp
Erica Lyn Hartmann
Heather Farmer Hoffmann
Phillip Carl Hoopes Jr
Kim Marie Huffman
Laura Lyn Jacimore
Charles Lyle Jacobson
Sibyl Elizabeth Jura
Steven Anthony Kagan
Michael John Kegan
George Paul Keogh III
Jamshed Khalid Khan
Ashutosh Vasudeo Kshirsagar
David Wayne Kutob
Melinda Peterson Lada
Erik Paul Lessmann
Mareen Ann Long
Tracy Lea Lovell
Jerry Lane Lowder
Glenn David Lubash
Tamer Hamdy Mahmoud Rajendraprasad
Venkatannasetty Makam
Inna Malostovker
Robert Dean Matthews
Joel Charles McClurg
Jeanette Nancy McDonald
Karen Stewart Milligan
Adelaida Maria Miro
Timothy Eugene Mitchell
Corazon Macorol Mulles
Ringland Smith Murray,Jr.
Troy Dean Myers
Brett Clayton Niblack
John Nicholas Nichols
Daniel Joseph Parsons
Kashyap Bhogilal Patel
Jamie Katherine Pietka
Henry K Poon
Jatinder Singh Pruthi
Owen Robert Rahman
Ajith Ramachandran
David Tompkins Rock
Claire Sanger
Shannon Mullis Sawin
Vincent Cyril Schooler
Rebecca Williams Shoaf
Richard Francis Smith
Natalia Jo Southerland
Joseph David Spataro
Ioana Cristiana Stanescu
Michael Joseph Stella
Deborah Ann Stengel
Phillip Marshall Stratton
Lalitha Tadikonda
Kevin Ray Tebrugge
Charles William Titone
William Thomas Trost
Gabriela Maria Ursin
Kerry Thomas Van Voorhis
Gretchen Yazmine Velazquez Mercado
Vincent John Vilasi
William Lockwood Walker
Paul James West
Marcus Craig Whaley
Matthew Lanier Williams
Joni Yamamoto
Joseph Robert Zanga
Robert Tobyas Ziegelmann

LICENSES APPROVED BY ENDORSEMENT AND EXAM

Dennis Joel Abraham
Felicity Adams Vanke
Maha Alattar
Terence Bielecki
Ram Mohan Rao Bongu
Curtis Edward Bower
Debra Ann Campbell
Gregory Michael Carbone
Rebecca Maya Carchman
Laura Chappell Cazier
Chanhthevy Sourisak Chai
Malcolm Lindsay Chaney
Jack Mabry Chapman Jr.
Bennett Bing Chin
Michael Jon Cicale
Wendy Georga Cipriani
James Paul Conde
Michael Joseph Cooney
Davey Benjamin Daniel
Albert Clarke Darlington
Madhusudan Nemchand Dharawat
Andrew John Dyksterhouse
Kimberly Paige Reynolds Edwards
Patrick Scott Edwards
Jennifer Taylor Ellis
John Edward Emmel

Alistair Robert Erskine
Linda Youngman Evans
Robert Evans Fines Jr.
Eduardo Mauricio Fraifeld
Michael Lawrence Friedland
Joseph William Galassi Jr.
Chandana Ganguli
Martin Johnson Gillespie
Melissa Danielle Gilmer-Scott
Denise Renee Gooch
Harriette Denice Green
Dirk Hamp
Erica Lyn Hartmann
Heather Farmer Hoffmann
Phillip Carl Hoopes Jr
Kim Marie Huffman
Laura Lyn Jacimore
Sibyl Elizabeth Jura
Steven Anthony Kagan
George Paul Keogh III
Jamshed Khalid Khan
Ashutosh Vasudeo Kshirsagar
David Wayne Kutob
Melinda Peterson Lada
Erik Paul Lessmann
Tracy Lea Lovell
Jerry Lane Lowder
Tamer Hamdy Mahmoud
Robert Dean Matthews
Joel Charles McClurg
Jeanette Nancy McDonald
Karen Stewart Milligan
Adelaida Maria Miro
Timothy Eugene Mitchell
Corazon Macorol Mulles
Ringland Smith Murray Jr.
Troy Dean Myers
Brett Clayton Niblack
DANIEL JOSEPH PARSONS
Kashyap Bhogilal Patel
Jamie Katherine Pietka
Henry K Poon
Jatinder Singh Pruthi
Owen Robert Rahman
Ajith Ramachandran
David Tompkins Rock
Claire Sanger
SHANNON MULLIS SAWIN
Vincent Cyril Schooler
Rebecca Williams Shoaf
Natalia Jo Southerland
Ioana Cristiana Stanescu
MICHAEL JOSEPH STELLA
Deborah Ann Stengel
Phillip Marshall Stratton
Lalitha Tadikonda
Charles William Titone
William Thomas Trost
Gabriela Maria Ursin
Kerry Thomas Van Voorhis
Gretchen Yazmine Velazquez Mercado
Vincent John Vilasi
William Lockwood Walker
Paul James West
Marcus Craig Whaley
Matthew Lanier Williams
Joni Yamamoto
Robert Tobyas Ziegelmann

INTERVIEW FORMS NOT RECEIVED
John Lindsay Green
Rajendraprasad Venkatannasetty Makem
Richard Francis Smith
Martha Johnston Chestnutt
Michael John Kegant
Joseph David Spataro
Gabriela Maria Ursin

APPLICANTS FOR REINSTATEMENT (LONG PROCESS)
John Kyle Dorman
William Howell Grover

APPLICANTS FOR FACULTY LIMITED LICENSE
Cormac John Michael Fahy

NORTH CAROLINA PHYSICIANS HEALTH PROGRAM (NCPHP) COMMITTEE REPORT

Robert Moffatt, MD; Aloysius Walsh; Edwin Swann, 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 6 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.

COMPLIANCE COMMITTEE REPORT

Michael Norins, MD, Chair; Robin Hunter-Buskey, PA-C; Aloysius Walsh; Edwin Swann

Discussion of minutes from 12/02.

Discussion of future audits:
-Collaborative agreement between NP and Physicians (this should be more of an educational task.)
-CME
-Ms. Forward is currently researching how other agencies audit including the Bar Association, AIM (Administrators in Medicine) and FSMB (Federation of State Medical Boards).

Discussion of Compliance Committee draft charge statement

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 Compliance Committee reported on one compliance case. 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 because these actions are not public information.

A motion passed to return to open session.

COMPLAINT COMMITTEE REPORT

Hari Gupta; Aloysius Walsh; Edwin Swann, MD; Walter Pories, 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 Complaint Committee reported on 57 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 because these actions are not public information.

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

A motion passed to return to open session.

INVESTIGATIVE COMMITTEE REPORT

Stephen Herring, MD; Arthur McCulloch; Charles Garrett, MD; Robert Moffatt, 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 22 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 because 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.

Six 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 because these actions are not public information.

A motion passed to return to open session.

MALPRACTICE COMMITTEE REPORT

Hari Gupta; Aloysius Walsh; Edwin Swann, MD; Walter Pories, 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 Malpractice Committee reported on 32 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 because these actions are not public information.

A motion passed to return to open session.

ADJOURNMENT

This meeting was adjourned on January 25, 2003.

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Stephen M. Herring, MD
Secretary