MINUTES

North Carolina Medical Board

July 19-22, 2000

1201 Front Street, Suite 100
Raleigh, North Carolina

Minutes of the Open Sessions of the North Carolina Medical Board Meeting July 19-22, 2000.

The July 19-22, 2000, 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 5:17 p.m., Wednesday, July 19, 2000, by Wayne W. VonSeggen, PA-C, President. Board members in attendance were: Elizabeth P. Kanof, MD, Vice President; Walter J. Pories, MD, Secretary/Treasurer; George C. Barrett, MD; John T. Dees, MD; John W. Foust, MD; Hector H. Henry, II, MD; Stephen M. Herring, MD; Mr. Paul Saperstein; Mr. Aloysius P. Walsh; and Ms. Martha K. Walston. Absent was Kenneth H. Chambers, MD.

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

MISCELLANEOUS

Presidential Remarks

Mr. VonSeggen commenced this meeting by reading the North Carolina Board of Ethics "ethics awareness and conflict of interest reminder." He commented that this legislative experience with HB 1049 (Physician Licensure) was a very eye-opening experience and would be one of the issues for discussion at the October 19th Board Retreat.

Barbara L. Pohlman, MD, Medical Director, North Carolina Department of Correction, Division of Prisons; A Meeting With

Dr. Pohlman was invited to meet with the Medical Board over dinner on Wednesday, July 19, 2000. She initially thanked the Board for its interest in the Department of Corrections and what they provide. She stated "there are many things that are the same in delivery of health care in the prison system, some obvious and some not. Rights her patients have: her patients have a legal right to health care as established by the Supreme Court in 1976 where 'you and I do not." (1) Access to health care unimpeded by the corrections system, (2) the right to access competent health care, and (3) the right to the care that is ordered by that provider.

In one year there are approximately 20,000 admissions and not as many discharges. Most are native to North Carolina; a number are special needs patients such as wheelchair bound inmates; there are severely mentally ill with 500 mental health beds. The Department of Corrections is the fifth largest mental health institution in the State and at one point in time had about 1,000 inmates with IQs less than 70. They have a few deaf inmates, a few blind and a few hearing impaired. The corrections system has 77 prisons across the State. She explained that North Carolina is unique as many states put in large prisons where North Carolina has little prisons. They are building larger facilities for greater efficiencies, security and improved provision of health care. They have the same issues with recruiting (physicians) as anyone else has. The greatest challenges are in the facilities. The medical facility at Central Prison is woefully inadequate. Originally designed as a prison it was retrofitted and made to function as a hospital. It has a mobile operating room contracted to be onsite. The state did appropriate 2.5 million dollars to design a new hospital to be part of Central Prison. The designs are in the final stages. It will have all single rooms and be constructed so that it could be licensed by the State even though as a prison it is not required to be licensed. However, it will meet those licensing standards. The other major medical facility is McClain Correctional Hospital which a number of years ago was turned into a minimum security hospital. Within the corrections system it is the only true hospital that was built as a hospital. This is the best medical facility in spite of its age. She noted that the female population is growing at a more rapid rate than the male population.

Regarding expectations of medical autonomy, Dr. Pohlman stated that custody staff may sometimes question a physician, not about the care being needed but about the logistics of providing necessary care. Medical autonomy is well established by the National Commission on Health Care. When a physician gives an order that medical care is supposed to happen it is a violation if it does not happen. Another standard that is important is continuity of care. She estimated that the correctional system has probably more than 40 primary care providers. She needs consistency in continuity of care when prisoners are moved around. Another issue that is often brought up which people think should be different is staff safety. When you walk into a prison can you be safe? She has had staff that had those concerns. You are either comfortable doing it or not. "I know who my bad actors are." She feels much safer walking into a prison hospital than at Wake Medical. At Wake Medical one does not know who is walking in the door. In prison, if that person is a known bad actor they will be left in restraints and guards posted. There will be an officer present. There is an officer always within shouting distance (just down the hallway). If a special risk the officer will stay nearby. The worst of the worst inmates would not be the death row inmates. They tend to be the best patients. Dr. Pohlman has never been threatened by inmates. She has filled in on several occasions. She did not feel threatened when going through Central Prison on her own (she knows where she is going). Dr. Pohlman extended an invitation to Board Members to come into any of the facilities. She would arrange it. She noted that Mr. Breeze, a Board Attorney, did a recent presentation to her staff. She stated that writing letters to the Medical Board by prisoners is a hobby for some. The prison system provides medical, dental, mental, podiatry, optometry services and contract services with particularly UNC in the past. If the patient initiates a visit for a sore throat, sprained ankle from basketball, etc., there is a $3.00 co pay. Over the counter medications can be purchased in the canteen.

When asked what percent of inmates were mentally ill, Dr. Pohlman responded about 5 percent with axis I and about half of her population for character disorders. She continued that they do not define a character disorder as being mentally ill. Inmates have no access to computers; there is a library at each facility; they are allowed to have magazine subscriptions (no pornography) and that subscriptions depend on their custody status and control status. These types of privileges can be restored with behavior change. There are no televisions in individual cells, only in open areas. Most education in the prisons are GED's which is a very active program. Some inmates have even taken college courses. Eventually through

behavior and time more than 90 percent of her population is going to be part of our population some day. There are work release programs and when trust is gained they can get passes to go to community college. The State is committed that inmates will work and not have solely idle time. The inmates you see beside the road are getting $1.00 a day. Car tags are made at Central Prison. Her business cards are made by inmates. They have a canning facility, a sewing plant and do their own laundry.

Dr. Dees gave some background with his experience in the corrections system as a physician. He stated that with Dr. Pohlman's leadership there has been a great improvement. He stated that prison physicians at outlying units has historically had problems in getting consultations they had ordered.

Dr. Pohlman replied that at any given time they have 550 HIV infected inmates, that the inmate population is aging and that they face all those problems. They are always trying to justify additional staff. Regarding utilization review (UR) and right to care, they have a right to necessary care, not plastic surgery or transsexual surgery, but the right to necessary care. Part of the UR process is to ensure that it is necessary. Also, the cost of transportation and public safety are issues as well. They now have UR full time whereas in the past it was only part time (one day a week) and delays did happen.

Dr. Pohlman stated that when she first came onboard an important issue was money. She now believes they are competitive. What was most difficult when trying to hire staff at Central Prison was not salaries but location of the facility and adverse publicity from the *News & Observer* during the fall of 1997. She had trouble finding qualified physicians. She ended up hiring three very fine internists from out of state. "Historically corrections has not attracted the finest and brightest physicians." This is a perception issue she battles regularly.

Transcript of public meeting held July 21, 2000, at the North Carolina Medical Board:

Medical Board Members present were: Wayne W. VonSeggen, PA-C, President; Elizabeth P. Kanof, MD, Vice President; Walter J. Pories, MD, Secretary/Treasurer; George C. Barrett, MD; John T. Dees, MD; John W. Foust, MD; Hector H. Henry, II, MD; Stephen M. Herring, MD; Mr. Paul Saperstein; Mr. Aloysius P. Walsh; and Ms. Martha K. Walston. Absent was Kenneth H. Chambers, MD.

Mr. VonSeggen: We apologize for starting about a half an hour late as we have had business that we have been dealing with all day. The task we're doing today and most of this afternoon was informal interviews of physicians, PA's , and so forth that we do not have any control over how long a certain interview will take so we feel lucky to be here at this time. But we apologize for getting started a little bit late. This meeting was called at the request of Mr. Alan Skipper, the director for the Ophthalmologist and we granted the time. The Board has worked exceptionally hard to get through a lot of agenda items already so we have somewhat cleared off our agenda so we have more time than a half an hour to hear the concerns that you may have. We certainly want to do that. Let me introduce the members of the Board that are here. (Board Members introduced themselves: Dr. Barrett, Dr. Dees, Dr. Foust, Dr. Henry, Dr. Herring, Dr. Kanof, Dr. Pories, Mr. Saperstein, Mr. VonSeggen, Mr. Walsh and Mrs. Walston.) Without any further taking time I would like to encourage all the speakers to be succinct and to the point. We are very familiar with these codes and the history of how things got the way they got. We are very interested in hearing what you have to say about the dilemma that this Board has because we are charged with properly regulating the practice of medicine and surgery. One thing you may be able to help us with is to help us understand if our definition of surgery is different than your definition of surgery. We invite you to help us to understand what your position is. The Board will certainly consider your information. We want to ensure that the Ophthalmologist have asked for this meeting this afternoon but at the end we will make time available if there is anyone else here who would like to make

comments regarding these issues. We will invite you to speak at that. But we do have a speaker list that we are going to go through first and I would encourage each speaker to try to present new information and try not to be redundant if you can. We will get the message. We have very good memories. This Board is excellent with that. So, without further ado I will let Julian Bobbit, is Mr. Bobbit here. If you will identify yourself and who you represent. You may sit down if you like. Just test the microphone to make sure we have it right.

Julian D. Bobbit, Jr., Legal Counsel: Thank you I am Bo Bobbit an attorney here for the Medical Society and the Ophthalmology Society and Pediatrics Society. Succinct is not my middle name but I have been asked to speak to review the frame work for consideration of the scope of practice in North Carolina. It does address what is surgery and whether one can change that definition or how one would properly regulate and go about addressing competency issues as they may change from time-to-time. I am compelled also to be brief because there are a number of esteemed experts who are here and we barely have five minutes apiece. At the risk of preceding wave caps, actually on these issues I will try and move through that and not take more than about five minutes myself. Anticipating this and to try to make the most use of your busy schedules I have prepared a memo that I got to Jim Wilson, your legal counsel, earlier today, shared with colleagues I'm friends with and Johnny Loper the attorney for the Optometry Board and my remarks reflect that. I encourage you at the appropriate time to review that. It contains for example citations to authority in cases and precedent and attorney general's opinions and I am not going to bore you with here. This one point would be to try to at least as a housekeeping matter to determine what happened or was officially the act of the Board was on June 21st when it made its decision. I'm understanding it to have been a directive to pursue an amendment to the settlement agreement that grew out of the 1994 litigation. And I wrote a letter to Bill Breeze indicating I heard back from Dave Taylor to the effect that the Pediatric Society he was an individual party to it and I think his American Academy of Pediatrics instructed me not to sign it. So, I assume that the technical decision is moot since the amendment to the settlement agreement was not enacted. By quick review, the legislature and the framework that we have approached all of this and most of this is repetitious for you I am sure, but I think it is worth establishing the frame work for where we are coming from. Only the legislature can change the scope of practice. As part of the executive branch all agencies may only execute what the legislature has done and you are not authorized, no agency from the eighth grade up, the separation of powers and civic suits taken may not legislate. So as you all know you are here to interpret the statute and interpret the law. Very quickly, what is the law? The Medical Practice Act which is all of Chapter 90 establishes as you know that if any of the 16 limited license practitioners in North Carolina exceed their authority they are under GS 90-18 engaged in the unauthorized practice of medicine. It is therefore a well earned role that you have as fiduciaries to the State but an unshakable one. It therefore falls within your jurisdiction. I know it is a burden to you on these types of issues but that is why you are, you are asked to do what you do from time-to-time on scope of practice. We did review the notes of the June 7th meeting and there is an indication that the scope of practice may have changed for Optometry. We disagree. The 1997 legislation did drop a collaboration requirement for prescriptions but that is not germane to this issue. The issue is whether this is surgery as has been stated. There is also a reference that to a change in the legislation. That said that what is taught in the Optometry schools could somehow effect the scope of practice and that is cited in my memo, you know the law. That is very clearly not the case. For well over 50 years from the case of State vs Baker that was virtually delegation of legislative authority, not only to an agency or a college. That would be unconstitutional. That is not what the statute, if you read it, says and let me read one sentence from State vs Baker and I have reviewed this with your legal counsel so if I am not available for questions Mr. Loper or I am sure Jim is very familiar with this case. "The colleges cannot change the law in North Carolina or widen the scope of the Osteopath Certificate so as to permit him to practice other systems of healing by the simple expedience of varying their curriculum." I don't know

but look at the rest of the minutes of that meeting it seems like there was a lot of discussion on the nature of what was taught or would be taught or could be taught in the schools and it seems it may have been a misunderstanding as to how that's direct impact on the legal scope of practice. We also believe that it is well settled that invasive procedures are surgery. The attorney general's opinions, one was to you, I can't find a copy of it but it was between 1983 and 1985 or 1986 to Pete Paris indicating Chiropractors could not draw blood as that would constitute surgery citing with approvals State v Baker, that's how I learned of that case. There is a 1986 opinion to that effect. I did obtain copies of that from the attorney general's office and of course your own rulings in prior reviews and precedent. Well what about injections? Other non-physicians do perform injections. Looking at the Medical Practice Act and looking at the scope of practice, frankly if its safe and efficacious the general assembly should allow it. I've seen legislation where other states will say a Chiropractor may draw blood. I think that's fine I think it's philosophically ideal and it is the way it ought to be. If there are providers who shouldn't be doing it they should not be allowed to do it. If perhaps they are but nobody's raised it I've heard the conversation about "well other people do it." Emergency situations, if a physician is not available, some care is better than no care. So I think it is a prudent health policy to lower the bar, so to speak, and allow maybe an injection or a cutting in emergency situation that at least some training and the preferred is not available. Obviously, it is perfectly appropriate for allied providers to perform certain services where a physician is appropriately available. Physician supervision is something with which you deal on a very regular basis. But if a patient crashes the practitioner may know how to perform the specific procedure but may not know the medical complication when there is an arrest or seizure or hemorrhage or along those lines and that is where the additional training and experience of a licensed physician comes in. Again, if there is no counter indication for a particular type of injection the law should allow that and to me that is the way the construct of scope of practice should work in any state. Redefining surgery I fear is a wholesale authorization of how does one stop at a particular procedure or a particular matter and of course surgery is involved in a lot of the limitations on many of the other allied provider services. I don't think to redefine surgery is a public legislative act but even if there were authority to just do that as opposed to a specific enabling legislation when and where appropriate seems to be too bold a brush. What about the settlement agreement? I was involved in that litigation. Let me remind us all what got it started. There was a notice from Medicaid that said there were 154 codes that should be covered when performed independently by an Optometrist. There was concern there was litigation to address that. Ultimately the Medical Board thought 50 of those 154 were not appropriate and to avoid some of the expense of protracted litigation there was a settlement agreement. That was to address a healthcare issue when one board unilaterally went forward and the settlement agreement naturally enough said "hey let's don't do that before we rush down to legislature or rush into court or rush down to Medicaid or something along those lines if a unilateral announcement, let's talk to one another and see if it is that interface." That probably was fine, the settlement agreement. It's really cumbersome going forward. I for one it was not the working protocol collegial exchange of ideas and clinical information that I certainly had heard and I know many had heard and I certainly would recommend that for new codes and new matters it not be involved. Furthermore, it has tangled things up and bogged things down. So it is not in furtherance of health policy and probably it is not useful as a going forward document. And finally, even though we feel to address invasive procedures is a legislative act. What you say is extremely influential in all the bodies where that is reviewed and considered. The remaining speakers have assembled to address in the time available to help issues and to present that information to you for your consideration. The first speaker is Dr. Don Chaplin.

Mr. VonSeggen: Please introduce yourself.

Don C. Chaplin, MD, President, North Carolina Medical Society: Good afternoon Mr. Chairman and members of the Board. I am Don Chaplin. I am an Internist from Burlington, North Carolina and I am the President of the North Carolina Medical Association. I appreciate the opportunity to speak with you today regarding the Board's recent decision to support a modification of the optometric agreement to include certain codes in the scope of Optometry. I do not wish to take away from my physician colleagues who will be presenting a great deal of very important information to you this afternoon. I simply would like to say that the Medical Society remains very concerned that this decision of potential adverse affect to the quality of healthcare to the citizens of North Carolina. We all have a responsibility including the North Carolina Medical Association to provide you with timely information and an input on these important public policy issues. We are confident today that the additional information provided to you regards patient care will have some additional impact on your decision. If this information is not helpful or is not available to the Board we will be glad to try to help at a later time. We do think we have a group of individual experts who will be able to share some information that you do not have about the importance of the decision that you did make and hope we can find some remedy that will better serve the citizens of North Carolina. We thank you very much for your time and Dr. Cindy Hampton will lead off the group who will give the presentation this afternoon. Thank you very much.

Mr. VonSeggen: Thank you.

Cynthia Hampton, MD, President, North Carolina Society of Eye Physicians & Surgeons: I am doctor Cindy Hampton. I am a general Ophthalmologist and practice in Henderson, North Carolina with Dr. Dan Bernstein. I am currently the President of the North Carolina Society of Eye Physicians and Surgeons. I am going to start off this sort of section of our presentation with a review of the specific codes that are at issue today. I was present at the June 7th scope of practice committee meeting and I feel somewhat responsible for this situation because perhaps if I had been more forceful in my arguments abut the seriousness of these injections and the threat that they pose to patient safety when placed in the hands of anyone other than a fully trained Ophthalmologist perhaps we would not be in this situation. I would like to briefly discuss one issue with you before we get to codes and this is this issue of turf. This is a term that seems to always come up when we (and I speak collectively as not only ophthalmologists but we as a physicians) attempt to speak out proactively for our patients and our profession. This always seems to be delegated to being just another turf battle. I know some of you believe that the communication that was generated by this issue that you received from ophthalmologists is primarily due to eye doctors worried about how it will affect their pocketbooks I admit and I think we all know that there are colleagues of all of our specialties who operate under this sort of situation of philosophy. If this were the case however, working in about these codes would probably affect a practice very similar to mine – a general ophthalmology practice a "primary eye care practice." These codes would probably affect me the most financially if it's going to affect any practice. But as I will reiterate later outside of the use for surgical purposes a general ophthalmologist simply does not either use these injections or only very rarely uses them for the reasons that the optometrists indicated they want to use them for on June 7th. They are simply not the treatment of choice for the disorders that have been purported that they were to be used for. The majority of general ophthalmologist do not even do Fluorescein angiograms or if they do they do very few of them similarly to myself. I probably do four a month because they are only used for treatment, retinal laser surgery treatment and not all general ophthalmologists perform retinal laser surgery. So, I'd offer to you that the eye doctors who put their pocketbook above the interest of their patients looked at this issue, looked at these codes and they realized that they would not have the financial impact on them. They didn't even bother to write to you or email you or fax you or phone you. So if its not financial to me why are we here, any of us physicians? Because it's very difficult to sit before this Board with all the experience and wisdom and tell you that we think you made a wrong decision. We are here because before

we were ophthalmologist we were trained as physicians and I may be a bit Pollyanna in this but I do truly believe that most physicians still seriously consider their role as patient advocates to be the utmost role that we have. And that role supersedes any trepidation involved in sitting before you today. It also supersedes acceptance of this opinion just to maintain collegiality amongst physicians and it supersedes maintenance of referral patterns between ophthalmologist and optometrist. Now I would like to go ahead and start briefly with the codes and I have some handouts. I only have twelve of them, I am sorry. We are going to start with Code 68200, Subconjunctival Injections. What I am providing you are color prints and a description in the back on the use of these codes, the use of these injections in my own general ophthalmology practice. The prints were actually provided by Dr. Jonathan Dutton an oculoplastic surgeon in Cary. Basically, the body of the eye is made of an outer covering called the sclera. This is covered by two layers the Tenon's layer and the conjunctiva. The conjunctiva is a transparent membrane made up of about 6-9 loosely organized cell layers full of tiny blood vessels and nerve ending. A Subconjunctival Injection perforates the conjunctiva so to place the injected material beneath it in a potential space between the conjunctiva and Tenon's layer. These injections are usually placed near the Limbus. (pointing to the model she brought with her) This area of the eye here between the cornea the clear part of the sclera, that is where these injections are usually placed. In this area the sclera is .825 millimeters in thickness. The eye is usually anesthetized with drops prior to this injection. Even so this injection must be delivered very carefully. If injected too quickly or unsteadily stretching of the conjunctiva nerve fibers will induce pain and the patient can move. It is just as easy to perforate a globe which is the consequence of sudden movement possibly. It is just as easy to perforate a globe attempting to perform a subconjunctival injection as it is to perform a sub Tenon's injection. And doing this was an injection that I think the Board decided was too deep for the optometrists to perform. Perforations of the globe is not only the most serious complication that any ophthalmologist can experience but is also the most imminent potential complication of this particularly injection. The prints provided to you show you the intimate relationship between the conjunctiva and the globe. On June 7th the use of this injection that was mentioned was primarily to use it to inject steroids beneath the conjunctiva in severe inflammatory disorders. Again, I rarely and most general ophthalmologist rarely, if ever, use this injection for this purpose because there is a better injection, called a posterior sub-Tenon's injection. There is a better treatment for this disorder. Also, at the current time this presents itself very rarely because we have very broad current topical drops or oral steroids to treat patients with this problem. The problem with these injections is that the steroids can form a little depot or a pocket where they will sit for weeks to months. This can cause a marked increase in the pressure of the eye of the patient that can be very difficult to treat with drops. If this occurs it requires surgical excision of the steroids. So the question comes, why allow allied health practitioners who claim to be primary care practitioners to perform a procedure that is not a primary therapy for this disorder, more like a secondary or even tertiary treatment for this problem and particularly when those practitioners are unable to handle the complications by performing surgical excisions if that is necessary. My most common use of this injection is to inject anesthetic beneath the conjunctiva in order to perform a surgical procedure. There are other uses of this injection. They are listed on the handout but they were not mentioned on June 7th so we are not going to go into them. The next code and I also have some handouts is Code 11900, Intralesional Injections. Again, I have photo prints. Basically, again based on the June 7th meeting the only lesions that might be considered for injection are Chalazion. These are localized abscess of the upper and lower lids. Mention was made of injecting steroids into these inflammatory nodules. Now granted, Chalazion, these nodules are very commonly seen in a general ophthalmologic practice. If injection of steroids were the only treatment or the definitive treatment for this disorder then there truly could be an argument that there were needy patients lacking proper treatment because they couldn't get to their ophthalmologist in time for an injection but the medical reality is that the most successful treatment with this disorder is conservative medical management. Warm compresses and massage, perhaps

drop or ointment most of them go away on their own. The definitive treatment for these nodules is to surgically incise and drain them. Steroid injection where it has been purported to be used in some cases is not the definitive treatment. It's painful to the patient. If they're going to do it you might as well inject an anesthetic. If you are going to inject an anesthetic you ought to go ahead and incise and drain it. I tried it a couple of times early on in my practice and it didn't work and the patients didn't like it and I do not even do these injections at all in my general ophthalmology practice. The other problem with these nodules, and this is what the photo prints point out, is that it is not uncommon for them to masquerade as cancers and in my eleven years of practice now I have had a Chalazion that I attempted to incise and drain. It was more solid than it was supposed to be. Upon referral it turned out to be a Malignant Lymphoma. It is not difficult to find such cases and steroid into a nodule such as this could delay proper treatment and is devastating to the patient because these can be fatal cancers. There are other things listed on the handout the Intralesional Injections can be used for but again these were not mentioned on June 7th . Now, the last handout that I have is that either of these codes – intralesional or subconjunctival, could be used to justify injecting something into conjunctival lesions or nodules and these as well can both present as benign and malignant disorders and require the expertise of a fully trained ophthalmologist. To understand and know the pathology because they are potentially fatal disorders. This code also lends itself to possible non-ophthalmologic use. For instance, skin lesions that could perhaps located on or near the eyelids. This would fall more under the purview of dermatology and I would like to now give the floor to Dr. Lisa Abernethy, a Dermatologist from Raleigh.

Lisa Abernethy, MD, North Carolina Dermatology Association: Hi, I'm Lisa Abernethy, I am a member of the North Carolina Dermatology Association and I practice here in Raleigh. I was just asked to speak regarding how the Intralesional Code 11900 was used in dermatology. The code is used for a variety of medical diagnoses and a variety of medications are used. Some examples are Intralesional steroids are certainly used for inflamed epidermoid cyst. They are use for hypertrophic lesions of lupus. They are used for painful scars. They are used for keloids. They are useful for hair loss problems, Alopecia Areata particularly involving eyebrows and then we also in dermatology use a variety of chemotherapeutic agents including bleomycin, methotrexate, 5-FU to treat the benign and some malignant lesions including Kerito acanthoma type squamous cell carcinomas, benign warts, Kaposi sarcoma and then interferon is also used to treat warts and then more recently interlesional botulism toxin is used for hyperhidrosis or excessive sweating on the palms. So we have a wide variety of uses and a wide variety of medicines that we use in intralesional injections and in many of these cases particularly in tumor type cases there is a biopsy proven diagnosis prior to use except in a very absolutely classic cyst just to avoid in appropriate treatment or delay in diagnosis. I personally in the area of the eye and frequently biopsy regions or if I don't have the ability to refer to ophthalmology for a biopsy because of the threat to one of my patient's lesions. Thank you.

Sharon Fekrat, MD, Assistant Professor of Ophthalmology and Vitriolic Surgery, Duke University Eye Center: Thank you for allowing me as a retina specialist from Duke to express my concerns to you the Board about the safety of the citizens of North Carolina following the recent decision to allow the optometric community to perform Fluorescein angiography and Indocyanine-green video-angiography, two invasive angiographic procedures as well as my concerns about the national and international implications of such a decision that maybe standing on an unstable foundation. My close cousin is an optometrist and I would like to acknowledge the wonderful collegiality and professionalism within the optometric and eye and the communities as we both pursue our quest to eradicate blindness for North Carolinians and Americans. Both communities together must raise many important issues for the benefit of our families and children and the future of eye care in medicine. First, at the June 7th scope of practice committee meeting the representative for the optometric community

incorrectly conveyed to the Board that angiography is used to diagnose retinal and choroidal diseases. This is one of the first misconceptions that is cleared and was cleared up during my three years of concentrated studies during ophthalmology residency training. Angiography is not used for the diagnosis of vitreoretinal or choroidal diseases but these invasive tests are obtained to delineate where laser surgery should be performed and are almost exclusively obtained in preparation for the laser surgical procedure itself after the diagnosis is made by careful slitlamp fundus contact lens by a microscopic examination. I was taught during my residency when and why to perform Fluorescein and ICGN angiography when I was a resident at John Hopkins and this was further refined by two additional years of vitreoretinal surgical fellowship. For example, diabetic retinopathy one of the two most common blinding retinal diseases in the United States of America, a Fluorescein angiogram is not ordered to diagnose the retinal pathology but only to delineate the lesions to treat with laser surgery and both eyes that have already had the details and the subtleties of a retinal vascular disease diagnosed by a fully trained ophthalmologist who has undergone extensive and intensive one-on-one training, critiques, refinement of skills, understanding of the pathogeneses by retina specialists throughout the country using careful slitlamp eye biomicroscopy with fundus contact lens examination or for example, for macular degeneration, the other most common blinding retinal disease in the United States. Angiography again is not used to make a diagnosis as incorrectly conveyed to the Medical Board on June 7th but to delineate the angiographic details of the choroidal neurovascular lesion that are used to guide thermo laser surgery, photodynamic therapy surgery and sub-macular surgical treatments after the diagnosis has already been made by contact lens ophthalmoscopy, and this is used in the sub-macular surgery trials funded by the National Eye Institute of NIH. Moreover it was stated to the Medical Board on June 7th by the optometric representative that in his optometric practice an angiogram may be obtained ten times in one day. In my very busy tertiary retinal practice as well as that of all four of my retina colleagues at Duke, it would be a very busy and unusual day to obtain ten angiograms in one day. And angiograms are indeed not performed on basically everyone as was stated in a tertiary retinal practice as was stated on June 7th. And one must remember that almost all retina specialists would repeat the angiograms in their own office for interpretation and patient management even when a patient arrives with an angiogram because it was either obtained too long ago prior to the examination, is of poor photographic quality either out of focus, no stereo frames, over or under exposed, or did not correctly image the pathology in question. So, sending the patient for retinal evaluation with an angiogram already performed as suggested as a reason to perform angiography in an optometric practice is almost never of clinical use in guiding a surgical treatment by a retina specialists. So, if the person ordering the angiogram does not know when and why to order an angiogram as appears to be the case from the June 7th scope of practice committee meeting discussion, how useful can the information truly be? And is it worth the risk involved to the patient undergoing the procedure since angiography is not without the risk of death? Angiography would consequently be overused. Thus increasing the one and two hundred and twenty-five risks of death from angiography and even the high risk of an anaphylactic reaction requiring basic and advanced cardiac life support. Just because this disastrous complication has never been seen in one optometric practice over thirteen years of optometric practice as stated to the Medical Board on June 7th, this does not indicate that this is not an issue with which to be extremely concerned. A 20 year old male recently died from anaphylactic shock in western North Carolina following Fluorescein angiography. I have personally resuscitated four patients in the last four years. When it happens, and it will as we all know in medicine, it is real and all individuals must be able to efficiently and effectively resuscitate the patient as is taught first hand multiple time to an ophthalmologist during medical school and internship. At Willmer Ophthalmological Institute at Johns Hopkins Hospital where I have spent seven years the ophthalmalgics photographers who have had intensive training for years about how to safely perform the invasive angiographic procedures performed these invasive procedures either under the direct supervision of a physician trained in cardiac life support in the management

of an arrest or with that physician in the adjacent room. At the Duke University Eye Center fully trained nurses who have undergone extensive hands-on training and education regarding venipuncture and the administration of systemic medication performing angiographic injections under similar conditions. Moreover it was incorrectly stated to the Board on June 7th that the Fluorescein should be injected very quickly. Rapid injection would lead to further complications of angiography since the faster the Fluorescein is injected the more likely the patient is to experience immediate nausea and vomiting and consequently won't even facilitate any photographs to be taken at all. The optometric representative also stated on June 7th that one of the things that could happen commonly is that you will miss the vein and extravasate the dye. Well that is incorrect because I have almost never seen this since the person performing the invasive injection into the systemic vasculature are so well trained and experienced in venipuncture I have seen this once in my ten years of ophthalmology. We as a collegial community of optometrists and ophthalmologists thank you for listening to the very careful clarification of these very important issues and your consideration so that we may all feel proud about the solid foundation that we may provide for the future of eye care and medicine to our families and children in North Carolina, the United States of American and abroad. Thank you.

Dr. Hampton: I also have copies of affidavits from the original 1994 agreement on the codes that were on the original agreement as well as statements regarding the newer codes that were not on the original agreement and we would like to enter that into the record here. Our next speaker will be Dr. Terry Forrest.

Terry Forrest, MD, Past President, North Carolina Society of Eye Physicians & Surgeons: Thank you. I am an eye MD, I practice ophthalmology in Goldsboro, North Carolina, I provide ophthalmologic services to men, children, women in our community and I am here because like all of you I care that medical services be delivered ethically and appropriately in every fashion. My statement is not prepared. It basically comes from my heart and I come from the trenches and every day I perform many of these codes. The only code I have not performed is the ICG code, there's no need for that in even a technically, what I would consider, fairly general advanced general ophthalmic practice. The single message that I have to convey to you is that these codes do not constitute the practice of optometry. They are indeed medicine and surgery. And I have two brief stories to relay to you that will drive this point home. Parenthetically let me state that I work on a daily basis with optometry. There is an optometrist that works with me in my office on a daily basis and I have very, very close relations with optometrists in our community. I have a great deal of respect for the services that they render and for the individuals. We could not provide adequate services, adequate primary care services without optometrists in our State. They are essential. My point is that these codes do not constitute the practice of optometry. They constitute the practice of medicine. The two very, very brief stories that I have. I am starting my 15th year the only patient I have ever seen or that I have ever had to die from widespread metastatic carcinoma is from a primary eyelid tumor had been injected twice by an optometrist in our community three months prior to the presentation in my office. The other story I have is of a more personal nature. I was a fourth year medical student and I thought I was pretty hot stuff. I am sure many of you have been in that situation. I had been through rigorous training at the University of North Carolina School of Medicine. I had resuscitated dogs. I had assisted in resuscitating of patients and I indeed thought I was something else. In the final month of my medical school career I was doing an externship in a small community in the western part of our State, a thirty bed hospital and it was probably about half full, maybe 15 patients and I was the only doctor there. I had all of this great training. But I really hadn't had any hands-on experience. As you might have suspected something happened. A patient coded. He was receiving an intravenous delivery of antibiotics and this gentlemen, they called me got me up and I happen to be not more than four doors down. In fact, I was sleeping in a patient's bed, that's there they put the students. I wasn't ready. I had all of this great training but I hadn't

had any practical training. It had never been just me in the real world. The patient died. I will never forget that. Four years later after intensive internal medicine and ophthalmology training I had successfully resuscitated hundreds of patients. I had the confidence and I had the practical experience with very, very wise and practiced people to guide me during this four additional years of training so that if and when that patient does crumple, pass out or code in my office I will be much more prepared than I was after all that great training but no practical experience. And that is all I have to say. Thank you very much.

James Cornetet, MD/OD, Charleston, SC: Good afternoon. My name is Jim Cornetet. I would like to just briefly give you my educational background. I attended optometry school at the Illinois College of Optometry from 1978 to 1982 and then practiced optometry full time for ten years until 1992. At that time I began medical school at the Medical University of South Carolina in Charleston. Graduated in 1996. Started a year of internship and then an additional year of residency in Family Medicine and finally switched to ophthalmology in 1998. And I'm currently in my third year and final year of training, finally. Because of my unique background of being both an optometrist and a physician I would like to speak just a little bit about what in my experience was the major differences between optometric training and the training of an ophthalmologist. During the ten years that I practiced optometry I felt that I had been very well trained in optics, refraction, contact lenses and in evaluating an eye as to whether it was abnormal or normal. However, now that I have gone through medical training and residency I realize that I hadn't learned as much as I should have about ocular disease and treatment and management of that. The reason I say this is essentially two fold. First, in my third year of optometry school which is the first year that you actually see patients in optometry school, we had only nine patient contact hours a week. In the fourth year we had only ten patient contact hours a week. That was supplemented with a one month externship at a private optometrist's office during the fourth year. The remainder of the training was essentially didactic training and also self study. But that's the end of the training. There was no internships or residency required for optometry. To contrast that with my medical training, starting in my third year of medical school, continuing through my internship and then the three to four years of residency it takes to become a general ophthalmologist you are essentially inundated with patients. As the physicians in the room know, you can see between 40 to 80 patient contact hours a week depending on how much call you take and what service you are on. The main difference there is that you are learning from your patients and from the patient's family, from your upper level residents, from the nurses, from the attending physicians, from the physicians that you have consulted on specialty services, from the radiologist, from presenting at grand rounds and other medical conferences and from your own self study. Secondly, and of equal importance was the type of patient you see in optometry school. In general, the patients that we saw had essentially healthy eyes. They were there for primary care, for routine eye care, glasses, contact lenses. Therefore I saw very few patients during my optometric training who actually had ocular disease. To contrast that with an ophthalmology teaching hospital you see very few patients who have healthy eyes. We generally see the sickest patients with the sickest eyes there. Therefore the total learning experience is not something that is matched in optometry school. Now the optometrists that I have come to know during my career including some that have graduated recently I would say would share similar feelings with what I've just expressed – at least the ones that I've come in contact with. Most of them actually have expressed that they wished they had gone to medical school to receive more training and more understanding of what they were looking at. Essentially that brings me to the point of speaking here today. It's my opinion that the injection of medicines around the eye, the eyelid, intravenous injections is beyond the scope of practice for the average optometrist out there. It would have been for me. I don't feel like I would have had enough training knowing what I know now or the other optometrists that I've come into contact with. That's basically all I have to say. I feel it would not be in the best interest to allow this to occur. Thank you.

Dr. Hampton: I have a couple of one statement to add to Dr. Cornetet's statement. I received copies of almost all the communications that you've received and I noticed in one of the communications from a retinal specialist in the western part of the State mentioned that he had an optometrist externing through his practice. This is to answer the possible issue that may come up. Dr. Cornetet did say that he did finish his training in optometry in 1982. This retinal doctor has, I called him two days ago, I called him on Wednesday and asked him about the optometry students was are rotating through his practice and basically in his practice there are two employed optometrist both of whom are graduates of the Penn. College of Optometry and from what I understand this is the Harvard of optometric schools. And through these two optometrists they have at any given time about three externs rotating through their ophthalmology practice. These fellows are mere months from going out into practice. He said that even these students will admit that at this time they have had no significant education in either performing or interpreting Fluorescein angiograms or performing any of the injections at issue today. To quote his words to me he called this whole issue a "canard." At the June 7th hearing the only additional training that I heard that has occurred since the 1994 agreement was a two-hour lecture course on injections taught by optometrists. It was a requirement for relicensure by the Board of Optometry in 1997. There were other optometrists who also took an optional three hour wet-lab in which they practiced on animal eyes and on each other. Now these very same codes at issue today were requested by the optometrists before this Board in 1998. In 1999 you ruled that these still remain procedures that were outside the scope of practice of optometry. To our minds there has not been sufficient evidence or there was not sufficient evidence introduced on June 7th to justify the opinion rendered by the Board on June 21st. Now we are all well aware that this consent agreement has been a burden to this Board. I realize there is no other state that operates under such an agreement. There are 31 fortunate states whose laws prohibit injections by optometrists. Another 12 additional states allow injections for anaphylaxis only by optometrists. And these six other states have statutes such as ours in North Carolina in which the issue of injections is not really even addressed. It's a grey area. In North Carolina this grey area in the past six years has been defined by the consent agreement. All of us appreciate the time and effort you have spent dealing with this and I personally empathize with all you because of the time that this issue has taken up with me due to the events of the past month. I know that you've been hit hard with communications from eye MD's or ophthalmologists from all over the State, and even the nation. This is actually the result of a single broadcast fax but in a way I am a bit proud of my colleagues because they have responded to you in a manner that we asked. They responded to you personally and did not go to the media or any other outside entities. This Board, this current Board is obviously committed to proactively accepting your charge in protecting the public safety as evidenced by the bill that I know you desperately wanted to pass recently which would have made the unauthorized practice of medicine a felony. And I think we all found from that that it is very difficult to change statutory law when we thump heads or step on toes with other fields of healthcare whether it be allied health professionals or alternative medical providers. The problem I think we all understand is that statutory law is always susceptible to political maneuvering. This consent agreement we feel helped clarify some of the ambiguous areas in our current statute with regard to the scope of practice of this group of allied health professionals. And I feel that in any other situation other than the recent past legislative session which was a bit unusual, this consent agreement would have weathered any political maneuvering. Although the consent agreement is an unorthodox tool relative to having a statutory law that would prohibit injections. We hope that you can recognize the unique nature of the agreement and view it as a safeguard for quality of patient care rather than a barrier to any provider who wishes to extend their scope of practice. If nothing else this experience has clearly demonstrated the Medical Board's discomfort in its jurisdiction over this consent agreement. We would propose that there be further dialogue to explore more effective ways in dealing with such situations in the future. Even though all the legalese seems to render this opinion by the Board moot, and I am using the lawyer's term there. We

would like to remind the Board that we feel it is critical that you consider reversing or rescinding this opinion. Unaltered it will continue to send a very dangerous signal to insurers, legislators, regulators and other non-medical providers that will impact the safety of our patients and the citizens of North Carolina. Thank You.

Mr. VonSeggen: Are there other speakers?

Michael Clark, OD, Past President, North Carolina Optometric Society: I appreciate all the testimony that was given. It was interesting for me because in some ways it feels like I am in kind of a time warp. I was president in 1977 during the initial legislative movement to establish pharmaceutical agents prescribing therapeutic medicine for optometrists. And I heard many of the same concerns. And I would mention to everyone at this Board that I share the concerns for patient safety that were brought up today. We heard in 1977, somewhat exaggerated, patients would be dying, patients would be going blind. That optometrists would be prescribing helter-skelter with total disregard for appropriateness, and that just certainly isn't the case. History has proven that out. Twenty-three years have passed and our record speaks for itself. Our malpractice rates are probably the lowest of all allied health professions and we have a good history of providing eye health care. Again, as Mr. Bobbit stated earlier, I think optometry is not defined by the schools in terms of the scope of practice it is not defined by danger as we were addressed earlier. There's a lot of things that a lot of us do that are dangerous. When I see an Acanthamoeba infection of the cornea, I get very nervous and I consult with a cornea specialist. If I see a Toxoplasmosis, very dangerous condition. Sometimes giving Clindamycin can cause hemorrhaging of the gut and you can have a very serious consequence. We are all dealing with danger. Whether we are doing surgery like ophthalmologists are, whether we are medically treating like the optometrists, dangerous part of the game. I wish it would go away. It would be nice if everything was straight forward and simple but it is not. I disagree to some degree with Mr. Bobbit because I read the statute and I think the statute really defines the scope of practice. It says the employment of instruments, devices, pharmaceutical agents, procedures, other than surgery intended for the purpose of investigating, examining, treating, diagnosis, correcting visual defects. I interpret that statute as allowing optometrists to utilize medical therapy. Medical therapy can be utilized topically, it can be utilized orally, injections are another avenue, perhaps some day we will be using transdermal patches, who knows what avenue we will be using in the future. But the way the statute reads now, I think it is very clear that it allows optometrists to medically treat eye conditions. I think one thing that we are really getting confused on today and the implication is that optometrists are going to operate on the lowest level of clinical skills and I disagree with that totally. Remember the scope of practice of medicine allows every physician here to perform any medical procedure. Obviously standard of care does not allow that. Even within the area of ophthalmology Dr. Hampton mentioned last time she doesn't perform scleral buckling procedure, it's a retinal procedure. But other ophthalmologist do perform those procedures. The young lady sitting beside her presumably does. There's certainly variances in standard of care even within professions and one thing that the Optometric Board has clearly stated straight on and its on record, every optometrists is first of all expected to practice within the parameters of their scope as defined by the law but also within their clinical experience, their education and their training. My sympathies go out to everyone that has had a bad situation that has come upon their practice of medicine, optometry, ophthalmology – these things happen and they're very unfortunate but I think the Board needs to realize that the optometrists in North Carolina are no more less willing to look out for the interests of their patients. We are all here to look out for patients and our history speaks for that. We have had the opportunity to use pharmaceutical agents and in the past people have interpreted that to also include injections and the safety record is not perfect for any profession but it is certainly is reflected by the care we have given over the course of the last 23 years. I am asking the Board to allow optometrists to make a clinical judgment. Allow them to treat medically and we certainly are

sophisticated enough, we are caring enough, we are compassionate enough to call in specialty care whenever its involved or necessary. Whether that involves something that is straight forward and topically treated like a cornea ulcer, like a retinal condition i.e., or Fluorescein angiography. These Fluorescein codes are not going to dictate that every optometrists is going to be doing Fluorescein. It's certainly the last thing that I want to perform but I think looking at the statute and looking at the profession optometrists are capable of making the same clinical judgment to refer and to operate within their own clinical skills as anyone else and that's all we're asking for. Thank you.

Mr. VonSeggen: Anyone else who would like to speak?

Johnny Loper, JD, Womble, Carlyle, Sandridge & Rice: My name is Johnny Loper. I am special counsel to the Optometry Board and I hope that you understand that I was observing casual Friday and did not believe I was going to be called on to speak. So, I hope you view my dress as perhaps a fashion mistake but no sign of disrespect to this Board. I also have sympathy for your position. You find yourself sitting today more in the position of people that I traditionally talk to, that being judges, than physicians perhaps. You are in a situation which is going to cause you to either confirm a previous decision that you've made or change that decision. I can't speak to the medical aspect of what it is you have to do. I would like to speak to you for just a few minutes if I could about the legal aspect of what it is you may be called on to do and the decision you will have to make. Bo and I have known each other for a long time and I know he will not take it personally when I say what I am about to say and that is I disagree with him in several respects. That's what lawyers are paid to do. I don't think what you have done is redefining surgery. The problem here, and I say this with all due respect and I said this in 1994 I believe in Dr. Kanof's presence and perhaps in the presence of others of you who were in the court room when we had our first real shooting war with this agreement. The problem is that the legislature has not defined surgery in North Carolina. The Medical Board has not defined surgery in terms of a rule or a regulation and with all due respect, attorney general's opinions especially those which don't even appear in the attorney general's official reports, while they are advisory in nature I think the case law that I can cite you and I will ask you if you have any desire to hear anything else from a lawyer that I be able to respond to Mr. Bobbit's memorandum and brief to you with what I believe would be the Optometry Board's position on this issue.

Mr. VonSeggen: Please do that. I would appreciate that.

Mr. Loper: I will certainly do that. Attorney generals' opinions have nothing near the force of law. They are advisory only. Generally, the case law that you see says that while a board's, a board like yours, the board's definition or interpretation of a statutory term is not necessarily the be all and end all. Courts generally don't want to be in your position. They don't want to be determining what surgery is and therefore they give great deference to what people in your position determine about the meaning of terms in their own statutes. What I would hope is that you have already made that decision. You have not necessarily defined what surgery is in every instance but you have said two things I think that an injection in and of itself and in all cases is not surgery. There are instances in which an injection is not surgery and under the statute that Mike read to you a moment ago and under your statute if an injection is not surgery in every instance then I would argue to you that from there on this is not a Medical Board problem. If you are going to take the position that in every instance an injection is surgery then I don't know what we can do other than disagree with you. I really think the Optometry Board would have to disagree with you in any forum that was required. If you are saying though that there are instances in which an optometrist properly qualified and trained by education, training and experience can for certain conditions administer a therapeutic pharmaceutical agent by way of injection, then I think from that point on it's the Optometry Board's job to police that issue. Just as it was 23 years ago in 1977 the day before that

statute went into affect optometrists could not use certain types of drugs. The day after that statute went into affect they could and over those 23 years I echo my statement. The Board's record in policing its licensees has been, I think, exemplary. You're not redefining surgery. All you're doing is excluding a couple of things from the definition. Now I would, if you are going to define any invasion of tissue plane or any specifically any injection as surgery then my wife is practicing medicine without a license because she self injects Imitrex. You've got all sorts of problems with that definition. You've got all sorts of legal problems with that definition. People who self inject for diabetic conditions and there are probably others to which I am just ignorant, but I would argue to you those two things alone would cause a problem with a definition that has been urged on you. There's been a few comments about the agreement that we entered into back in 1994. The agreement in my Board's interpretation and I was part of drafting that agreement as I believe Mr. Bobbit was and others on the Board may have been on the Board then and at least known about it if you didn't take part in. That agreement does not have the force of law except to the point it is a contract. It was an agreement between several bodies at that point, a settlement agreement if you will, of a good way to solve a problem at least in part. We took what we could get. We defined three different groups of codes. One of which said or was defined to be a group of codes which everyone agreed, everyone involved agreed contained CPT Codes having procedures that could be performed by optometry, legally within the scope of practice. There was a second group of codes which everyone agreed contained at least one procedure that could legally be performed by optometrists. There was a third group of codes, and this is where the misconception comes in, and I've heard it said several times. There was a third group of codes that were never defined and never meant to be forever outside the scope of practice of optometry. There's an old statement, "hard cases make bad law." We decided not to make bad law bad medicine at that point, we set those codes aside and it's the next paragraph that people don't read in that agreement and I would urge you to read it. That next paragraph simply says we agree rather than getting into a shooting war like we've just done and spend resources which would be better put to use elsewhere, we agreed to sit down and talk with each other and try to work things out before either side takes a position. Before the Optometry Board declares that a certain code can be performed by optometry or before the Medical Board hauls someone up on charges and tries to have someone held to be in violation of the Medical Board Act and practicing medicine without a license that person being an optometrist. That paragraph simply says we'll agree to talk about other things in the future being these codes or others. This Board believes provisions that define once and for all never to be changed what the scope of medicine. I would argue with you there are new technologies and new things coming up all the time that you need to consider whether it is appropriate for physicians to do. All my Board is trying to get you to consider which you have done and you have agreed with at this point. Is that there are situations in which a properly educated trained and experienced optometrist is perfectly capable of performing certain procedures that do not constitute surgery. So I would simply ask you to consider whether you want to take the position I think that's been urged upon you even that any violation of a tissue plane is surgery or that all injections necessarily constitute surgery because I personally feel and I will be happy to provide some authority to you as I can, that those positions are going to be indefensible in a court of law and for God's sake lets hope we don't we go there, let's hope we can reach agreement on those issues. Again, I do ask that you allow me to submit something if you would like to set a time limit on me now or do that afterwards I am happy to talk with you about that but I will be happy to get you any sort of information, any sort of argument that you want me to do if you will just let me know what it is. Otherwise I will try to use better common sense than I did when I dressed this morning. Thank you.

Mr. VonSeggen: Is there anyone else?

Robert Sullivan, OD, North Carolina State Optometric Society: I am Dr. Robert Sullivan, private practice optometry in Gastonia, North Carolina. I had the pleasure at the meeting in

June where this all came about. Unfortunately the individuals who were here to discuss these codes, I am the only person that had the opportunity to speak. They are not here to defend themselves to some of the statements that were made but all I can say is that some of the comments that were made today were probably a little bit out of context and it would be nice to have both parties here to discuss these issues. We've listened to this for long enough so my main point today is to stress that my training and my role in life is to provide primary eye care to patients. When a patient comes to me they want me to identify their problem and give them my best information on what should be done for that patient. Whether it's no treatment, treatment, surgery, whatever that may be. I work in a group practice of optometrists and ophthalmologists so fortunately we do have surgical services available in our practice and my role in life to these patients is to identify whether or not they need to be treated and again, to identify what treatment modalities need to be done. There are patient cases that clearly indicate surgery is the primary mode of treatment and that patient is out the door to my colleagues that provide those services. Otherwise if there are procedures that can be done by me it's much better served by that patient for me to do those procedures and get that patient treated and on their way. That's what they want. They don't want the runaround, they don't want to see multiple practitioners, they want to be treated. We all know that. I'm held by a law and also held by an oath to do no harm. Just like every other physician is and therefore I am not going to choose to do something that I feel like I am not trained to do. I am not going to do something that I feel like is going to create harm or make me legally liable. We are all held by our law because of that and therefore I want to continue practicing optometry and therefore I am not going to make a mistake and do something that I feel is unright or wrong that is going to hurt the patient. That's basically the bottom line. If these codes are approved and passed we are not going to see an onslaught of optometrists doing these codes. In fact, you may not see a change at all. Again, as indicated a lot of these codes are not something that is done on a regular basis. But when it's indicated, it's indicated and therefore in the patient's best interest and I won't take anymore time. That's basically the point that I wanted to make. Thank you.

Mr. VonSeggen: Any other new speakers? Okay, Dr. Fekrat.

Dr. Fekrat: Thank you again for humoring me and letting me speak one more time. I wanted to address some of the issues Mike Clark brought up and it's easy to make generalizations. He stated that danger may be everywhere and it may be part of life and that's simple. But what you fail to mention, sir, is that optometrists are not trained in basic life support or advanced cardiac life support and yes danger is everywhere but you need to be prepared for it. He also stated that ophthalmologist can perform any medical procedure as any physician can perform any medical procedure but those of us who are physicians know that when you go to practice in a practice, or in a hospital, or in a university setting, following your training or changing to another hospital, that you fill out a form with all the privileges that you are trained to do. Those checklist are sent off to the people with whom you've trained to verify that you are indeed trained to do those procedures. So yes I am an ophthalmologist. I am not able to do corneal transplantation as a retina specialist. I am not able to do refractive surgery at Duke University Medical Center. I am not able to do glaucoma procedures even though I am an ophthalmologist and those are other procedures within ophthalmology. It was also stated that optometrists can go ahead and make the clinical judgment in the best interest of the patient and they are not trained to make the clinical judgment. The majority of eyes that they see have no pathology. So, I think that it's important for all of us and I do want to state that the facts that I mentioned earlier were all from the June 7th transcript and I would be happy to reconvene at any time with those people that made those to talk one-on-one and face-to-face about those very important issues. I think that we should all make what is the right decision so that we can all sleep at night and feel very proud because the implications are gonna be worldwide. Thank you.

Mr. VonSeggen: Anyone else here?

Dr. Clark: I would like to respond to that without getting into a shooting match here. I think there are quite a few optometrists that see in a lot of areas in North Carolina quite a bit of pathology.

Mr. VonSeggen: Dr. Clark please address the podium.

Dr. Clark: Okay, Okay. I would state that there a lot of optometrists that practice all over the State that see quite a bit of pathology and have to make clinical judgments all the time whether as Dr. Sullivan stated to treat or to refer and that responsibility goes whether any codes are passed or not. That's the reality. The point that I made and I think its maybe not understood as she brought it up I said there is a difference and I think we have to be real clear about is there is a difference between scope of practice and standard of care. She mentioned that she would not be performing the corneal transplant procedure and my discussion earlier was well it's within her scope of practice, it's probably not within her standard of care. And all I said earlier was that optometrists and the Board has on record stated that if optometrists are expected to not only operate within the scope of practice as defined by the statute but also within a standard of care. And that standard of care is defined by education, training and experience. Thank you.

Mr. VonSeggen: Any other new speakers, please identify yourself.

George Cooper, MD, Eye Physician & Surgeon, Fayetteville, North Carolina: My name is George Cooper I'm an eye physician and surgeon in Fayetteville, North Carolina. I hope that most of you are in receipt of a letter that was either faxed, e-mailed or mailed to your offices. Included in that letter are a few anecdotal cases that I've encountered in my practice and in response to Mr. Clark's statements about scope of practice and standard of care I just like you to find those letters and look at those few anecdotal cases that I've pointed out. I have it in front of me if you'd like me to go over them?

Mr. VonSeggen: If you've already submitted it, we'd rather you not. Please make your point.

Dr. Cooper: My point is that there are a number of things that have been done over the 23 years since the optometric scope of practice has increased that are not looked at in any critical way and the anecdotes I've included in my letter include the use of medications, missed tumors, missed diagnoses and I think that should be considered before any further, before any further privileges are granted or endorsed. That's my point. Thank you.

Mr. VonSeggen: I would to take the privilege of the chair at this moment to read the current definition of surgery as adopted by the North Carolina Medical Board and invite please short comments regarding your suggestions, improvements, modifications, problems with this definition. These definitions are available. We can provide you a written copy. It's in our standard position statements. If you have a copy they are there. This was originally adopted in July of 1999, was amended in January 2000. It's actually appended to the laser surgery position statement. But this is the most current definition of surgery by this Board. "Surgery, which involves the revision, destruction, incision, or structural alteration of human tissue performed using a variety of methods and instruments, is a discipline that includes the operative and non-operative care of individuals in need of such intervention, and demands pre-operative assessment, judgment, technical skills, post-operative management, and follow up." I would specifically like you to address that statement and if you can help us in any way to make that any clearer we've tried to be as clear as we can be. Please at this time if you would like to comment specifically to that definition I invite you to come to the chair.

Dr. Hampton: Specifically, I would like to know how you perform an injection without incising? A needle incises the skin. But more than that I think that…

Mr. VonSeggen: A needle punctures the skin. It does not incise the skin, technically.

Dr. Hampton: Still a form of puncture is a form of an incision. When I remember Chalazion I basically puncture the skin but I call it an incision. And again, we are speaking now about technicalities. I think what you're asking us to do, you are going back to our ill-defined statute which does not address the gray area of injections. Injections are a gray area, not defined by the North Carolina statute. The consent agreement defines that area. In states which have ill-defined statutes there have been renegade boards specifically the latest in Wisconsin. They have an ill-defined statute such as ours they declared laser surgery to be a procedure and declared that laser procedures, PRK, Lasix, etc., were within the scope of practice of optometrists.

Mr. VonSeggen: That is not going to happen. Our definition is appended to laser surgery definition.

Dr. Hampton: But it is not statutory law and so again this Board quickly had to rescind when they were threatened with a law suit, they had to rescind their declaration but simply beware of what's going on in other states.

Mr. VonSeggen: Thank you. Are there any other responses to the definition of surgery?

John Robinson, OD, Executive Director, North Carolina Board of Optometry: You can tell by what little hair I have being as gray as it is I've been around this barn for a few years. I would have had nothing to say beyond the fact that until the anecdotal cases came to light. I would like to leave as a matter of record a memorandum written on February 8, 1988, to our own Board and was used whenever people made inquiries about the allegations of mismanagement by optometrists over a period of years back in the early 70's. This memorandum covers the period of February 1984 through January of 1988. It gives a running account of the Board's attempt to subpoena records of alleged mismanagement, the Board's final action in the matter. I'm not going to go through it for you, you can read as well as I do. I would like to have that as part of the record.

Mr. VonSeggen: Thank you and I would invite anybody else who has any other documents or information you would like to submit to the Board to send it to Mr. Andy Watry our Executive Director for inclusion in our record and I would like to encourage you to do that within the next 30 days. If you can do that within the next 30 days, that way we will have a time frame to evaluate and in good faith continue to deliberate with you all on this. Thank you for coming and I hope you all have a casual Friday afternoon. Thank you.

Dale Lear, Board Investigator; Retirement of

A retirement dinner was held for Mr. Dale Lear Thursday evening, July 20th.

Research Task Force on Postgraduate Training Requirements; Update

At the May 2000 Board Meeting Mr. VonSeggen appointed Dr. Pories to Chair the Research Task Force on Postgraduate Training Requirements for Physicians in North Carolina. He also assigned the charge and composition of the task force. On July 22, Dr. Pories presented a letter to Mr. VonSeggen affirming the charge of the task force and requesting a change in the composition as follows:

Composition of Task Force:

For the Board:
Andrew Watry, Chair
George Barrett, MD
Hector Henry, MD
Stephen Herring, MD
Elizabeth Kanof, MD
Walter Pories, MD

For the Medical Schools:
The four Deans or their delegates
Gene Orringer, MD (for MD/PhD programs)

For AHEC:
Thomas Bacon, Dr.P.H.

Action: Mr. VonSeggen approved the above changes to the task force and gave the go-ahead to proceed.

MINUTE APPROVAL

Motion: A motion passed that the May 24-27, 2000, Board Minutes be approved as amended and that the June 21 and 22, 2000, Board Minutes be approved as submitted.

EXECUTIVE DIRECTOR'S REPORT

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

- **Legislation:** Mr. Watry briefed the Board on the legislative situation. He discussed some of the provisions in HB 432 that were also in HB 1049 and noted that some of the disciplinary avenues from HB 1049 were enacted into the Optometric Practice Act. Also, HB 432 amended NCGS §90-14 regarding immunity.

- **Office Automation:** Construction improvements are to begin Monday (cubbies, fire door, expansion of Conference Room 'A', etc.). CAVU, the company that made LINC, has moved to credit card reregistration which is more accurate, assures error free reregistration and moves dramatic overhead from the office. The Board will be sending out reregistration notices encouraging reregistration electronically. The feedback has been good so far. Forty-three physicians have gone through online reregistration so far in two days.

  We are continuing to correct and take care of issues from our file conversion. The new computer system is designed to be graphics-friendly. All public orders are now available in our database and available to DataLink users. The next step is to give access to the public and ultimately moving to licensing issues. One big burden is all of the querying from applicants which is a huge load on the staff.

- **Retreat:** Per the President's orders, a Board Retreat is planned as part of the October Board Meeting. Mr. Watry would like input from all the Board Members on what they want and what they thought about the last Retreat.

PUBLIC AFFAIRS/COMMUNICATIONS PROGRAM REPORT

Dale Breaden, Communications Director, presented the following information:

Forum

The second number of the *Forum* for 2000 has just appeared. It features, among other things, an article by Mr Watry introducing the now fully approved CME rule (with a copy of the rule's text); a piece on domestic violence by Ms Laura Queen, with commentaries by Dr Linn Parsons and Dr Elizabeth Kanof; personal essays by Dr Roufail and Dr Pories; a reprint of Karen Garloch's fine article on Dr Barrett from *The Charlotte Observer*; an announcement of Mr Walsh's appointment to the Board; reviews of two books, both produced in North Carolina and one of particular interest in the Asheville area; four letters to the editor; a message from Mr VonSeggen on the future of medicine and medical regulation as the new technologies push ahead; and a column by Mr Watry on the importance of access to patient records. Beyond the CME rule, this number also publishes the new Position Statement on Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist; a notice concerning inactive license status; the proposed rules for the clinical pharmacist practitioner; a brief comment on and a membership list of the NCMB Physician Assistant Advisory Council; and an announcement of the new electronic registration system.

As you know, beginning with the first number of the *Forum* for 2000, we reduced our distribution by over 3,000 copies due to the *Forum's* availability on the Internet. This reduction program has been accepted with good grace by most of those individuals and organizations cut from the mailing list. (Well, there has been just a bit of whingeing here and there.) Nonetheless, the inevitable growth of the regulated community will cause the circulation to slowly rise again over time. Fundamentally, the circulation covers the MD/DO, PA, and NP communities; all print and electronic news media (and key reporters attached to them); medical residents (drop-shipped); medical, PA, and NP students (drop-shipped); the EMS office (drop-shipped); related state regulatory boards and other relevant state agencies; North Carolina offices of professional organizations/societies; hospital staff offices; hospital libraries; state medical boards across the nation; the NC Society of Healthcare Attorneys; and the FSMB.

With recent improvements in the Web site now complete, we hope to add the full *Forum* index to the site fairly soon.

Web Page

Shannon Kingston and I have spent quite a bit of time planning improvement--evolutionary, not revolutionary--in our Web site. That process has now been completed and you will see the result the next time to examine the site. As you will see, we have remained committed to creative but simple ways to refresh the site and keep it vital. Needless to say, Shannon's technical skill has been invaluable in making the changes a reality.

Note first the change in the opening menu, which has been reduced in size, but allows the user to see all the submenu of any primary menu item in a yellow drop-down box. (We determined the frame approach to a menu had more negatives than positives from a user's point of view.) Also notice the creation of a Site Map, a copy of which is on the last page of this report. In one page, it gives the user a look at the entire site's structure and resources. It can also be used to link directly to any part of the site. The Site Map is the most significant single user improvement. The addition of a subtle complementary color to various pages also adds a bit more interest. On the home page, the colored borders around text reduce line size a bit and make the text more readable. The use of color and caps in the "welcome" line is also more appealing. Other subtle design changes and improvements have been made, but I won't belabor them. Overall, the friendliness of the site has been further enhanced.

Content, of course, is what the site is actually about, and our site remains rich in content. The Site Map makes that clear. And as you know, the site contains virtually all the Board=s publications, documents, and statements. They are easily available for printing from the site, some exactly as published by using the Adobe Acrobat Reader. Complaint forms can also be printed from the site, as can the Hospital Staff Reporting Form. Not too long ago, we added a section on the new registration system and inactive status. With Mr VonSeggen's advice and assistance, Shannon has now implemented the physician assistants section and gone on to add nurse practitioners. In the area of Featured Items, we have the most recent information on electronic registration and the new CME rule. In The Board section, we have added a revised

history of the Board and a list of directors. Information on the Board's videos and audio tapes has also been put on the site. Beyond these additions, each section has been reorganized and restructured.

Further additions and improvements are being planned, it is a constant process, and Shannon and I would welcome any comments or suggestions you might have. We are always open to new ideas we can steal.

[Ms Meelheim has informed us that, after long and careful work in the Operations Department, the Board's full public record file will be available on line, via DocFinder, very soon. The system for doing this is now being tested through use on our subscriber DataLink and our intraoffice Link and is proving successful. This step will be a major advance for the Web site and will enhance its value to the public dramatically. We will announce it with appropriate trumpets and tympani in the *Forum*, in a general news release, and on the Web site. Stay tuned!)

Informational Brochure

With the General Assembly now adjourned, publication of the revised brochure will go ahead as soon as possible. Most of its text is already on the Web site and we will not be printing as many copies as previously.

Other Publications

Mr VonSeggen's *Forum* article on communication recently appeared in the *Medico/Legal OB/GYN Newsletter*. A letter from Mr Watry appeared in the *North Carolina Medical Journal* for May/June in response to a letter from a physician complaining about the Board's examination of a complaint involving the reporting of child abuse. Recent numbers of the Mecklenburg Medical Society's *Mecklenburg Medicine* have featured articles on the Board's most recent position statements and made note of the soon to be introduced electronic registration system.

Radio/TV Broadcast Activities

Ms Corey Root has replaced Fran Diltz as producer at the NC Agency for Public Telecommunications. I have had a long conversation with her recently and will be meeting with her next week to discuss enhanced cooperation between the Board and the Agency. Meanwhile, we hope to publish articles about the Agency's health related programs in upcoming *Forums*.

PA/NP Materials

Shannon Kingston's work on the new PA/NP section of the Web site was noted above. She is also attending meetings of the PA/NP Committee to assist her in developing *Forum* materials related to PAs\NPs.

Presentations to Public and Professional Groups

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

Andrew Watry

1999

Wake County Medical Society--August 19
NC Association Medical Staff Services (at Board offices)--August 20
Wake Forest U School of Medicine (MAAP program)--September 30
Cabarrus Co Medical Society--November 4

2000

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

Diane Meelheim

1999

Womack Army Hospital (NP)--August 18
Regulatory Update, Duke University Medical Center PA/NP Program--September 25
2000
UNC School of Public Health students--February 22
Duke University School of Nursing/NP students (Fayetteville)--February 24
Wake Forest University PA Program--March 13
Duke PA Program--April 27
UNC School of Nursing, FNP students--May 23
ECU School of Allied Health, PA Students--June 29

James Wilson
1999
ECU School of Medicine Health Law Forum (Challenges for NCMB)--September 15
Wake Forest U School of Medicine (MAAP program)--September 30
East Carolina University School of Medicine (Med Jurisprudence and mock trial)--March 6
2000
UNC School of Law, Presentation to students on Health Law--January 24
ECU Medical School, Fourth Year Students on Health Law--March 6
ECU School of Medicine Health Law Forum, Medical Errors--September 13
NC Society of Healthcare Attorneys, Telehealth--October 6
Wake Forest U School of Medicine (MAAP program)--November 2

John Jargstorf
1999
Led FSMB Investigator Workshop Seminar: Prescribing Issues--November 5-6

Donald Pittman
1999
Led FSMB Investigator Workshop Seminar: Prescribing Issues--November 5-6

Mr VonSeggen
1999
Winston-Salem Medical Group Managers Meeting--November 10
Physician Assistant Section, North Carolina Medical Society Meeting--November 13
Board Meeting, North Carolina Academy of Physician Assistants--November 14
2000
Cape Fear PA Regional Meeting, Wilmington--February 22
East Carolina University PA Program--February 22
Wake Forest University Conference on Inappropriate Patient Relationships--February 25
Wake Forest University PA Program--March 13
NC Medical Group Managers Spring Meeting--March 31
"Job Powwow" session on Regulatory Issues in Job-Seeking, Winston-Salem--April 1
Forsyth Co Med Society, retired physicians, re: Volunteer Licenses, Wake Forest U--April 5

Mr Saperstein
1999
Wake County Medical Society--August 19
Wake Forest U School of Medicine (MAAP program)--September 30

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

Board Action Report

The detailed bimonthly disciplinary report system continues to function well, making disciplinary information available to all health care institutions and media in the area of subject licensees' practices and to organizations and agencies with statewide responsibilities. A full year of reports appears on our Web site. This use of the Web site, combined with our new e-mail facility, has now made it possible to reduce the number of print copies of the report needed for mailing. A cumulative report also appears in the *Forum*, and special notices concerning revocations, summary suspensions, suspensions, and surrenders are sent out when the information is received by Public Affairs. These are posted on the Web site for several months under What's News and AImmediate Releases.Thanks to the Internet, media throughout the state, not just in counties where subject practitioners live, can now receive full listings of Board actions on a regular basis.

Our thanks, as always, go to Mr Wilson and to Jenny Olmstead for reviewing each Board Action Report prior to its release.

[I should note that we do not actively distribute Charges and Allegations when they are filed by the Board. However, they are public record documents and we make them available as soon as they become effective to anyone who requests them. We also send them automatically to all members of the media that have asked us to inform them of any charges filed against practitioners in their coverage areas. We have not placed Charges and Allegations on the Web site.]

Annual Board Action News Release

We received excellent coverage on our data release and saw little press attention given to either the Public Citizen or the FSMB reports. The Board Action report will be left on our Web site throughout the year.

News Clippings

We continue to make the regular weekly packet of clippings from the Internet available to you on disk. (Some items, of course, are not available electronically and hard copy must be sent. This includes materials from our own NC clipping service and the FSMB's clippings from Bacon. The latter, as you have noticed, are sent to us by the FSMB in a rather scrambled form, often poorly copied and hard to read.) I should note that the electronic items are received here in a form that is triple spaced, with items running directly into one another. Shannon restructures these into an easily readable form for your convenience.

[The above is not intended to be a report on all activities of the PA department, director, or staff.]

NOMINATING COMMITTEE REPORT

Wayne VonSeggen, PA-C; Elizabeth Kanof, MD; Paul Saperstein

The Nominating Committee met at the Offices of the Medical Board. Present were: Wayne VonSeggen, PA-C; Elizabeth Kanof, MD and Paul Saperstein. The following nominations for 2001 were made to the Board:

President -	Elizabeth Kanof, MD
Vice President -	Walter Pories, MD
Secretary/Treasurer -	John Dees, MD

Motion: A motion passed to approve the Nominating Committee Report as presented to the Board; the following Board Members were elected for the noted positions for 2001: President, Elizabeth Kanof, MD; Vice President, Walter Pories, MD; and Secretary/Treasurer, John Dees, MD.

ATTORNEY'S REPORT

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

The Legal Department reported on 61 cases. A written report was presented for the Board's review. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

EXECUTED CASES

AUSLEY, Mett Bagley Jr. MD
Order terminating Consent Order executed 7/10/2000

BALOCH, Mohammad Haroon MD
Order to Dismiss executed 6/3/2000

COLLINS, Natalear Rolline MD
Order terminating Consent Order 7/10/2000

COBB, Timothy Lee PA
Consent Order executed 6/15/2000

ENGLEMAN, James Donald Jr. MD
Order terminating Consent Order executed 7/10/2000

EPPS, Mark Harrison PA
Denial mailed to PA 7/7/2000

GROGAN, Patricia Jo MD
Consent Order executed 6/21/2000

KNISELY, Samuel Scott MD
Order of examination executed 7/10/2000

LANIER, Deborah
Letter to Attorney General's office – 7/17/2000

MCCLELLAND, Scott Richard DO
Consent Order executed 6/22/2000

REES, Terry Taylor MD
Order to Dismiss executed 6/3/2000

RIDDLE, William Mark MD
Consent Order executed 6/14/2000

STEWART-CARBALLO, Charles Willy MD

Termination of Consent Order executed 7/10/2000

ZABENKO, Robert Tracy DO
Consent Order executed 6/15/2000

HEARINGS

CHUMAK, Bogdan Alberto, MD
BOARD ACTION: None (Not served with Notice of Hearing) Hearing scheduled for September

FINCHER, Ronald Edwin, MD
BOARD ACTION: Suspend indefinitely, stay after 30 days if MD signs a Consent Order admitting the particulars of the Virginia action and get a prior PHP assessment.

KONG, Lok King, MD
BOARD ACTION: Consent Order executed

POLICY COMMITTEE REPORT

John Foust, MD, Chair; Elizabeth Kanof, MD; Hector Henry, MD; Paul Saperstein; Stephen Herring, MD; George Barrett, MD, Aloysius Walsh

The Policy Committee was called to order at 12:10 pm, Wednesday, July 19, 2000, at the office of the Board. Present were: John W. Foust, MD, Chair; George C. Barrett, MD; Stephen M. Herring, MD; Elizabeth P. Kanof, MD; Paul Saperstein; John T. Dees, MD, Board Member; Aloysius P. Walsh, Board Member; Andrew W. Watry, Executive Director; Dale G Breaden, Director, Public Affairs (PC Staff); Jeffery T. Denton, Board Recorder (PC Staff); Shannon Kingston, Public Affairs Assistant. Absent was Hector H. Henry, II, MD

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

Review of Minutes
The minutes of the June 21, 2000, Policy Committee were reviewed and accepted.

Scope of Practice Subcommittee Update (Dr Herring, Mr Saperstein, and Dr Kanof)
This subcommittee is in the process of setting up a meeting.
Status: A work in progress.

Alternative Medicine Subcommittee Update (Drs Kanof and Henry)
Ms Meelheim continues to distribute alternative medicine literature to subcommittee members. Dr Martin Sullivan, Director of Duke's Center for Integrative Medicine, will make his presentation to the Committee and the Board at 12:00 Noon on Wednesday, August 16, 2000, during the Board's regularly scheduled committee meetings.

Office-Based Surgery/Anesthesia: Report on Progress of Draft Position Statement (Dr Herring)
A "draft" position statement was distributed for review. Dr Herring called this version 1 and referred to it as a very general statement that does not go into specific details. A discussion ensued regarding the definition of an ambulatory surgical facility and office-based surgery, certificates of need, the proposed rules presented by the Health Care Commission at the last Committee meeting, and the responsibility of the Health Care

Commission. Generally, it was felt that under the current statute a physician's office set up for surgery could fall under the definition of an ambulatory surgical facility.

Whatever the case, the issue is whether the Board should adopt a statement designed to protect patients in the context of office-based surgery. During the discussion growing out of the review of Dr Herring's first proposal, Dr Kanof emphasized that particular attention should be paid to the concept of "transfer protocols," because some specialties do not routinely have admitting privileges. She was concerned that the implication would be that a physician must have admitting privileges. It was strongly felt by the Committee that if a physician does not have hospital admitting privileges he or she should, as a minimum, have "stand-by" arrangements for admissions. The so-called "911" transfer protocol was not considered acceptable.

It was determined that emphasis in any statement should be placed on the "responsibility of the physician in an office-based surgical setting" rather than on the facility itself. The consensus was that the position statement should be more general than specific (too much detail could limit the Board's flexibility).

Action: Dr Herring will continue his work on the statement, making revisions in keeping with the Committee's recommendations and bring another "draft" position statement back to the next regularly scheduled Policy Committee meeting.

The Role of EMS in Injury Prevention

The PA/NP/EMS Committee referred a document titled "The Role of EMS in Injury Prevention, Community and Public Health" for review and comment. The Policy Committee was concerned with some of the activities listed in the document and what they could become. It was felt that some of the activities could be seen as the practice of medicine and that EMS might be stepping into the home health arena. More refinement and definition is needed. The Committee felt strongly that adding home medical visits to the scope of practice for EMS would be a significant departure from the standard and would probably require a change in the name of the profession itself. Dr Kanof briefly described how California EMS personnel had linked up with the Fire Department and now cross-train with firefighters.

Recommendation to Board: The Committee recommends the Board not endorse this document because it does not reflect what is understood to be the purview of Emergency Medical Services.

Motion: A motion passed that the Board not endorse this document because it does not reflect what is understood to be the purview of Emergency Medical Services.

The Use of Non-Physicians in Medical Offices

The PA/NP/EMS Committee asked the Policy Committee if it believes a position statement should be developed on the use of non-physicians (other than licensed nurses, PAs, or NPs) in medical offices. Concern was focused on medical assistants, EMTs, and others. It was noted that EMTs have been working part-time in physicians' offices as medical assistants. A discussion ensued regarding what physicians can let non-physicians in their offices do and the responsibility of physicians regarding the activity of such non-physicians. The point was also raised as to whether EMTs should wear identification badges noting they are EMTs when working in physicians' offices. The Committee could think of no significant reason why this should not be allowed.

Recommendation to Board: No policy statement is needed at this time on the use of non-physicians as medical assistants.

Annual Review of Position Statements

A page-by-page review of the Board's Position Statements was undertaken. Several suggestions were made and noted by staff. Due to time constraints, the review was curtailed and will resume on page 30 of the Position Statements at the next regularly scheduled Committee meeting.

Role of Optometrists in the Pre-surgical Evaluation of LASIK/PRK Patients

An attorney in Charlotte, who represents an ophthalmologist in Charlotte, sent a package of information to the Board for review. Her client is concerned that in some centers optometrists perform all pre-surgical evaluations and one-day post-surgical care of LASIK/PRK patients. In her client's opinion, only medical doctors are qualified to perform the pre-surgical evaluation, to discuss the risks and benefits of surgery with a patient, and to recommend a patient for surgery. It is also her client's opinion that, as with cataract surgery, only the operating surgeon, or another medical doctor with appropriate training, is qualified to perform the one day post-operative visit for LASIK/PRK patients. It was suggested that the Board may want to consult with the Ophthalmological Society regarding this issue. Mr Walsh observed that some ophthalmologists send these patients to family practitioners for the workups. What constitutes a presurgical evaluation would need to be defined. Is an optometrist equipped for that or should it be a physician?

Action: This matter is referred to the Scope of Practice Subcommittee for an in-depth review and recommendation back to the Committee. The position statement regarding "Care of Cataract Patients" will also be reviewed during this process.

There being no further business, the meeting adjourned at 2:50 p.m., Wednesday, July 19, 2000.

Motion: A motion passed to accept the Policy Committee Report as amended.

OPERATIONS COMMITTEE REPORT

Paul Saperstein; Wayne VonSeggen, PAC; Elizabeth Kanof, MD; Walter Pories, MD

(The Operations Committee did not meet during July 2000)

EMERGENCY MEDICAL SERVICES (EMS) COMMITTEE REPORT

Wayne VonSeggen, PAC; Walter Pories, MD; John Foust, MD; Aloysius Walsh

(The EMS Committee did not meet during July 2000)

PA ADVISORY COUNCIL REPORT

Wayne VonSeggen, PAC; Elizabeth Kanof, MD; Walter Pories, MD

The PA Advisory Council was called to order at 3:00 p.m., July 19, 2000. Members Present: Laura Gail Curtis, PA-C, Bill Dillard, PA-C, John Foust, MD, Debbie A. Hauser, PA-C, James E. Hill Jr., M.Ed., PA-C, Elizabeth Kanof, MD, Marc Katz, PA-C, Wade H. Marion, PA-C, Walter Pories, MD, Bud Shelton, PA-C, Wayne Vonseggen, PA-C, Al Walsh. Staff Present: Andy Watry, Erin Gough

1. Introduction of New Members

2. Updating Address and Contact Information

3. Discussion on Making the PA Advisory Council a Permanent Committee

    a. Mission statement developed
        i. Maintain and enhance PA care in NC by informing the NCMB of matters regarding PA practice, regulation, education, and professional issues

ii. Keep the communication channels open to the leaders of the PA profession in NC
iii. Suggest recommendations for improvements in regulations affecting practice of PAs
iv. Provide educational opportunities to PA students, graduate PAs, and PA educators regarding the regulations affecting PA practice

b. Suggestions on who should be members of the Council (i.e., representative from NCAPA, NC PA Program Directors, etc.)
c. Terms of Appointment
    i. Terms will consist of 3 years, maximum of 6 years (2 terms). After 2 terms, member must leave for 1 year
    ii. Consideration of ex officio members
        1. NCAPA leaders
        2. NCMS PA section
        3. PA program directors
        4. Gov't affairs committee of NCAPA
        5. All members of PA Committee from NCMB
d. Meetings and Contact with Full NCMB
    i. It was suggested that it be written into the bylaws of the NCMB that the PA Council may meet with the Full Board, at least once per year, if needed
    ii. Council will meet a minimum of 2 times per year, or as needed. An e-mail network for communication in between meetings will be developed

4. Organization of Council
    a. It was determined that the Council needs to elect a chairperson, an assistant chair, and a secretary
    b. It will be necessary for the chairperson to be a PA
    c. Bylaws also need to be developed for PAAC
    d. Recommended including in NCMB bylaws the ongoing relationship with PAAC

PHYSICIAN ASSISTANT COMMITTEE REPORT

Wayne VonSeggen, PAC; John Foust, MD; Walter Pories, MD; Aloysius Walsh

PA License Applications-

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

Board Action: Issue full licenses

PHYSICIAN ASSISTANT	PRIMARY SUPERVISOR	PRACTICE CITY
Carter, James Patrick	***	
Daignault, Thomas Harold	***	
D'Avilar, Philip Antoninus		
Okwara, Benedict		Monroe
Davison, Loralee Hope	Kadakia, Ajay S.	Greensboro
Finch, Jessica Anne	***	
Gerni, Kimberly Thaxton	***	
Hooper, Arthur Ross	***	
Long, Traci Celeste	***	

PA Temporary License Applications-

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

Board Action: Issue temporary licenses

PHYSICIAN ASSISTANT	PRIMARY SUPERVISOR	PRACTICE CITY
Hatfield, Misty Ann	**Sapp**, Amy C.	Winston-Salem
Mundy, Jonathan Todd	**Kernodle Jr**., Harold B.	Burlington

The following physician assistants hold a temporary license and are requesting a full license by submitting passing NCCPA results-

Board Action: Issue full licenses

Lonigan, Cynthia G., PA-C
Pepper, Jeremy Seth, PA-C

Reactivation of Full PA License-

Gibson, Martha Brockington ***

PA Intent to Practice Forms Acknowledged-

PHYSICIAN ASSISTANT	PRIMARY SUPERVISOR	PRACTICE CITY
Banner, Phyllis Prewitt	**MacGuire**, Osborne Rainer	Morganton
Caceres, Jorge Luis	**Meyer**, Graham Scott	Fayetteville
Caceres, Jorge Luis	**Tonog Jr**., Jose Tan	Fayetteville
Cotton, Peggy Diane	**Clary**, Bryan Marshall	Durham
Crump, Carole McAlister	**Fleury**, Robert Andre	Southern Pines
D'Amico, Keith Charles	**Egidio**, Robert John	Banner Elk
DeBarth, Kenneth Allen	**Oak**, Chang Yoon	Plymouth
Echard, Earl Vester	**Banks**, Kenneth	Zebulon
Ellis, Dale Edwin	**Adams**, Richard Wesley	Statesville
Ellis, Dale Edwin	**Coryell**, Carolyn Margaret	Statesville
Fetzko, Karen M.	**Klimas**, John T.	Charlotte
Giddings III, Joseph E.	**Crocker**, Daniel Lind	Rocky Mount
Hawryschuk, Michael C.	**Stephens**, Wayland Chad	Winston-Salem
Hedt, Stephen M.	**Talerico**, Paul J.	Smithfield
Hoard, John Thomas	**Risk**, Gregory Conway	New Bern
Holliday Jr., Robert Henry	**Kon**, Neal David	Winston-Salem
Hollo, Mark Walter	**Inman**, Joel Ray	Taylorsville
Horton, Ann Smyth	**Adams**, Richard Wesley	Statesville
Horton, Ann Smyth	**Dunaway**, Byron Edward	Statesville
Horton, Ann Smyth	**Seward**, Daniel Peter	Statesville
Horton, Ann Smyth	**Wood**, Kenneth Ervin	Statesville
Idacavage, Valery Mora	**Pelligra**, Salvatore John	Greensboro
Ingle, Carolyn Collins	**Stephens**, Wayland Chad	Winston-Salem
Ingle Jr., George Ballard	**Stephens**, Wayland Chad	Winston-Salem
Lamonica, Jami Lynnette	**Smith**, Bernard Michael	Dunn
Mullins, Diane Lancaster	**Nichols**, Gregory Scott	Goldsboro
Murphy, Kristen M.	**Passero**, Nicholas John	Winston-Salem
Newbrough, David Chester	**Battels**, Ralph Clare	Elizabeth City

Patterson, Andrew Henry	**Thompson**, Donovan Aaron	Charlotte
Pixton, Jan Maree	**Kleinsteuber**, Walter K.	Franklin
Rahn, Jennifer Lynne	**Gerber**, Patricia Sue	Greenville
Reece, Michealle Ann	**Patel**, Ramesh	Fayetteville
Rinehuls, David L.	**Crenshaw**, Brian Sanders	Greensboro
Schuster, Rikki Rose	**Keith**, Kimberly Davis	Nags Head
Seatvet, Mark Lee	**Oaks**, Timothy Eugene	Winston-Salem
Steitler, Laura Lynn	**Osbahr**, Albert James	Clyde
Sterling, David Matthew	**Harpe**, Keith Gray	New Bern
Strand, Justine	**Gradison**, Margaret	Durham
Streahle, Michael Yvan	**Roberson**, Jill Renae	Rockingham
Strupp, Matthew Lloyd	**Watters**, Karyn Renee	Greensboro
Troncale, Anthony David	**Raines Jr**., Arthur Lee	High Point
Warren, Edward Carl	**Medford**, Mark Frederic	Windsor
Williams, Alicia Ann	**Morrison**, Marion Ellen	Raleigh
Wolfe, Jon Richard	**Hooten Jr**., James P.	Burlington
Zimmerman, Daniel J.	**Hines**, Michael Herbert	Winston-Salem

Public Agenda Items for Committee Discussion-

A. The current PA regulations do not specify if a supervising physician has to have a full license.

Board Action (GB, EK) Staff is to develop a rule that addresses the issue of supervising physicians in training settings, etc. and bring it back to the Board.

Motion: The Physician Assistant Committee report was approved as amended.

NURSE PRACTITIONER JOINT SUBCOMMITTEE REPORT

Wayne VonSeggen, PAC; John Foust, MD; Walter Pories, MD; Aloysius Walsh

The NP Joint SubCommittee Meeting was called to order at 12:00 noon, Wednesday, July 19, 2000 at the North Carolina Board of Nursing Office.

Committee Members Present: Cheryl Proctor, RN, Marsha Pitts, RN, Marsha Rowe, RN(via Conference Call), Walter Pories, MD, Wayne VonSeggen, PA-C.
Committee Members Absent: Hector Henry, MD.
Staff Present: Ann Forbes, RN, Polly Johnson, RN, Linda Thompson,RN, Jean Stanley, CPS, Erin Gough, Diane Meelheim, NP,JD, Andy Watry, MHA.
Visitors: David Work, NC Board of Pharmacy, Barbara Morales Burke, Department of Insurance, Chelle Stinson, NCAPA.

The minutes of the May 24, 2000 meeting were approved. (see attachment A)

Pharmacy Issues:

1. Problems associated with Pharmacy Benefit Managers requiring DEA numbers as identifier numbers for processing even non-scheduled medication prescriptions were discussed. Some providers have chosen to not apply for DEA numbers, and do not feel that having a DEA number should be required for non-scheduled prescriptions. Providers who have had to surrender their DEA number have problems getting non-scheduled prescriptions covered. Mr. Work presented an obscure Agriculture statute 106-134.1 (see attachment B) which implies that a DEA number is supposed to be on all prescriptions !! This was news to everyone in the room.

2. The requirement to offer child-proof containers when providers dispense sample medications was discussed. Since this does not seem to be common knowledge it was decided that additional information should be provided to prescribers.

Old Business/New Business:

1. Issue of change in fee allocations, and effects of revisions of NP fees was briefly discussed. (see attachment C)
2. Revisions in NP regulations were presented which would (among other things) allow for portability of approval to practice for the NP. (copy for NP Joint Subcommittee members only at this time)

Both of these items were tabled for review by both Boards, and will be discussed at a meeting scheduled for September 19, 12 noon.

Next Meeting: November 15, 2000 at 11 AM at the NCMB.

The meeting was adjourned at 2:30 PM.

NURSE PRACTITIONER COMMITTEE REPORT

Wayne VonSeggen, PAC; John Foust, MD; Walter Pories, MD; Aloysius Walsh

NP Initial Applications Recommended for Approval after Staff Review-

Board Action: Approve

NURSE PRACTITIONER	PRIMARY SUPERVISOR	PRACTICE CITY
Abimbola, Emunolulia	**Ray**, Larry D.	Greensboro
Allison, Jan Stone	**Chang**, Paul S.	Asheville
Andrews, Valeria M.	**Guerra**, Marc F.	Lenoir
Brest, Jennifer	**Powell Jr**., Hugh M.	Cary
Brown, Asadra Sue	**Banzon**, Roberto P.	Rutherfordton
Bush, Tara Denise	**Callihan Jr**., Richard L.	Smithfield
Cockman, Patty Kiser	**Maughan**, Robert E.	Fayetteville
Forloines-Lynn, Wanda Sue	**Jaques**, Paul Francis	Chapel Hill
Gibbons, Emily Rebecca	**Downs Jr**., David Adams	Hickory
Johnson, Michelle Mitchell	**Tapson**, Victor Fallis	Durham
Joseph, Sally Ann	**Clayton-McCaskill**, Christy	Cary
Key, Susan Marie	**Smith**, Tony Preston	Durham
Kirk, Robin Ann Lynn	**Weatherly-Jones**, Cathi	Raleigh
Lewis, Karen Melissa	**Curran**, Diana Renee	Hendersonville
Moore, Cammie Barrett	**Gipson**, Debbie S.	Chapel Hill
Murphy, Anita Kathryn	**Wells**, Ellen C.	Chapel Hill
Oxendine, Victoria Faye Denise	**Schleupner**, Charles John	Wilmington
Pennell, Shannon Waters	**Abernethy**, David L.	Lenoir
Quinlan, Patricia Ann	**Sanderson**, Iain	Durham
Richards, Barbara Lee	**Onwukwe**, Augustine N.	Charlotte
Ross, Mary Katherine	**Rathbun**, Mary Anne	Charlotte
Ross, Mary Katherine	**Berkowitz**, Gerald P.	Charlotte
Wells, Holly Heather	**Kopelman**, Arthur E.	Greenville
Williams, Renee DuSold	**Liverman Jr**., Joseph Thomas	Smithfield

NP Initial Applications for Committee Review-

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

NP Subsequent Applications administratively approved-

Board Action: Approve

NURSE PRACTITIONER	PRIMARY SUPERVISOR	PRACTICE CITY
Barney, Julie Wood	**Edwards**, Joel Lynn	Mocksville
Bell, Judy Collins	**Link**, Arthur S.	Winston-Salem
Barrus, Anne Griffith	**Bobbe**, Dorothy J.	Burnsville
Beres, Michael Wayne	**Beres**, Mary Emma	Independence,VA
Boykin, Kathleen Day	**Meehan**, Joan	Clayton
Cartwright, JoAnna Kay	**Young**, Thomas Edward	Raleigh
Casaw, Patricia Pease	**Bridgers**, Stephen Burney	Wallace
Cunningham, Lynda F.	**McKay**, Cecilia S.	Chapel Hill
Daniel, Janice DeBell	**Abbott**, Thomas D.	Winston-Salem
Davies, Affivia Amy	**White**, Lena K.	Charlotte
Donnelly, Angela T.	**Semble**, Elliott I.	Winston-Salem
Dunston, Catherine L.	**Harris**, James M.	Camp Lejeune
Durham, Maria Gwen	**Cummings**, Lorraine M.	Asheville
Ellwood, Pamela Ann	**Collins**, Warren J.	Shelby
Eure, JoAnne H.	**Hooper**, Thomas E.	Wilson
Fennell, Karen Lynn	**Berkowitz**, Gerald P.	Charlotte
Ferris, Judy A.	**Baugham**, Leonard A.	N. Wilkesboro
Fisher, Gwendolyn Ball	**Lovin**, Vickie W.	Hickory
Fulbright, Melissa Martin	**Firnhaber**, Jonathon M.	Shelby
Fulbright, Melissa Martin	**Jones**, Stephen W.	Shelby
Griffith, Roberta Lu	**Molai**, Ashton V.	Ronda
Haaga, Margaret H.	**Bobbe**, Dorothy J.	Asheville
Harris, Crystal T.	**Soucie**, Carol J.	Harrisburg
Harshaw-**Ellis**, Karol	**Cobb**, Fred	Durham
Hessenflow, Louise H.	**Barri**, Michael John	Wilmington
Johnson, Kathryn A.	**Gaither**, Anthony Clark	Goldsboro
Kimble-**Hahn**, JoAnn	**Walters Jr**., Henry C.	Statesville
Kimball, Janice Louise	**Noble**, Richard Clayburn	Raleigh
McKnight, Patsy O.	**Beres**, Mary E. Holleman	Independence,VA
Pickett, Jan Greeson	**Girmay**, Aregai A.	Gastonia
Reed, Carol Jean	**Watters**, Karyn R.	Greensboro
Richards, Betsy E.	**McCord**, Marcella T.	Zebulon
Richards, Betsy Eddins	**Davis**, Cara L.	RTP
Rodgers, Teri C.	**Ajao**, Olufolarin	Gastonia
Sanford, Christine	**Forehand**, Mary Leigh	Wilmington
Shanley Jr., John Richard	**Cooley Jr**., Cornell T.	Fayetteville
Shinn, Susan Ellen	**Kelischek**, Sabine A.	Asheville
Simpson, Kathy Denise	**Link**, Arthur Stanley	Winston-Salem
Simpson, Kathy Denise	**Phipps**, John	Winston-Salem
Skaife, Anne Maureen	**Linster**, Dorothy M.	Durham
Strong, Susan	**Jones**, Thomas Howard	Chapel Hill
Vawter, Jean Ann	**English**, Martin E.	Huntersville
Wazenegger, Wanda E.	**McCall Jr**., Robert D.	Sanford

Whalen, Dara Marie	**Goudarzi**, Kamran	Wilmington
Zimmerman, Jill Allison	**Salyers**, Martha Jane	Asheville

LICENSING COMMITTEE REPORT

Kenneth Chambers, MD; Hector Henry, MD; John Foust, MD; George Barrett, MD; Martha Walston

FCVS
CATCHLINE: Discussion regarding adoption of FCVS as part of the application process for license by endorsement.

BOARD ACTION: Make FCVS an acceptable part of the current credentialing process.

MD certification for off shore medical schools
CATCHLINE: Will the Board accept certification of MD degrees from the US offices of these schools? Other foreign schools that have US offices are the American Univ of Beirut and Universidad de Guadalajara. Applicants say that the certifications are done by US offices, mailed to the campuses and then mailed back to the State Board office.

BOARD ACTION: Keep accepting what has been accepted in the past (certification from either location). Conduct further inquiry for what FCVS accepts before considering a change to the Rules.

Issuing Special Volunteer License
CATCHLINE: Volunteer licenses have been issued at the time of the interview prior to Board Vote. Should this procedure be changed to require Board approval before issuing the license.

BOARD ACTION: Present file to the Board before issuing license. If Physicians are volunteering their services at local youth camps and need a license prior to Board vote, issue temporary license at no charge.

Fee for Faxing
CATCHLINE: Dr. Herring has requested the Board reconsider charging a fee to FAX interview materials to Board Members in view of the time involved for staff.

BOARD ACTION: Consider e-mailing in PGP by scanning (only in emergency situations when a file did not get delivered).

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

A motion passed to return to open session.

SPLIT BOARD LICENSURE INTERVIEWS

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

The Board conducted 26 Split Board licensure application interviews. A written report was presented for the Board's review. The Board adopted the committee's recommendation to approve the written report as modified. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

APPLICANTS PRESENTED TO THE BOARD

Abbas , Haider
Adams , Jeffrey Gene
Adan , Victor
Aho , Todd Raymond
Alahari , Durga
Alexander , James Chester
Alexander , Joseph Tirone
Allan , Michael Leslie
Allen , Joseph Claudius
Aloia , Thomas Anthony
Alpers, Adam Lee
Amani-Yazdi , Rambod
Ameer , Nazim
Arnaud , Catherine Helen
Aronson , Lori Anne
Arthur , Jennifer Culbertson
Atkinson , Hal Huntley
Atree , Susheel Vaidya
Auge , Brian Keith
Avgeropoulos , Nicholas George
Ayala , Dwight Guido
Azizi , Ghobad
Bailey , Ronald Wesley
Bainbridge, Daniel Tom
Baker , Michael Dean
Baksh, Masud Reza Quadir
Balla , Somasekhara Raju
Basegoda , Mario Baldomero
Battaile , Melinda June
Becker , Marta Taylor
Belafsky , Peter Charles
Bengtson , Hans Eric
Bergin, Diane
Bhalla , Harpreet Singh
Bhushan , Susan Denice
Bini , John Kennedy
Bitar , George John
Bodenstine , Thomas Robert
Bonner , Mark W.
Bornstein, Jeffrey David
Bovio , Sylvia Gutierrez
Braunsteiner , Aaron Joseph
Braunsteiner , Melissa Marie
Breitfeld , Philip Paul
Browne , Lauren Indira
Browne , Richard Everette
Brumfield , Christopher Scott
Buchanan , Hope Renee
Burns , Bennett Stuart
Burton , David Scott
Butler , Rushia Lorraine
Cabinum-Foeller , Elaine Sharon
Cahn , Michael Louis
Calicott , Randy Wayne
Campbell , Robert Coulter
Caputo, Mark Edward
Carter , Shawn Lawrence
Chauhan, Ajit Singh
Chepuri , Neeraj Babu
Chiritescu , Micsunica-Elvira St.
Chiritescu , Mihai M.
Chow , Andrew On-Shing
Claiborne , Claudia Viola
Clark , Hollins Peel
Clevenger , Jeffrey Cabot
Collins-Ogle , Michelle Denise
Conley , Mary Gaffney
Corrington , Kip Alan
Cosenza , David Antonio
Cottey , Jessica Danforth
Coulson, Carol Catherine
Craigie , James Ernest
Cranfield , Terri Linn
Crockett, Robert Kemp
Daniels , Anthony Maurice
Daughtridge , Sarah Ellen
Davidowitz , Sheri Ryan
Davis , Brent O'Bryan
Davuluri , Ashwini Kumar
DeBuys , Holly Virginia
DeClerck, Paul A.
Desai , Pratibha Rameschandra
Desai , Ramesh P.
Deveshwar , Sanjeev Kumar
Deveshwar , Shaili
Dibble , Timothy David
Dickson , Loretta Anne
Doherty Jr., Richard Donald
Doody , Regina Marie
Doonquah, Kofi Adeleke

Doperak , Martin
Dorn, Henry H, III
Dua , Sakshi
Duckett , Olly Christopher
Duran , Mary Katherine
Eagle , Khanh Le
Elder , Kerren Harry
Ellingham, John Grant
Ellis , Thomas Leon
Ellis, Matthew James
Enendu, Osealuka Gabriel
Erdmann, Detlev
Ericson, Douglas Paul
Evans , Gregory Francis Felix
Exar , Elliott Nicholas
Fabiszewski , Nina Laurie
Fallin , Cheryl Lynn
Feiler , Alan Howard
Felix , Ana Cristina Goncalves
Feng , David H.
Finch , James Patrick
Flynn , Joseph Patrick
Foster , Mary Helen
Frey , Mary Elizabeth
Frost , Stefani Clemmensen
Funk , Kathryn Robb
Gaither, Kecia
Gaylord , Kevin Michael
Geideman , William Michael
Ghassemzadeh , Ali Reza
Giese , Jeffrey Alan
Goldberg , Joel Lee
Gonzalez , Carmen Laura
Gordon , Katherine Elizabeth
Gould , John Jay
Graham , Dwight David
Grandey , Emilymarie Forini
Greenberg , Myles David
Grimes III, John Alexander
Grimm , Paul Jeffrey
Gross , Ned Jay
Hamby , Andrew Logan
Hamerski , Douglas Andrew
Hames , Melanie Irene
Hansen-Bundy , Sherri Linn
Hardee , Michael Wayne
Hardin , James Ronald
Harvey, Robert
Hashmi , Saira Faryal
Hazey , Jeffrey Wallace
Hazlett , Donald Arthur
Heller , Cherrie Dawn
Hern , Tricia Lynn
Hodges , Ana Ceide
Hoffman, Stanley David
Holzhauer, Markus
Howden, James Keir
Huang , Xuemei
Hultman, Charles Scott
Hunt-Harrison , Tyehimba Afrika
Husain , Ali Khalid
Hutcheson , Joel Collier
Hwang , Janice Jeehyun
Ibrahim, Hassan
Ito , Kristin Elizabeth
Jacobe , Heidi Tewich
Jacobs, Kenneth Lee
Jain , Swati
Jamshidi , Maryam
Jindal , Vinod Kumar
Johns , Charise Bowman
Johnson , David Joseph
Johnson , Jeri Benton
Johnson , Yewande Joy
Jones , Alan Edward
Jordan , Christopher Page
Jordan , Mary Helen Allen
Kassem-Moussa, Hassan Ahmed
Katwa , Geeta
Kay , Lay Khin
Keeton , Lisa Gwyn
Keogh , Tracy Scheibling
Khan , Rashid Mahmood
Kile , Robert Merlin
Kim , Andrew Myong
Kim , Eugene Jacob
King-Thiele , Robin Lynn
Kirk , Shannon Richard
Kocis , Keith Christopher
Kodali , Sathish
Koehler , Jan O
Koss , James
Kraska-Cwikla , Alicja
Kratz, Sarah Smith
Kreissman , Susan Gail
Krumm , Erich Richard
Kucharski , Andrzej
Kulas , Donald Thomas
Kulubya, Edwin Samuel
Lager , Joanne Jenkins
Lagoo-Deenadayalan, Sandhya Anand
Lahiri , Nandini
Landis , Eric Tyler
Lanford Sr., Charles Amon
Langford , Joseph Scott
Lavelle , John Paul William Mary
Law , Michael Morris
Lee , Benjamin

Leon, Jorge Andres
Lepak , Christopher Jason
Lester , Susan M. Stephen
Liao , Ray Poonjui
Lin , Wei-Chen
Lipton , Melissa Faye Canham
Little Jr., Michael Edward
Lostetter Jr, Stephen John
Lucktong , Ekachai
Lucktong , Tananchai A
Maitra , Ranjan Simon
Maldonado Jr., Jose Roel
Mallemala , Sirisha Reddy
Mallette III, James Elmore
Mansfield , Richard Jeffrey
Markowitz , Michael Alan
Marlowe-Rogers , Heidi Cruz
Martin , Amy Godwin
Matl , Leona
Mbaoma , Rowland Oliver
McAdams , Stephen A.
McCreath, Brian James
McGonigle, Edward James
McQuilkin , Nancy Altamirano
Mehendru , Radhika
Mehendru , Raveen
Mellon , Christine Marie
Mellon , Richard Wilson
Michel , Jeffrey Bryan
Milko , John Edward
Miller , Elizabeth Anne
Mims , James Whitman
Mims III, Dawson Aultman
Mishra , Nilamadhab
Mitchell Jr., Jerry Wayne
Moore , Alan Rather
Morris , Paul Russell
Morse, Caryn Gee
Mosley, Diahann Frances
Mullis , Brian Heath
Murphy Jr., Richard Wayne
Murphy, Timothy G.
Muscoreil , Steven James
Mustillo , Peter John
Myers , Earl Joseph
Myers , Leticia Shawn
Nadaud , Matthew Clifford
Naseem , Kashif
Newcomer , Michael Kermit
Newsome , Janice May
Nickeleit , Volker
Ogle , Adrian Mahendra
Olson Jr., John Ackerman
Onaitis , Mark William
Ornstein , David Keith
Otero-Truitt , Tessie
Ott , Michael Robert
Page, Leslie Ellen
Parekh , Asha Ishwar
Park , Sun Mie
Patel , Jayesh Bhovandas
Payne , Margaret Manning
Payne , Robert Kenneth
Perry , Maurice Clive
Peters , Richard Mallory
Petree , Anelia Rose
Pezzi , Thomas Andrew
Pontzer , John Tucker Haywood
Poole, Georgina Aya-ay
Porter , Scott Edward
Powderly II, John Dwyer
Pruitt , Enas Lee
Qian , Xiao Yan
Quinlan , Aveline F.
Qumei , Moh'd Khaldoon
Raboi , Carl Andrew
Reddy , Vijaya-Kumar Konda
Reddy, Viswanatha Kurukundha
Reed III, Ward Loomis
Reeder , John David
Reger , Lance Boyd
Relacion , Valerie Kay Thornton
Reynolds , Stacee Elizabeth
Rice , Alan Michael
Rich , Preston Berkeley
Richardson , Ryan Nelson
Richardson Jr., Homer Allen
Richter , Brad Arthur
Richter, Holly Mallett
Ries, Kenneth Lange
Rikhye , Rakesh Kumar
Riley , David Michael
Ritsema , Marc Edward
Ritter , Ann Marie
Rodak , David
Rogers, Sherry Anne
Rosenberg , Jason Charles
Rothschild , Andrew Coleman
Rothschild , Barbra Bluestone
Roux , Jeffrey Jude
Russ III, Edmond V.
Samardar , Polya
Sang, Charlie Joseph, Jr.
Sangueza , Omar Pastor
Sappington, John Shannon
Satterfield , Robert Nelson
Sayeg , Ayoub
Scherczinger , Richard

Scherer , Lynette Ann
Schnorr , Amy Lynn
Schwab , Jodi Erin
Schwartz , Jeffrey Howard
Schwartz, David Albert
Scott , Timothy James
Seth, Satish Kumar
Shanbhag, Ashish Gajanan
Sharpe , Donna Estelle
Shaw, Frank
Spiekerman , Jill Marie
Stafford , Renae Elizabeth
Stamatakos , Theodore Steve
Steffens , Rebecca Rowland
Steffens , Robert Mark
Stella , M. Merikaton Feaver
Stemmler , Bertram Jason
Stevenson , James R.
Struller , Marcus S.
Suh , Jung-Gon
Sullivan, Daniel Carl
Sumner , Brian Andrew
Surdulescu , Sever Catalin
Swartz , Zachary Theodore
Sweeney , Scott Allen
Tatum-Kodzai , Za'Vette Mignong
Taylor Jr., William Fitzhugh
Tejera , Tinerfe Jacinto
Templeton , John Douglas
Tetzlaff , Thomas Ross
Tharwani , Haresh Mohan Das
Thiele , Robert Werner
Thielman, Nathan Maclyn
Thomas , David Carl
Tidwell , Christopher K.
Ting , Juk Ling
Toedt , Dominique Marie
Toloza , Eric Miguel
Tubera , Butch Baclig
Turi , Jennifer Lilly
Turner , Shannon Renee
Urban , Ann Marie
Urbanosky , Leah Renee
Valente , Anne Marie
Van Horn, William Archie
Vanderwel , Mark Roger
VanNess III, William Charles
Vaughan , Wendi Karen
Vaughan, Howell Anderson
Venkatesh , Boothapuri
Verde , Katrina Kay
Vick , Pamela Gale
Vines , Dain Edsel
Wallace , Graham Wilson
Wang , Sherry Chen-Yu
Warren , Deborah Parry
Wehrum , Mark John
Wei, Michael Ho Chi
Weinstein , David Harris
Weismantle , Karen Lyn
Welch , Mary Katherine
West , Shelly Lorraine
White , Rebekah Ruth
Wilke , Lee Gravatt
Williams , Felecia Gwenevere
Williams, Roberta Gay
Williamson , John Andrew
Wilson , Michael
Windham , Laura Clark
Wolf, Elizabeth Anne
Wolicki , Joanna
Wong , Leslie P.
Young , Deana Ann
Young , Frank Kevin
Young , John Joseph
Young, Richard Lane
Zura , Marianne Gerar

LICENSES ISSUED BY ENDORSEMENT AND EXAM

Abbas , Haider
Adams , Jeffrey Gene
Adan , Victor
Aho , Todd Raymond
Alahari , Durga
Alexander , James Chester
Alexander , Joseph Tirone
Allan , Michael Leslie
Allen , Joseph Claudius
Aloia , Thomas Anthony
Amani-Yazdi , Rambod
Ameer , Nazim
Arnaud , Catherine Helen
Aronson , Lori Anne
Arthur , Jennifer Culbertson
Atkinson , Hal Huntley
Atree , Susheel Vaidya
Auge , Brian Keith
Avgeropoulos , Nicholas George
Ayala , Dwight Guido
Azizi , Ghobad
Bailey , Ronald Wesley
Baker , Michael Dean
Balla , Somasekhara Raju
Basegoda , Mario Baldomero
Battaile , Melinda June
Becker , Marta Taylor
Belafsky , Peter Charles
Bengtson , Hans Eric
Bhalla , Harpreet Singh
Bhushan , Susan Denice
Bini , John Kennedy
Bitar , George John
Bodenstine , Thomas Robert
Bonner , Mark W.
Bovio , Sylvia Gutierrez
Braunsteiner , Aaron Joseph
Braunsteiner , Melissa Marie
Breitfeld , Philip Paul
Browne , Lauren Indira
Browne , Richard Everette
Brumfield , Christopher Scott
Buchanan , Hope Renee
Burns , Bennett Stuart
Burton , David Scott
Butler , Rushia Lorraine
Cabinum-Foeller , Elaine Sharon
Cahn , Michael Louis
Calicott , Randy Wayne
Campbell , Robert Coulter
Carter , Shawn Lawrence
Chepuri , Neeraj Babu
Chiritescu , Micsunica-Elvira St.
Chiritescu , Mihai M.
Chow , Andrew On-Shing
Claiborne , Claudia Viola
Clark , Hollins Peel
Clevenger , Jeffrey Cabot
Collins-Ogle , Michelle Denise
Conley , Mary Gaffney
Corrington , Kip Alan
Cosenza , David Antonio
Cottey , Jessica Danforth
Craigie , James Ernest
Cranfield , Terri Linn
Daniels , Anthony Maurice
Daughtridge , Sarah Ellen
Davidowitz , Sheri Ryan
Davis , Brent O'Bryan
Davuluri , Ashwini Kumar
DeBuys , Holly Virginia
Desai , Pratibha Rameschandra
Desai , Ramesh P.
Deveshwar , Sanjeev Kumar
Deveshwar , Shaili
Dibble , Timothy David
Dickson , Loretta Anne
Doherty Jr., Richard Donald
Doody , Regina Marie
Doperak , Martin
Dua , Sakshi
Duckett , Olly Christopher
Duran , Mary Katherine
Eagle , Khanh Le
Elder , Kerren Harry
Ellis , Thomas Leon
Evans , Gregory Francis Felix
Exar , Elliott Nicholas
Fabiszewski , Nina Laurie
Fallin , Cheryl Lynn
Feiler , Alan Howard
Felix , Ana Cristina Goncalves
Feng , David H.
Finch , James Patrick
Flynn , Joseph Patrick
Foster , Mary Helen
Frey , Mary Elizabeth
Frost , Stefani Clemmensen
Funk , Kathryn Robb
Gaylord , Kevin Michael
Geideman , William Michael
Ghassemzadeh , Ali Reza
Giese , Jeffrey Alan
Goldberg , Joel Lee

Gonzalez , Carmen Laura
Gordon , Katherine Elizabeth
Gould , John Jay
Graham , Dwight David
Grandey , Emilymarie Forini
Greenberg , Myles David
Grimes III, John Alexander
Grimm , Paul Jeffrey
Gross , Ned Jay
Hamby , Andrew Logan
Hamerski , Douglas Andrew
Hames , Melanie Irene
Hansen-Bundy , Sherri Linn
Hardee , Michael Wayne
Hardin , James Ronald
Hashmi , Saira Faryal
Hazey , Jeffrey Wallace
Hazlett , Donald Arthur
Heller , Cherrie Dawn
Hern , Tricia Lynn
Hodges , Ana Ceide
Huang , Xuemei
Hunt-Harrison , Tyehimba Afrika
Husain , Ali Khalid
Hutcheson , Joel Collier
Hwang , Janice Jeehyun
Ito , Kristin Elizabeth
Jacobe , Heidi Tewich
Jain , Swati
Jamshidi , Maryam
Jindal , Vinod Kumar
Johns , Charise Bowman
Johnson , David Joseph
Johnson , Jeri Benton
Johnson , Yewande Joy
Jones , Alan Edward
Jordan , Christopher Page
Jordan , Mary Helen Allen
Kassem-Moussa , Hassan Ahmed
Katwa , Geeta
Kay , Lay Khin
Keeton , Lisa Gwyn
Keogh , Tracy Scheibling
Khan , Rashid Mahmood
Kile , Robert Merlin
Kim , Andrew Myong
Kim , Eugene Jacob
King-Thiele , Robin Lynn
Kirk , Shannon Richard
Kocis , Keith Christopher
Kodali , Sathish
Koehler , Jan O
Koss , James
Kraska-Cwikla , Alicja
Kreissman , Susan Gail
Krumm , Erich Richard
Kucharski , Andrzej
Kulas , Donald Thomas
Lager , Joanne Jenkins
Lagoo-Deenadayalan, Sandhya Anand
Lahiri , Nandini
Landis , Eric Tyler
Lanford Sr., Charles Amon
Langford , Joseph Scott
Lavelle , John Paul William Mary
Law , Michael Morris
Lee , Benjamin
Lepak , Christopher Jason
Lester , Susan M. Stephen
Liao , Ray Poonjui
Lin , Wei-Chen
Lipton , Melissa Faye Canham
Little Jr., Michael Edward
Lostetter Jr, Stephen John
Lucktong , Ekachai
Lucktong , Tananchai A
Maitra , Ranjan Simon
Maldonado Jr., Jose Roel
Mallemala , Sirisha Reddy
Mallette III, James Elmore
Mansfield , Richard Jeffrey
Markowitz , Michael Alan
Marlowe-Rogers , Heidi Cruz
Martin , Amy Godwin
Matl , Leona
Mbaoma , Rowland Oliver
McAdams , Stephen A.
McQuilkin , Nancy Altamirano
Mehendru , Radhika
Mehendru , Raveen
Mellon , Christine Marie
Mellon , Richard Wilson
Michel , Jeffrey Bryan
Milko , John Edward
Miller , Elizabeth Anne
Mims III, Dawson Aultman
Mims , James Whitman
Mishra , Nilamadhab
Mitchell Jr., Jerry Wayne
Moore , Alan Rather
Morris , Paul Russell
Morse, Caryn Gee
Mullis , Brian Heath
Murphy Jr., Richard Wayne
Muscoreil , Steven James
Mustillo , Peter John
Myers , Earl Joseph
Myers , Leticia Shawn

Nadaud , Matthew Clifford
Naseem , Kashif
Newcomer , Michael Kermit
Newsome , Janice May
Nickeleit , Volker
Ogle , Adrian Mahendra
Olson Jr., John Ackerman
Onaitis , Mark William
Ornstein , David Keith
Otero-Truitt , Tessie
Ott , Michael Robert
Parekh , Asha Ishwar
Park , Sun Mie
Patel , Jayesh Bhovandas
Payne , Margaret Manning
Payne , Robert Kenneth
Perry , Maurice Clive
Peters , Richard Mallory
Petree , Anelia Rose
Pezzi , Thomas Andrew
Pontzer , John Tucker Haywood
Porter , Scott Edward
Powderly II, John Dwyer
Pruitt , Enas Lee
Qian , Xiao Yan
Quinlan , Aveline F.
Qumei , Moh'd Khaldoon
Raboi , Carl Andrew
Reddy , Vijaya-Kumar Konda
Reed III, Ward Loomis
Reeder , John David
Reger , Lance Boyd
Relacion , Valerie Kay Thornton
Reynolds , Stacee Elizabeth
Rice , Alan Michael
Rich , Preston Berkeley
Richardson Jr., Homer Allen
Richardson , Ryan Nelson
Richter , Brad Arthur
Rikhye , Rakesh Kumar
Riley , David Michael
Ritsema , Marc Edward
Ritter , Ann Marie
Rodak , David
Rosenberg , Jason Charles
Rothschild , Andrew Coleman
Rothschild , Barbra Bluestone
Roux , Jeffrey Jude
Russ III, Edmond V.
Samardar , Polya
Sangueza , Omar Pastor
Satterfield , Robert Nelson
Sayeg , Ayoub
Scherczinger , Richard
Scherer , Lynette Ann
Schnorr , Amy Lynn
Schwab , Jodi Erin
Schwartz , Jeffrey Howard
Scott , Timothy James
Sharpe , Donna Estelle
Spiekerman , Jill Marie
Stafford , Renae Elizabeth
Stamatakos , Theodore Steve
Steffens , Rebecca Rowland
Steffens , Robert Mark
Stella , M. Merikaton Feaver
Stemmler , Bertram Jason
Stevenson , James R.
Struller , Marcus S.
Suh , Jung-Gon
Sumner , Brian Andrew
Surdulescu , Sever Catalin
Swartz , Zachary Theodore
Sweeney , Scott Allen
Tatum-Kodzai , Za'Vette Mignong
Taylor Jr., William Fitzhugh
Tejera , Tinerfe Jacinto
Templeton , John Douglas
Tetzlaff , Thomas Ross
Tharwani , Haresh Mohan Das
Thiele , Robert Werner
Thomas , David Carl
Tidwell , Christopher K.
Ting , Juk Ling
Toedt , Dominique Marie
Toloza , Eric Miguel
Tubera , Butch Baclig
Turi , Jennifer Lilly
Turner , Shannon Renee
Urban , Ann Marie
Urbanosky , Leah Renee
Valente , Anne Marie
Vanderwel , Mark Roger
VanNess III, William Charles
Vaughan , Wendi Karen
Venkatesh , Boothapuri
Verde , Katrina Kay
Vick , Pamela Gale
Vines , Dain Edsel
Wallace , Graham Wilson
Wang , Sherry Chen-Yu
Warren , Deborah Parry
Wehrum , Mark John
Weinstein , David Harris
Weismantle , Karen Lyn
Welch , Mary Katherine
West , Shelly Lorraine
White , Rebekah Ruth

Wilke , Lee Gravatt
Williams , Felecia Gwenevere
Williamson , John Andrew
Wilson , Michael
Windham , Laura Clark
Wolicki , Joanna
Wong , Leslie P.
Young , Deana Ann
Young , Frank Kevin
Young , John Joseph
Zura , Marianne Gerard

INTERVIEW FORMS NOT RECEIVED
Chauhan, Ajit Singh
Doonquah, Kofi Adeleke
Ries, Kenneth Lange

FACULTY LIMITED LICENSES
Bainbridge, Daniel Tom
Bergin, Diane
Bornstein, Jeffrey David
Ellingham, John Grant
Ellis, Matthew James
Erdmann, Detlev
Holzhauer, Markus
Howden, James Keir
Leon, Jorge Andres
McCreath, Brian James
Schwartz, David Albert

APPLICANTS FOR REINSTATEMENT OF NC LICENSE
Coulson, Carol Catherine
Crockett, Robert Kemp
Hultman, Charles Scott
Kulubya, Edwin Samuel
Sang, Charlie Joseph, Jr.
Sullivan, Daniel Carl
Thielman, Nathan Maclyn

APPLICANTS FOR REACTIVATION
Reddy, Viswanatha Kurukundha
Richter, Holly Mallett
Williams, Roberta Gay
Wei, Michael Ho Chi

NORTH CAROLINA PHYSICIANS HEALTH PROGRAM (NCPHP) COMMITTEE REPORT

John Dees, MD; Hector Henry, MD; Kenneth Chambers, 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 24 cases involving participants in the NC Physicians Health Program. A written report was presented for the Board's review. The Board adopted the committee's recommendation to approve the written report. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

COMPLAINT COMMITTEE REPORT

Walter Pories, MD; Elizabeth Kanof, MD; John Dees; Stephen Herring, MD; Martha Walston; Aloysius Walsh

The full Board reviewed and approved the complaint committee report noted below, which includes the monthly statistics and the full committee recommendations for complaints.

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

A motion passed to return to open session.

INVESTIGATIVE COMMITTEE REPORT

Hector Henry, MD; Paul Saperstein; Elizabeth Kanof, MD; Wayne VonSeggen, PA-C; Stephen Herring, MD; George Barrett, 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 4 investigative cases. A written report was presented for the Board's review. The Board adopted the committee's recommendation to approve the written report. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

INFORMAL INTERVIEW REPORT

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

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

A motion passed to return to open session.

MALPRACTICE COMMITTEE REPORT

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

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

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

A motion passed to return to open session.

ADJOURNMENT

This meeting was adjourned on July 22, 2000.

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Walter J. Pories, MD
Secretary/Treasurer