MINUTES

North Carolina Medical Board

September 21-23, 2011

1203 Front Street
Raleigh, North Carolina
General Session Minutes of the North Carolina Medical Board Meeting held September 21-23, 2011.

The North Carolina Medical Board met September 21-23, 2011, at its office located at 1203 Front Street, Raleigh, NC. Janice E. Huff, MD, President, called the meeting to order. Board members in attendance were: Donald E. Jablonski, DO, Past President; Ralph C. Loomis, MD, President-Elect; William A. Walker, MD, Secretary/Treasurer; Ms. Pamela Blizzard; Thomas R. Hill, MD; John B. Lewis, Jr., LLB; Peggy R. Robinson, PA-C; Paul S. Camnitz, MD; Karen R. Gerancher, MD and Eleanor E. Greene, MD. Absent was Ms. Thelma Lennon.

**Presidential Remarks**

Dr. Huff commenced the meeting by reading from the State Government Ethics Act, “Ethics awareness and conflict of interest reminder.” No conflicts were reported.

**Minute Approval**

**Motion:** A motion passed to approve the July 20, 2011 Board Minutes and the August 18, 2011 Hearing Minutes.

**Announcements**

1. Dr. Donald Jablonski recognized Mr. David Henderson, Executive Director, on his fifteen-year anniversary at the NCMB.

2. Mr. Henderson reminded the Board that the NCMB 2011 Retreat would convene Friday afternoon at 3:00pm and adjourns Saturday afternoon.

**EXECUTIVE COMMITTEE REPORT**

The Executive Committee of the North Carolina Medical Board was called to order at 1:45 pm, Thursday September 22, 2011, at the offices of the Board. Members present were: Janice E. Huff, MD, Chair; Ralph C. Loomis, MD, William A. Walker, MD, Pamela L. Blizzard and Donald E. Jablonski, DO. Also present were R. David Henderson (Executive Director), Hari Gupta (Director of Operations) and Peter T. Celentano, CPA (Comptroller).

1) Financial Statements

a) Monthly Accounting July and June 2011

   The Committee reviewed the July and June 2011 compiled financial statements. July is the ninth month of fiscal year 2011.

   Committee Recommendation: Accept the financial statements as reported.

   Board Recommendation: The Board accepted the Committee recommendation.

b) Investment Account Statements
The Committee reviewed the August and July 2011 investment account statements from Fifth Third Bank.

Committee Recommendation: Accept the investment account statements as reported.

Board Recommendation: The Board accepted the Committee recommendation.

2) Old Business

a) Reporting Public Letters of Concern

The Committee discussed whether to continue reporting public letters of concern to the Federation of State Medical Boards (FSMB) Board Action Data Bank.

Committee Recommendation: Defer to the full Board for discussion.

Board Recommendation: The Board decided to continue to report public letters of concern to the Federation of State Medical Boards (FSMB) Board Action Data Bank.

3) New Business

a) Proposed Fiscal Year 2012 Budget

The Committee reviewed a draft of the proposed budget for fiscal year 2012.

Committee Recommendation: The Committee recommends the full Board accept the proposed budget for fiscal year 2012 as presented.

Board Recommendation: The Board accepted the Committee recommendation.

b) North Carolina Physicians Health Program (NCPHP) Financial Statements

The Committee reviewed the audited financial statements of the NCPHP for the years ended December 31, 2010 and 2009.

Committee Recommendation: Accept as information. (Drs. Huff and Loomis recused.)

c) NC Board of Electrolysis Examiners (NCBOEE) Nomination

In January 2011, Governor Purdue appointed Dr. Gilly Munavalli, a dermatologist from Charlotte, to an unexpired term on the NCBOEE. The term expired in August and Dr. Munavalli is eligible for reappointment to a full two year term. Dr. Munavalli is willing to continue serving on the NCBOEE and he has the support of the NC Medical Society and the NC Dermatology Society.

Committee Recommendation: The Committee recommends the full Board nominate Dr. Gilly Munavalli to a two year term on the NCBOEE.
Board Recommendation: The Board accepted the Committee recommendation.

d) Executive Director Performance Review

Members of the Executive Committee met with its Executive Director, Mr. David Henderson, in a closed session pursuant to NC General Statute §143-318.11(a)(6) to complete the annual performance evaluation.

POLICY COMMITTEE REPORT
Committee Members: Dr. Loomis, Chairman; Dr. Camnitz and Dr. Greene

1. Old Business
   a. Position Statement Review continued
      i. Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist (APPENDIX A)

Issue: In November 2009, the Board approved the Policy Committee’s recommendation to review Position Statements at least once every four years. A review schedule has been formulated for the Committee’s consideration.

3/2011 Committee Discussion: Mr. Brosius suggested that the Board may need to establish some bright lines, because the current position statement leaves room for some treatments that the Board may deem unethical depending on physician interpretation. Dr. Loomis suggested that he preferred a hardline approach and would recommend eliminating minor treatment of illness. He indicated that the Board’s interest is for the patients to receive the best care. Dr. Greene agreed that eliminating treatment of minor illness would remove any room for confusion, but also felt we should leave the ability to treat during an emergency in the position statement. Dr. Camnitz indicated that he did not like the vagueness of the position statement and would prefer it be more specific regarding over-the-counter medications and prescription medications, possibly indicating specific schedules that would be restricted. The Committee further discussed chronic versus acute. It was also recommended that “physician” should be replaced with “licensee” to be consistent with edits made in previous position statement reviews.

3/2011 Committee Recommendation: Table issue for the Legal Department to incorporate the recommendations from the Committee discussion.


This Position Statement has now been assigned to a Task Force specifically analyzing the issue and headed by Dr. Loomis.

5/2011 Committee Discussion: Dr. Loomis reported that the Task Force was scheduled to meet in June 2011. Dr. Kirby stated that the AMA has a statement regarding treatment of professional peers and suggested that something similar be included in our position statement.
5/2011 Committee Recommendation: Table issue until Task Force report is presented to the Committee. Dr. Kirby is to provide the AMA position prior to the Task Force meeting.

5/2011 Board Action: Accept Committee recommendation

7/2011 Committee Discussion: The Committee discussed the potential benefits of revising the current position statement. Comments were received by Board members and senior staff that were present. One comment that had been received numerous times is that the licensees would like the terms of the position statement better defined. The Committee agreed that prescribing narcotics to one’s self or family members is never appropriate. It was suggested that adopting a rule prohibiting prescribing narcotics to one’s self or family members might be a more efficient method for the Board to enforce compliance. The Committee concurred. There was additional discussion that identifying what constitutes a significant emotional relationship may be difficult.

7/2011 Committee Recommendation: Instruct Legal to begin drafting a rule to cover prescribing narcotics to ones self or family member. The Office of the Medical Director is to provide definitions to help clarify the Board’s statement. The proposed changes will be provided to the Committee and Task Force for review.

7/2011 Board Action: Accept Committee recommendation.

9/2011 Committee Discussion: The Committee reviewed the proposed revised position statement as well as the proposed rule changes for PAs, NPs and physicians. There was also discussion regarding the large response we received from the Board licensee population. There was discussion regarding the need to identify with whom an emotional relationship may exist. It was felt that the revised position statement could be modified to better reflect the position on the Board. Additionally the consensus of the Committee was that the proposed rules changes were appropriate and should go forward.

9/2011 Committee Recommendation: Dr. Camnitz will work with Mr. Brosius and Dr. Kirby to revise the position statement and present it to the Committee at the November Board meeting. Proceed with the rule-making process on the proposed rule change.


1. Old Business:
   a. Position Statement Review
      ii. Prescribing Legend or Controlled Substances for Other Than Valid Medical or Therapeutic Purposes, with Particular Reference to Substances or Preparations with Anabolic Properties (APPENDIX B)

5/2011 Committee Discussion: Dr. Loomis has concerns about the last paragraph in the General Section. He inquired about why and when this paragraph was added. Dr. Loomis stated that if there was no good reason for it to exist, the Committee might consider removing it. Dr. Greene and Dr. Camnitz both offered alternative wording, instead of removing the paragraph in question. The Committee discussed the definition of legend drugs.
5/2011 Committee Recommendation: Table issue to provide staff an opportunity to research the origin of the paragraph in question. Additionally, add a description of legend drugs to the position statement.

5/2011 Board Action: Accept Committee recommendation

7/2011 Committee Discussion: The Committee discussed the meaning of Legend drugs and agreed the term is no longer needed.

7/2011 Committee Recommendation: Table issue until the September meeting. The staff is to provide an edited version of the position statement, which removes references to Legend drugs.

7/2011 Board Action: Accept Committee recommendation.

9/2011 Committee Discussion: The Policy Committee reviewed the proposed amendments to the position statement removing references to Legend drugs.

9/2011 Committee Recommendation: Approve proposed changes.


1. New Business:
   a. Position Statement Review (APPENDIX C)

      1/2010 Committee Recommendation: (Loomis/Camnitz) Adopt a 4 year review schedule as presented. All reviews will be offered to the full Board for input. Additionally all reviews will be documented and will be reported to the full Board, even if no changes are made.

      1/2010 Board Action: Adopt the recommendation of the Policy Committee.

2. New Business:
   a. Position Statement Review
      i. Availability of Physicians to Their Patients (APPENDIX D)

      9/2011 Committee Discussion: The Committee reviewed the current position statement. It was suggested that the term physician be replaced with licensee in order to be consistent with past revisions to the Board’s position statements. Dr. Kirby pointed out the need to relate this position statement to providers who are providing care through telemedicine.

      9/2011 Committee Recommendation: The staff is to provide a revised position statement at the November Committee meeting.

LICENSE COMMITTEE REPORT
Thomas Hill, MD, Chair, Donald Jablonski, DO, Karen Gerancher, MD, John Lewis, Eleanor Greene, MD, Scott Kirby, MD, Thom Mansfield, Patrick Balestrieri, Carren Mackiewicz, Joy Cooke, Michelle Allen, Mary Rogers, Amy Whitted, Nancy Hemphill, and Jean Brinkley

Open Session

Old Business

1. Application/Renewal Questions

Issue: Question 7 currently reads "In the past five (5) years, have you had, or have you been told you had, a mental health or physical condition (not referenced above) which in any way limits or impairs or, if untreated, could limit or impair your ability to practice medicine in a competent or professional manner?"

September Board action was to have legal staff review wording for Question 7 for clarity.

Committee Recommendation: Do not change current wording. (Mansfield/Balestrieri)

Board Action: Do not change current wording.

2. Letters of Advice (LOA)

Issue: Following a discussion regarding the “origin” of “letters of advice” for license applicants during the July meeting, the need for limiting criteria and who and under what circumstances can an LOA be recommended, Dr. Kirby offers the following:

1. These are not disciplinary in anyway and should not be reported to any agency.
2. They are not considered an investigation. They do not need to be reported by the licensee to any other licensing Board or credentialing agency.
3. Any Board member, upon reviewing a license application and entirely on his own initiative and with consultation or later discussion with SSRC, the Licensing Committee, or the entire Board, may request a letter of advice be sent to the licensee regarding an item on the application.
4. No review of the Board members decision to request a letter of advice is necessary. There needs to be no review or discussion
5. These are below (of lesser significance) than preapproved PLOC’s.
6. These are simply an expression of a single Board member’s concern about something Noticed in the license application during review.
7. A copy of the letter of advice is scanned into the licensee’s file as an additional document attached to the license application. I do not believe a case should be opened. It is not necessary to track or follow these letters of advice and they do not need a case number. If the issue or item of concern is of such importance that it needs to be tracked with a case number then the licensee should not be receiving a letter of advice but rather some other vehicle such as a preapproved PLOC or PLOC, etc.
8. Letters of advice are words of wisdom from an experienced Board member who is familiar with how physicians come to the attention of the Board later in their careers and the Board member simply wants to provide an informal suggestion to the new North Carolina licensee about how to stay out of trouble.

9. Letters of advice are simply no more than, and similar to, verbal comments that might be made to a license applicant by a Board member at a single Board member interview for licensees who do not warrant a licensing interview.

10. Each Board member will have his own idiosyncratic threshold or criteria for requesting a letter of advice. There nothing wrong with this. Some Board members will request more letters of advice than others. No problem.

Committee Recommendation: Table for discussion in November. Legal to develop a tracking method for letters of advice. Dr. Kirby to rewrite the criteria to be more precise.

Board Action: Table for discussion in November. Legal to develop a tracking method for letters of advice and the need for a rule making process. Dr. Kirby to rewrite the criteria to be more precise.

New Business

1. Emergency & Disaster Licensing

Issue: Staff has been working on a procedure for licensing physicians in the event of state declared emergency or disaster.

The purpose of this memo is to discuss the federal and state laws regarding the licensing of physician and physician assistant volunteers following a natural or man-made disaster in North Carolina. The state’s plans for responding to disasters or emergencies which require volunteer medical personnel are extensive, intertwined, and well organized.

a. Authority at the national level:
   i. All fifty states and US territories participate in the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). ESAR-VP has been in existence since 2002; it now is administered by the Office of the Assistant Secretary for Preparedness and Response in the US Department of Health and Human Services. With this program, the federal government works with states to establish a national network of state-based programs for pre-registration of a broad range of volunteer health professionals. Under ESAR-VHP, volunteers' identities, licenses, credentials, accreditations, and hospital privileges are all verified both in advance and at the time of deployment of a public health or medical disaster or emergency. In NC, this program is called "ServNC", the state emergency registry of volunteers. Most state programs have similar names.

There are several new ESAR-VP plans being created at the federal level with continued input from the states. When these are finalized, they will be shared with the states for adoption if they so choose. The NC Department of Emergency Management (NC DEM) believes that the relevant ESAR-VP will be adopted as a supplementary agreement (as
permitted by N.C. Gen. Stat. § 166A-47) rather than as a new statute or administrative rule. The new ESAR-VP plans are being developed to deal with the diversity of programs across the states. Some state programs have more robust staffing and quality than others. States also differ in how they handle issues of professional liability and workers compensation. Generally speaking, professional liability insurance continues to provide coverage to a volunteer in another state, if their current employer agrees. In some states, workers’ compensation is available to a volunteer from another state who is injured while serving, as though that volunteer were employed by state in the disaster zone. This is a contentious area and the NC law on this is unsettled.

ii. Most of the fifty states and US territories are members of EMAC (Emergency Management Assistance Compact). This is a congressionally-ratified organization that provides form and structure to interstate mutual aid. Through EMAC, a disaster-impacted state can request and receive assistance from other member states quickly and efficiently, resolving two key issues upfront: liability and reimbursement. The EMAC provides for the requesting state to reimburse the rendering state (and hospitals, etc) for expenses incurred in responding. This funding goes through federal channels and can be very slow in processing. The EMAC is activated when a Governor declares a State of Emergency.

iii. One of the lessons learned from Katrina is the importance of state and local response to a disaster or emergency. While the federal government (through FEMA) can play an important role financially, it is better to maximize the use of state and local knowledge, coordination, and personnel.

1. To the greatest extent possible, valuable personnel should be retained in their communities rather than encouraging outsiders to respond. In Katrina, when LA and MS hospitals and clinics were destroyed, many LA and MS physicians relocated out of state. It would have been better to create mobile hospitals or provide interim housing so those local physicians could continue working with their same teams, patient population, and cultural connections. A role for government is to have Disaster Medical Assistance Teams (DMATs) available, and also to provide temporary housing, if necessary, so local providers can stay in their communities.

2. Although most teams will come with their own resources for up to 72 hours, when unaffiliated outside volunteers come to the scene of a disaster, their need for food, water, and shelter can strain already scarce resources.

3. Retaining local medical professionals alleviates the need for state medical boards to create and execute temporary licensing protocols for incoming physicians and others.
b. Organization at the State Level

i. ServNC, North Carolina’s ESAR- VP program, provides a structure to recruit, inform, mobilize and track health care providers and other volunteers to respond to a crisis. This is true both for internal disasters (for example, a hurricane hits the coast and Charlotte physicians respond) and for situations that call for assistance from out of state (Kentucky gets hit with an ice storm and asks North Carolina to assist.)

ii. Physicians, other health care providers and other volunteers register on-line. NCMB licensees may be drawn to it by a link on the NCMB annual renewal page. It takes about 10 minutes to register. In addition to demographic information, the licensee lists specialty, occupation, certifications, medical history, and geographic areas to which he/she would be willing to respond. The licensee also lists the best way to be contacted, i.e., email or cell phone. Volunteers often are deployed in teams; if a person wishes to be assigned to team, ServNC can facilitate that process.

iii. Other emergency response resources:

1. There are eight trauma regions in North Carolina, designated as Regional Advisory Committees (RACs). Each RAC has a State Medical Assistance Team (SMAT II). They each have the ability to set up a small field hospital. The SMAT was formed following 9/11/01, primarily to respond to biological and terrorism events which include chemical agents. Each RAC/SMAT is anchored by a major hospital: Mission (Asheville); Carolinas Medical Center (Metrolina); WFUBMC (Triad); Duke (Durham); UNC (Central Carolina); WakeMed (Capital); Pitt County Memorial (Eastern); and New Hanover Regional (Southeastern).

2. The state also has four mobile hospitals which can be set up in a matter of hours. The state also has mobile pharmacies and 29 SMAT III which have decontamination capabilities. They are spread out across the state and are run by the local EMS agencies.

c. What if there was a disaster in NC?

i. The NC Governor would declare a State of Emergency under N.C. Gen. Stat. §166A.

ii. Requests for Assistance (RFAs) would come from local counties and municipalities to the NC DEM, who would aggregate those needs. The State Office of Emergency Medical Services (OEMS) would in turn determine what medical providers were needed. The OEMS would coordinate with the State Medical Asset Resource Tracking Tool (SMARTT). (OEMS also works with the NC EMS Advisory Council, of which Dr. Liz Kanof is a member.)
iii. The OEMS would formulate a specific mission request: X doctors, X nurses, X paramedics, plus specified equipment and other resources. The mission request would be relayed to the ServNC program. The first approach would be for NC DEM/ ServNC to compile teams of responders of North Carolina volunteers.

iii. If the extent of the crisis were larger than could be dealt with using NC personnel alone, the Governor could authorize an EMAC/ Request for Assistance (RFA), which would be posted to the EMAC network. The request would be very specific, asking for particular numbers and skill types of personnel and equipment. One or more states would respond to that request, offering NC a team and itemizing the cost of that team. The NCEM could then accept one or more of these proposals.

v. The responding state’s ESAR-VP program would check the credentials of physicians and other licensees requested by NC’s RFA. If North Carolina had an agreement with the responding state covering this term, the NC OEMS would not check incoming physicians’ credentials, however, but would rely on the other state’s diligence in doing so. States differ in their protocols and the robustness of their programs, but in general, each state checks:

   a. Federal ESAR VP database
   b. Active state license with state medical or osteopathic board (Volunteers whose licensees are close to renewal or have other licensing issues may be rejected.)
   c. FSMB databank
   d. AMA and AOA databanks
   e. ABMS for specialty board certification
   f. DEA
   g. OIG for improper use of federal funds

vi. The North Carolina EMAC is codified in Article 4 of Chapter 166A, the Emergency Management Act. Among other things, the EMAC gives the Governor plenary powers in the event of a declared emergency or disaster, and the authority to declare that professionals from other participating states have reciprocal authority to practice in this state, subject to any limitations or conditions placed by the Governor. Specifically, N.C. Gen. Stat. § 166A-45 states:

   Whenever any person holds a license, certificate, or other permit issued by any party state evidencing the meeting of qualifications for professional, mechanical, or other skills, and when assistance is requested by the receiving party state, the person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving skill to meet a declared emergency or disaster, subject to any limitations and conditions the governor of the requesting state may prescribe by executive order or otherwise. (1997-152, s. 1.)
vii. The state Emergency Management Director would look to the NCMB if their office ran into any problems verifying the credentials of a physician. The NCMB would also be involved in licensing under emergency conditions if a physician intended to practice here for an extended period of time. However, the general rule is that the NCMB would not issue emergency licenses; incoming physicians vetted by another state would enter NC and practice medicine without any authority by the NCMB. The Governor, by Executive Order, might place geographic, time, and other restrictions on the practice of the incoming volunteer physicians.

B. The state discourages anyone (whether licensed in NC or not) from simply arriving at a disaster zone. They feel it is unlikely that a hospital would extend privileges to physicians who simply showed up. As to physicians who do express willingness to serve at the last minute, the best thing is to direct them to register through ServNC. That way, their information is included in the central database. The state would provide “Just in time Training” before deploying them, and would keep track of volunteers who have been mobilized.

C. The recommendation from the state Emergency Management office is that the NCMB continue to promote ServNC by providing the link to it during the online renewal process, and including references to it on the NCMB website, The Forum or other media, to encourage physicians, PAs, and other licensees to register.

d. What if there were a disaster in another state, and NC licensees were willing to assist?

i. If the Governor of another state filed a RFA through EMAC, to which NC responded, the ServNC program would compile a group of volunteers who agreed to serve in that time and place. OEMS would check their credentials against the roster which Hari provides each month. The NC EMS also has access to, and checks, the credentials of nurses, pharmacists, veterinarians, social workers, EMS, Respiratory Therapist and a few other professions.

ii. The ServNC program would provide immediate training about the mission, and would mobilize the team for their specific mission. Again, the NC DEM would contact the NCMB if it had questions about a particular NC licensee’s credentials.

(a) The existence of a state of disaster may be proclaimed by the Governor, or by a resolution of the General Assembly if either of these finds that a disaster threatens or exists.
(a1) If a state of disaster is proclaimed, the Secretary shall provide the Governor and the General Assembly with a preliminary damage assessment as soon as the assessment is available. Upon receipt of the preliminary damage assessment, the Governor shall issue a proclamation defining the area subject to the state of disaster and proclaiming the disaster as a
Type I, Type II, or Type III disaster. In determining whether the disaster shall be proclaimed as a Type I, Type II, or Type III disaster, the Governor shall follow the standards set forth below.

(1) A Type I disaster may be declared if all of the following criteria are met:
   a. A local state of emergency has been declared pursuant to G.S. 166A-8, and a written copy of the declaration has been forwarded to the Governor;
   b. The preliminary damage assessment meets or exceeds the criteria established for the Small Business Administration Disaster Loan Program pursuant to 13 C.F.R. Part 123 or meets or exceeds the State infrastructure criteria set out in G.S. 166A-6.01(b)(2)a.; and
   c. A major disaster declaration by the President of the United States pursuant to the Stafford Act has not been declared.

A Type I disaster declaration may be made by the Governor prior to, and independently of, any action taken by the Small Business Administration, the Federal Emergency Management Agency, or any other federal agency. A Type I disaster declaration shall expire 30 days after its issuance unless renewed by the Governor or the General Assembly. Such renewals may be made in increments of 30 days each, not to exceed a total of 120 days from the date of first issuance. The Joint Legislative Commission on Governmental Operations shall be notified prior to the issuance of any renewal of a Type I disaster declaration.

(2) A Type II disaster may be declared if the President of the United States has issued a major disaster declaration pursuant to the Stafford Act. The Governor may request federal disaster assistance under the Stafford Act without making a Type II disaster declaration. A Type II disaster declaration shall expire six months after its issuance unless renewed by the Governor or the General Assembly. Such renewals may be made in increments of three months each, not to exceed a total of 12 months from the date of first issuance. The Joint Legislative Commission on Governmental Operations shall be notified prior to the issuance of any renewal of a Type II disaster declaration.

(3) A Type III disaster may be declared if the President of the United States has issued a major disaster declaration under the Stafford Act and:
   a. The preliminary damage assessment indicates that the extent of damage is reasonably expected to meet the threshold established for an increased federal share of disaster assistance under applicable federal law and regulations; or
   b. The preliminary damage assessment prompts the Governor to call a special session of the General Assembly to establish programs to meet the unmet needs of individuals or political subdivisions affected by the disaster.

A Type III disaster declaration shall expire 12 months after its issuance unless renewed by the General Assembly.

(a2) Any state of disaster declared before July 1, 2001, shall terminate by a proclamation of the Governor or resolution of the General Assembly. A proclamation or resolution declaring or
terminating a state of disaster shall be disseminated promptly by means calculated to bring its contents to the attention of the general public and, unless the circumstances attendant upon the disaster prevent or impede, promptly filed with the Secretary of Crime Control and Public Safety, the Secretary of State and the clerks of superior court in the area to which it applies.

(b) In addition to any other powers conferred upon the Governor by law, during a state of disaster, the Governor shall have the following powers.

(1) To utilize all available State resources as reasonably necessary to cope with an emergency, including the transfer and direction of personnel or functions of State agencies or units thereof for the purpose of performing or facilitating emergency services;

(2) To take such action and give such directions to State and local law enforcement officers and agencies as may be reasonable and necessary for the purpose of securing compliance with the provisions of this Article and with the orders, rules and regulations made pursuant thereto;

(3) To take steps to assure that measures, including the installation of public utilities, are taken when necessary to qualify for temporary housing assistance from the federal government when that assistance is required to protect the public health, welfare, and safety;

(4) Subject to the provisions of the State Constitution to relieve any public official having administrative responsibilities under this Article of such responsibilities for willful failure to obey an order, rule or regulation adopted pursuant to this Article.

(c) In addition, during a state of disaster, with the concurrence of the Council of State, the Governor has the following powers:

(1) To direct and compel the evacuation of all or part of the population from any stricken or threatened area within the State, to prescribe routes, modes of transportation, and destinations in connection with evacuation; and to control ingress and egress of a disaster area, the movement of persons within the area, and the occupancy of premises therein;

(2) To establish a system of economic controls over all resources, materials and services to include food, clothing, shelter, fuel, rents and wages, including the administration and enforcement of any rationing, price freezing or similar federal order or regulation;

(3) To regulate and control the flow of vehicular and pedestrian traffic, the congregation of persons in public places or buildings, lights and noises of all kinds and the maintenance, extension and operation of public utility and transportation services and facilities;

(4) To waive a provision of any regulation or ordinance of a State agency or a political subdivision which restricts the immediate relief of human suffering;


(6) To perform and exercise such other functions, powers and duties as are necessary to promote and secure the safety and protection of the civilian population;
To appoint or remove an executive head of any State agency or institution the executive head of which is regularly selected by a State board or commission.

a. Such an acting executive head will serve during:
   1. The physical or mental incapacity of the regular office holder, as determined by the Governor after such inquiry as the Governor deems appropriate;
   2. The continued absence of the regular holder of the office; or
   3. A vacancy in the office pending selection of a new executive head.

b. An acting executive head of a State agency or institution appointed in accordance with this subdivision may perform any act and exercise any power which a regularly selected holder of such office could lawfully perform and exercise.

c. All powers granted to an acting executive head of a State agency or institution under this section shall expire immediately:
   1. Upon the termination of the incapacity as determined by the Governor of the officer in whose stead he acts;
   2. Upon the return of the officer in whose stead he acts; or
   3. Upon the selection and qualification of a person to serve for the unexpired term, or the selection of an acting executive head of the agency or institution by the board or commission authorized to make such selection, and his qualification.

To procure, by purchase, condemnation, seizure or by other means to construct, lease, transport, store, maintain, renovate or distribute materials and facilities for emergency management without regard to the limitation of any existing law.

In preparation for a state of disaster, with the concurrence of the Council of State, the Governor may use contingency and emergency funds as necessary and appropriate for National Guard training in preparation for disasters. (1951, c. 1016, s. 4; 1955, c. 387, s. 4; 1959, c. 284, s. 2; c. 337, s. 4; 1975, c. 734, ss. 11, 14; 1977, c. 848, s. 2; 1979, 2nd Sess., c. 1310, s. 2; 1993, c. 321, s. 181(a); 1995, c. 509, s. 125; 2001-214, s. 3.)

§ 166A-43. Party state responsibilities.

(a) It shall be the responsibility of each party state to formulate procedural plans and programs for interstate cooperation in the performance of the responsibilities listed in this Article. In formulating the plans, and in carrying them out, the party states, insofar as practicable, shall:

(1) Review individual state hazards analyses and, to the extent reasonably possible, determine all those potential emergencies the party state might jointly suffer, whether due to natural disaster, technological hazard, man-made disaster, emergency aspects of resource shortages, civil disorders, insurgency, or enemy attack.
(2) Review the party states' individual emergency plans and develop a plan that will determine the mechanism for the interstate management and provision of assistance concerning any potential emergency.

(3) Develop interstate procedures to fill any identified gaps and to resolve any identified inconsistencies or overlaps in existing or developed plans.

(4) Assist in warning communities adjacent to or crossing the state boundaries.

(5) Protect and assure uninterrupted delivery of services, medicines, water, food, energy and fuel, search and rescue, and critical lifeline equipment services, and resources, both human and material.

(6) Inventory and set procedures for the interstate loan and delivery of human and material resources, together with procedures for reimbursement or forgiveness.

(7) Provide, to the extent authorized by law, for temporary suspension of any statutes or ordinances that restrict the implementation of the above responsibilities.

(b) The authorized representative of a party state may request assistance of another party state by contacting the authorized representative of that state. The provisions of this Compact shall only apply to requests for assistance made by and to authorized representatives. Requests may be verbal or in writing. If verbal, the request shall be confirmed in writing within 30 days of the verbal request. Requests shall provide the following information:

(1) A description of the emergency service function for which assistance is needed, including fire services, law enforcement, emergency medical, transportation, communications, public works and engineering, building inspection, planning and information assistance, mass care, resource support, health and medical services, and search and rescue.

(2) The amount and type of personnel, equipment, materials and supplies needed, and a reasonable estimate of the length of time they will be needed.

(3) The specific place and time for staging of the assisting party's response and a point of contact at that location.

(c) There shall be frequent consultation between state officials who have assigned emergency management responsibilities and other appropriate representatives of the party states with affected jurisdictions and the federal government, with free exchange of information, plans, and resource records relating to emergency capabilities. (1997-152, s. 1.)

§ 166A-45. Licenses and permits.

Whenever any person holds a license, certificate, or other permit issued by any party state evidencing the meeting of qualifications for professional, mechanical, or other skills, and when assistance is requested by the receiving party state, the person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving skill to meet a declared emergency or disaster, subject to any limitations and conditions the governor of the requesting state may prescribe by executive order or otherwise. (1997-152, s. 1.)
Committee Recommendation: Accept as information.

Board Action: Accept as information.

2. Pending Applications Over a Year Old

Issue: Staff has been requested to report to the Committee every meeting the number of pending applications that are more than 1 year old. Currently we have 23. Of those 23, 2 have open investigations in other states and their NCMB application is on hold; 1 has been assigned to the Legal Department to issue a PUBLOC as a result of the May Board meeting; the remaining 20 never finished submitting their application materials.

Committee Recommendation: Accept as information

Board Action: Accept as information.

3. Review of Board Book Tab 335 – Licensing Interviews

Issue: Dr. Hill requests discussion of this policy/procedure. A copy of Tab 335 is bookmarked in this tab.

Committee Recommendation: Keep the procedure as is.

Board Action: Keep the procedure as is.

4. PLOCs and Fines

Issue: In an effort to serve the needs of the state and residents of NC the Board previously pre-authorized staff to issue a license when a Board member agrees with issuing a license with a PLOC. Recent license recommendations are to issue license with PLOC and an administrative fine. These recommendations have been requiring Board approval thus delaying an application that would otherwise move forward.

Committee Recommendation: Pre-authorize staff to move applications forward with the approval of one Board member when the Board member decision is to issue a license with a PLOC and administrative fine.

Board Action: Pre-authorize staff to move applications forward with the approval of one Board member when the Board member decision is to issue a license with a PLOC and administrative fine.

5. Resident Training Licenses Issued in 2011

Issue: Every year at the September Board meeting staff reports the number of resident training licenses issued since the first of the year. A list of those issued along with the institution where they are serving is book marked as part of this tab.
Committee Recommendation: Accept as information.

Board Action: Accept as information. Future reports should identify physicians as MD or DO as well as identify the school from which the physician received their medical degree.

6. Reporting withdrawals to FSMB

Issue: It has been determined that when reporting withdrawals to FSMB the information is available to all organizations that query the FSMB, not just licensing/regulatory Boards.

Committee Recommendation: Accept as information

Board Action: Accept as information.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes 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/or to preserve attorney/client privilege.

Nine licensure cases were discussed. A written report was presented for the Board’s review. The Board adopted the Committee’s recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

LICENSE INTERVIEW REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes 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/or to preserve attorney/client privilege.

Six licensure interviews were conducted. A written report was presented for the Board’s review. The Board adopted the Committee’s recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.
The Allied Health Committee of the North Carolina Medical Board was called to order at 3:30 p.m., Wednesday, September 21, 2011 at the office of the Board.

Committee Members present were: Peggy Robinson PA-C, Chairperson, William Walker, MD, and Pamela Blizzard. Also present were Marcus Jimison, Lori King, CPCS, Quanta Williams, Jane Paige, Katharine Kovacs, PA, Thomas Hill, MD, Mike Borden, Ryan Vann, and Elmira Powell.

Committee Members Absent: None.

Open Session Physician Assistants

1. NCCPA Physician Assistant National Certifying Examination – Number of Attempts. Ms. Robinson to discuss.

Issue: NCCPA does not list the number of attempts a PA takes the PANCE exam on their transcripts. What is the reason the number of attempts is not reported by NCCPA? The NCMB limits the number of attempts for physician exams. Should the Board entertain a Rule to require passage of the PANCE within a certain number of attempts?

Committee Recommendation:

The Committee discussed PA certification and determined that the NCCPA has good policies in place regarding certification and that a new NCMB Rule would not be necessary. Ms. King contacted the NCCPA to see if other state licensing boards set a limit on how many times a PA can take the exams and the NCCPA responded that it does not keep track of this information. As for the NCCPA’s policy, PAs that graduated on or after January 1, 2003 are eligible to take the PANCE up to six years after graduation and within those six years they have six attempts to pass. If they do not pass by the sixth year or sixth attempt, whichever comes first, they must again complete and graduate from an ARC-PA accredited PA program in order to be eligible for the PANCE again. If they graduated before January 1, 2003, there is no limit to the number of attempts the PA may take in order to pass the PANCE. Ms. King also contacted the NCCPA for the reason why the NCCPA does not report the number of exam attempts on its transcripts. Per the NCCPA, it can provide the information based upon request. It is currently working to enhance the State Board portals so that this option will be available to state boards. The enhancement will include the type of exams and the number of attempts for a particular exam. This project should be complete by the 1st quarter of 2012.

Board Action: Accept as information.

Open Session NC Emergency Medical Services


Issue: Information received by Dr. Kanof on August 31, 2011.
Committee Recommendation: For information.

Board Action: Accept as information.

**ALLIED HEALTH COMMITTEE REPORT LP/AA/CPP**

The Allied Health Committee of the North Carolina Medical Board was called to order at 3:00 pm, September 21, 2011 at the office of the North Carolina Medical Board. Members present were: Peggy Robinson, PA-C, Chair and William Walker, MD; and Pamela Blizzard. Also present were Marcus Jimison, Jane Paige, Lori King, Katharine Kovacs, and Quanta Williams.

1. Open Session Anesthesiologist Assistants
   a. No Items for discussion

2. Open Session Nurse Practitioners
   a. No Items for discussion

3. Open Session Clinical Pharmacist Practitioners
   a. 21 NCAC 46 .2507 – Administration of Vaccines by Pharmacists
      i. A CPP has requested an amendment to the rule to allow pharmacists who have a physical disability that prevents them from obtaining a provider level CPR certification to administer vaccines in the presence of a pharmacy technician or pharmacists who holds a current provider level CPR certification.

      Board Action: Approve the amendment to rule 21 NCAC 46 .2507

4. Open Session Perfusionists
   a. Open session portion of the minutes of the July PAC meeting.
      i. The open session minutes of the July PAC meeting have been sent to the Committee members for review.

      Committee Recommendation: Accept as information

      Board Action: Accept as information

   b. Rules 32V .0105 & .0115
      i. These rules have been reviewed by the Perfusionist Advisory Committee.

      Committee Recommendation: Approve rule changes

      Board Action: Approve rule changes
5. Open Session Polysomnographic Technologist  
a. Update on Sleep Tech registration  
   i. The deadline for NC sleep techs to register with NCMB is January 1, 2012. The registration process has been set up on the Board’s website. So far 86 have registered. Once they have registered, their certification status will be checked using the Board of Registered Polysomnographic Technologists (BRPT) website. BRPT shows 687 sleep techs registered in NC.

Committee Recommendation: For information

Board Action: Accept as information

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes 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/or to preserve attorney/client privilege.

One licensee application was reviewed. A written report was presented for the Board’s review. The Board adopted the Committee’s recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

NURSE PRACTITIONER JOINT SUBCOMMITTEE
The Nurse Practitioner Joint Subcommittee (NPJS) was called to order at 1:00 pm September 21, 2011 at the office of the NC Board of Nursing. Members present were: Nancy Bruton-Maree, RN, Chair (NCBON); Peggy Robinson, PA-C (NCMB); Mary Ann Fuchs, RN (NCBON); Dan Hudgins (NCBON); William Walker, MD (NCMB); and Pamela Blizzard (NCMB). Also present was: Donna Mooney (NCBON); Julie George (NCBON); David Henderson (NCMB); Marcus Jimison (NCMB); David Kalbacker (NCBON); Katharine Kovacs (NCMB); Paulette Young (NCBON); Don Pittman (NCB); Gail Marshall (NCBON); Linda Burhan (NCBON); Eileen Kugler (NCBON); Jean Stanley (NCBON); and Quanta Williams (NCMB).

1. Approval of minutes of May 19, 2011 meeting  
a. Motion: To approve the minutes of the May meeting with a correction to include Anna Choi’s last name. Passed.

2. Additions to agenda  
a. None

3. Old Business  
a. NP Board Certification  
i. There was a question as to why this would be converted to a FAQ as opposed to being a position statement. The NP Joint Subcommittee decided that it should be a position statement.
Motion: To approve the information presented as a position statement. Passed.

b. Report on the change to the renewal question
   i. Jean Stanley reported that the new wording had been piloted from July 2010 through July 2011. There have been two yes responses during that time. The NP Joint Subcommittee feels that the current wording is clearer than how the question previously read.

Motion: To continue using the current wording of the renewal question. Passed.

4. New Business
   a. Report of any disciplinary actions, including Consent Agreements, taken by either Board since the last meeting
      i. The Board of Nursing reported one public action taken against a nurse practitioner since the last meeting.
      ii. The Medical Board reported two public actions taken against a nurse practitioner since the last meeting.

b. Re-entry into practice comparisons between PA and NP
   i. The NP Joint Subcommittee did a compare/contrast evaluation of the two Boards’ rules on re-entry into practice. There was a recommendation for the Board of Nursing to review the refresher course requirements and consider reducing the time out of practice requiring the course from 5 years to 2 years. Ms. Kugler reminded them that this would require a rule change.

Motion: To refer this to the Board of Nursing and bring the recommendation to the November meeting. Passed.

c. Approval of new NP FAQs
   i. Four new FAQs were presented for the Subcommittee’s review. There was discussion regarding the wording of the answer for question number 2. It was suggested that the first paragraph be removed and the second sentence changed to say, “…a federally employed NP who holds a NC approval…”

Motion: To approve the additional FAQs with changes to the answer of question number two. Passed.

d. NP Joint Subcommittee Policy Revisions
   i. The Board of Nursing is in the process of completing a review of existing policies. Proposed policy revisions were presented to the Subcommittee for review and approval.

Comments on the proposed revisions:
JSC-2: Extract since the issue has been referred back to the Board of Nursing. Section 2b to say “A graduate level pharmacology course approved by the Board of Nursing…”

JSC-3: Specify 3 days

JSC-4: Add “e. any other actions authorized by Joint Subcommittee by” (cite both Boards’ rules)

Motion: Approve revisions with the changes suggested by the Joint Subcommittee. Passed.

e. Compliance Review Report
   i. The Subcommittee reviewed the compliance review report. One site visit and sixteen mail-in compliance reviews were completed as of September 7, 2011. The report showed 47% of NPs reviewed were in total compliance with NP rules of initial submission of evidence.

(For information)

5. Other Business
   a. Compact Licensure
      i. A report was given by Donna Mooney explaining compact licensure and how it works.
      ii. Gail Marshall gave a demonstration of the BON and NURSYS websites and how disciplinary information is displayed and used by other states.

6. Next Meeting
   a. November 16, 2011
      i. Midwifery Joint Committee at 10:30 am
      ii. NP Joint Subcommittee at 12:30 pm

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes 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/or to preserve attorney/client privilege.

Eleven approval applicants were reviewed. A written report was presented for the Board’s review. The Board adopted the Committee’s recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

7. OPEN SESSION
a. Motion: To accept the closed session items.

b. The Compliance Review team suggests closing a compliance case and opening an investigation when evidence of dishonesty or falsification of records is found.

c. Motion: Make changes to the compliance protocols open an investigation when evidence of dishonesty or falsification of records is found. November agenda item. Passed.

REVIEW (COMPLAINT) COMMITTEE REPORT
Paul Camnitz, MD, Chair; Peggy R. Robinson, PA-C; John B. Lewis

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes 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/or to preserve attorney/client privilege.

The Review (Complaint) Committee reported on twenty-seven complaint cases. A written report was presented for the Board’s review. The Board adopted the Committee’s recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

DISCIPLINARY (COMPLAINTS) COMMITTEE REPORT
William Walker, MD, Chair; Dr. Thomas R. Hill, MD; Pamela Blizzard; Karen R. Gerancher, MD; Eleanor E. Greene, MD

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes 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/or to preserve attorney/client privilege.

The Disciplinary (Complaints) Committee reported on nine complaint cases. A written report was presented for the Board’s review. The Board adopted the Committee’s recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.
DISCIPLINARY (MALPRACTICE) COMMITTEE REPORT
William Walker, MD, Chair; Dr. Thomas R. Hill, MD; Pamela Blizzard; Karen R. Gerancher, MD; Eleanor E. Greene, MD

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes 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/or to preserve attorney/client privilege.

The Disciplinary (Malpractice) Committee reported on forty-two cases. A written report was presented for the Board’s review. The Board adopted the Committee’s recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

INVESTIGATIVE INTERVIEW REPORT

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes 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/or to preserve attorney/client privilege.

Twenty-two investigative interviews were conducted. A written report was presented for the Board’s review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

DISCIPLINARY (INVESTIGATIVE) COMMITTEE REPORT

The Investigative Disciplinary Committee was called to order at 10:45 a.m. on Wednesday, September 21, 2011, at the office of the Medical Board. Members present were: William Walker, MD, Chair, Ms. Pamela Blizzard, Karen Gerancher, MD, Eleanor Greene, MD, and Thomas Hill, MD.

Open Session:

New Business:

Proposed Physician CME Audit Process
Survey of the Effect of NCMB Disciplinary Actions on Board Certification, presented by Christina Apperson

Conclusion: The relationship between state licensing board action and resulting specialty board action has been the subject of ongoing discussions and formal Federation of State Medical Board policy for about two decades. Prior to NCMB’s inquiry, there was no comprehensive survey in existence to demonstrate all specialty boards’ policies and procedures for collecting and acting upon state medical board disciplinary information. NCMB undertook a survey of ABMS-member boards and received responses from about half of the organizations. Superficial commonalities exist: all receive DANS alerts from ABMS based on FSMB data; all have a policy
in place concerning limitations, suspensions and revocations of a state medical license as mandated by ABMS; nearly all afford some sort of due process hearing; and all apply their policies consistently to initial applicants, current diplomates and candidates for reinstatement. In terms of outcome of discipline, none take action on private or public letters of concern and all take action when a physician licensed in a single state has his or her license suspended or revoked. Beyond that, there is a wide variation in specialty board action based on state board discipline with few discernible trends.

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes 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/or to preserve attorney/client privilege.

The Disciplinary (Investigative) Committee reported on forty investigative cases. A written report was presented for the Board’s review. The Board adopted the Committee’s recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

**REVIEW (INVESTIGATIVE) COMMITTEE REPORT**
Paul Camnitz, MD, Chair; Peggy R. Robinson, PA-C; John B. Lewis

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes 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/or to preserve attorney/client privilege.

The Review (Investigative) Committee reported on thirty-one investigative cases. A written report was presented for the Board’s review. The Board adopted the Committee’s recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

**NORTH CAROLINA PHYSICIANS HEALTH PROGRAM (NCPHP) COMMITTEE REPORT**
Thelma Lennon, Chair; Janice Huff, MD; Ralph C. Loomis, MD

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes 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/or to preserve attorney/client privilege.
The Board reviewed forty-one cases involving participants in the NC Physicians Health Program. 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.

MEDICAL SCHOOL EDUCATIONAL OUTREACH PROJECT

The meeting of the Medical School Educational Outreach Project workgroup of the North Carolina Medical Board was called to order at 3:35 pm on Thursday, September 22, 2011 at the office of the Medical Board. Members present were: Peggy Robinson, PA-C, Chair; Janice Huff, MD; Karen Gerancher, MD and Pamela Blizzard. Staff present were: Nancy Hemphill and Jean Fisher-Brinkley.

1. Old Business: staff work to date:
   a. Jean reported that she has discussed project with Dr. Patrick Ober of WFUBMC, head of medical school curriculum; he is enthusiastic about our program and is at our disposal to review/test at any phase of the project’s development.
   b. Dr. John Kaufmann, new dean of Campbell University School of Osteopathy, is interested in integrating this into their program when they begin admitting osteopathic students in 2013.
   c. Jean discussed possibility of streaming NCMB public meetings on the Web (on demand video/audio) with Granicus, a company that specializes in streaming solutions for government and nonprofit clients. They gave price quotes of $20,000 for the first year and $12,000 for subsequent years. In addition, the NCMB would have to purchase cameras. The workgroup was intrigued by the possibilities this could offer, especially that segments of hearings could be indexed & edited as educational tools, but felt it is too early in this project to use this service, and too expensive at this point. This type of thing is cutting edge in education, according to Ms. Blizzard. Action item: ask Legal Department if real licensee identities can be used in educational materials.

2. New Business:
   a. Workgroup debated the target audience for Module 1 and discussed differences in understanding and capabilities of first year medical or PA students versus resident physicians. The first module should be targeted to the younger cohort.
   b. Rather than the outline proposed, the workgroup wants the first module to be about professionalism. Overall, the concepts should be introduced, with examples from real cases, but also with humor or cartoons. We can look to the core competencies for guidance; workgroup members may also pass along to staff materials they have on professionalism. Some ideas:
      i. Accountability
      ii. Professionalism begins on day 1 of medical school
      iii. You’re a professional 24/7
iv. You’re held to a higher standard
v. Profession is for service to humanity, not money or prestige
vi. Compassion, integrity and competence
vii. How you treat patients and staff is crucial
viii. Don’t have sex with your patients or staff
ix. Issues of social networking: HIPAA violations, unprofessional photos, need for all communications to be on secure lines, don’t text to wrong numbers

c. The workgroup agreed to have staff meet with one or more experienced professionals, possibly to outsource creation of these modules. Public Affairs has up to $5,000 in FY 2011 budget, plus $5,000 in FY 2012, for professional consulting and is working to identify possible consultants. Ms. Blizzard is interested in participating in those meetings if possible.

3. The next meeting is tentatively scheduled during November 2011 Board meeting. At that time, staff will present an outline of the professionalism module and will have some information about consultants.

ADJOURNMENT
This meeting was adjourned at 12:45 p.m. September 23, 2011.

_____________________________________________________
Karen R. Gerancher, MD
Secretary/Treasurer
Self-treatment and treatment of family members and others with whom significant emotional relationships exist*

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

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

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

*This position statement was formerly titled, "Treatment of and Prescribing for Family Members."


DRAFT RULE FOR SELF TREATMENT TASK FORCE
August 10, 2011

We have three existing rules on prescribing authority for NCMB licensees: one each for physicians, PAs and NPs, so it makes sense to amend each of those to include this prohibition. The Board will need to consult with, and get a reciprocal rule change from the Board of Nursing on the one affecting NPs. Also, the Allied Health Committee will have to approve the change for PAs. This preliminary language has been vetted by Rules Review Commission staff.

1. Physician authority to prescribe:

21 NCAC 32B .1001 AUTHORITY TO PRESCRIBE
(a) A license to practice medicine issued under this Subchapter allows the physician to prescribe medications, including controlled substances, so long as the physician complies with all state and federal laws and regulations governing the writing and issuance of prescriptions.

(b) A physician must possess a valid United States Drug Enforcement Administration ("DEA") registration in order for the physician to supervise any other health professional (physician assistant, nurse practitioner, clinical pharmacist practitioner) with prescriptive authority for controlled substances. The DEA registration of the supervising physician
must include the same schedule(s) of controlled substances as the supervised health professional's DEA registration.

(c) A physician shall not prescribe controlled substances, as defined by the state and federal Controlled Substances Acts, for the physician's own use or that of a member of the physician's immediate family, which shall mean a spouse, parent, child, sibling, parent-in-law, son or daughter-in-law, brother or sister-in-law, step-parent, step-child, step-sibling, or any other person living in the same residence as the licensee, or anyone with whom the physician is having a sexual relationship.

History Note: Authority G.S. 90-2(a); 90-14; Eff. June 1, 2007.; amended

2. Nurse Practitioner Authority to Prescribe:

21 NCAC 32M .0109 PRESCRIBING AUTHORITY

(a) The prescribing stipulations contained in this Rule apply to writing prescriptions and ordering the administration of medications.

(b) Prescribing and dispensing stipulations are as follows:

(1) Drugs and devices that may be prescribed by the nurse practitioner in each practice site shall be included in the collaborative practice agreement as outlined in Rule .0110(b) of this Section.

(2) Controlled Substances (Schedules II, IIN, III, IIIN, IV, V) defined by the State and Federal Controlled Substances Acts may be procured, prescribed or ordered as established in the collaborative practice agreement, providing all of the following requirements are met:

(A) the nurse practitioner has an assigned DEA number which is entered on each prescription for a controlled substance;

(B) dosage units for schedules II, IIN, III and IIIN are limited to a 30 day supply; and

(C) the prescription or order for schedules II, IIN, III and IIIN may not be refilled.

(3) The nurse practitioner may prescribe a drug or device not included in the collaborative practice agreement only as follows:

(A) upon a specific written or verbal order obtained from a primary or back-up supervising physician before the prescription or order is issued by the nurse practitioner; and

(B) the written or verbal order as described in Part (b)(3)(A) of this Rule shall be entered into the patient record with a notation that it is issued on the specific order of a primary or back-up supervising physician and signed by the nurse practitioner and the physician.

(4) Refills may be issued for a period not to exceed one year except for schedules II, IIN, III and IIIN which may not be refilled.

(5) Each prescription shall be noted on the patient’s chart and include the following information:

(A) medication and dosage;

(B) amount prescribed;
(C) directions for use;
(D) number of refills; and
(E) signature of nurse practitioner.

(6) Prescription Format:
(A) All prescriptions issued by the nurse practitioner shall contain the supervising physician(s) name, the name of the patient, and the nurse practitioner’s name, telephone number, and approval number.
(B) The nurse practitioner’s assigned DEA number shall be written on the prescription form when a controlled substance is prescribed as defined in Subparagraph (b)(2) of this Rule.

(7) A nurse practitioner shall not prescribe controlled substances, as defined by the state and federal Controlled Substances Acts, for the nurse practitioner’s own use or that of a member of the nurse practitioner’s immediate family, which shall mean a spouse, parent, child, sibling, parent-in-law, son or daughter-in-law, brother or sister-in-law, step-parent, step-child, step-sibling, or any other person living in the same residence as the licensee, or anyone with whom the nurse practitioner is having a sexual relationship.

(c) The nurse practitioner may obtain approval to dispense the drugs and devices other than samples included in the collaborative practice agreement for each practice site from the Board of Pharmacy, and dispense in accordance with 21 NCAC 46 .1700, that is hereby incorporated by reference including subsequent amendments of the referenced materials.

History Note: Authority G.S. 90-6; 90-18(14); 90-18.2; 90-171.23(14); 90-171.42; 58 Fed. Reg. 31,171 (1993) (to be codified at 21 C.F.R. 1301);
Eff. February 1, 1991;
Recodified from 21 NCAC 32M .0106 Eff. January 1, 1996;
Amended Eff. November 1, 2008; August 1, 2004; May 1, 1999; January 1, 1996; September 1, 1994; March 1, 1994.

3. Physician Assistant Authority to Prescribe:

21 NCAC 32S .0212 PRESCRIPTIVE AUTHORITY
A physician assistant may prescribe, order, procure, dispense and administer drugs and medical devices subject to the following conditions:
(1) the physician assistant complies with all state and federal laws regarding prescribing including G.S. 90-18.1(b);
(2) each supervising physician and physician assistant incorporates within their written supervisory arrangements, as defined in Rule .0201(8) of this Subchapter, instructions for prescribing, ordering, and administering drugs and medical devices and a policy for periodic review by the physician of these instructions and policy;
(3) In order to compound and dispense drugs, the physician assistant complies with G.S. 90-18.1(c);
(4) in order to prescribe controlled substances,
   (a) the physician assistant must have a valid Drug Enforcement Administration (DEA) registration and prescribe in accordance with DEA rules;
(b) All prescriptions for substances falling within schedules II, IIN, III, and IIIN, as defined in the federal Controlled Substances Act, shall not exceed a legitimate 30 day supply;
(c) the supervising physician must possess the same schedule(s) of controlled substances as the physician assistant's DEA registration;
(5) each prescription issued by the physician assistant contains, in addition to other information required by law, the following:
(a) the physician assistant's name, practice address and telephone number;
(b) the physician assistant's license number and, if applicable, the physician assistant's DEA number for controlled substances prescriptions; and
(c) the responsible supervising physician's (primary or back-up) name and telephone number;
(6) the physician assistant documents prescriptions in writing on the patient's record, including the medication name and dosage, amount prescribed, directions for use, and number of refills; and
(7) a physician assistant who requests, receives, and dispenses medication samples to patients complies with all applicable state and federal regulations.

(8) A physician assistant shall not prescribe controlled substances, as defined by the state and federal Controlled Substances Acts, for the physician assistant’s own use or that of a member of the physician assistant’s immediate family, which shall mean a spouse, parent, child, sibling, parent-in-law, son or daughter-in-law, brother or sister-in-law, step-parent, step-child, step-sibling, or any other person living in the same residence as the physician assistant, or anyone with whom the physician assistant is having a sexual relationship.

History Note: Authority G.S. 90-18(c)(13); 90-18.1; 90-18.2A; 90-171.23(14); 21 C.F.R. 301; Amended ____________; Eff. September 1, 2009.

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Self-treatment and treatment of family members

It is the position of the Board that licensees generally should not treat themselves or their immediate family members. In addition, it is the Board’s position that licensees should refrain from treating other person’s with whom the licensee has a significant emotional relationship. In such situations, professional objectivity may be compromised, and the licensee’s personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Furthermore, licensees may fail to inquire about sensitive subjects when taking a medical history or fail to perform intimate parts of a physical examination.

Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the healthcare provider is a family member. Concerns regarding patient autonomy and informed consent are also relevant when licensees attempt to treat members of their immediate family because family members may be reluctant to decline a treatment recommendation or seek a second opinion for fear of offending the licensee.

There are, however, certain limited situations in which it may be appropriate for licensees to treat themselves or their family members. If the patient has an emergency condition and there is no other qualified physician available, it may be appropriate for licensees to treat themselves
or their family members until another physician becomes available. In addition, while licensees should not serve as a primary or regular care provider for themselves or their family members, there are situations in which routine care may be acceptable for acute minor illnesses. It is not appropriate for physicians to write prescriptions for controlled substances or perform procedures for themselves or their family members unless the patient has an emergency condition. In such circumstances, the licensee should only provide treatment until another physician becomes available.

Those licensees who inappropriately treat themselves, their family members or others with whom they have a significant emotional relationship should be aware that they may be subject to disciplinary action by the Board. In addition, those licensees who treat themselves or their family members in a manner consistent with this position statement will be held to the same standard of care applicable to licensees providing treatment for patients who are not family members. Thus, licensees should not treat problems beyond their expertise or training and should be sure to maintain a medical record documenting any care that is given.

Definitions

Emergency Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.*

Family Members – The Board considers family members to include the licensee's spouse or domestic partner and either of the licensee's, spouse's, or domestic partner's parents, stepparents or grandparents; the licensee's natural or adopted children or stepchildren and any child's spouse, domestic partner or children; the siblings of the licensee or the licensee's spouse or domestic partner and the sibling's spouse or domestic partner; or anyone else living with the licensee.

NOTE: Licensees may also want to familiarize themselves with the Board's position statement on Treatment of Peers.

* This definition is taken primarily from the definition provided in the Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd(e).
Prescribing legend or controlled substances for other than validated medical or therapeutic purposes, with particular reference to substance or preparations with anabolic properties

General
It is the position of the North Carolina Medical Board that prescribing any controlled or legend substance for other than a validated medical or therapeutic purpose is unprofessional conduct.

The physician licensee shall complete and maintain a medical record that establishes the diagnosis, the basis for that diagnosis, the purpose and expected response to therapeutic medications, and the plan for the use of medications in treatment of the diagnosis.

The Board is not opposed to the use of innovative, creative therapeutics; however, treatments not having a scientifically validated basis for use should be studied under investigational protocols so as to assist in the establishment of evidence-based, scientific validity for such treatments.

Substances/Preparations with Anabolic Properties
The use of anabolic steroids, testosterone and its analogs, human growth hormone, human chorionic gonadotrophin, other preparations with anabolic properties, or autotransfusion in any form, to enhance athletic performance or muscle development for cosmetic, nontherapeutic reasons, in the absence of an established disease or deficiency state, is not a medically valid use of these medications.

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

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

<table>
<thead>
<tr>
<th>POSITION STATEMENT</th>
<th>ADOPTED</th>
<th>SCHEDULED FOR REVIEW</th>
<th>LAST REVISED/REVIEWED/ADOPTED</th>
<th>REVISED/REVIEWED</th>
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<tr>
<td>Availability of Physicians to Their Patients</td>
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<td>Physician Supervision of Other Licensed Health Care Practitioners</td>
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<td>Professional Obligations pertaining to incompetence, impairment, and unethical conduct of healthcare providers</td>
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<td>What Are the Position Statements of the Board and To Whom Do They Apply?</td>
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</table>
Availability of physicians to their patients

It is the position of the North Carolina Medical Board that once a physician-patient relationship is created, it is the duty of the physician to provide care whenever it is needed or to assure that proper physician backup is available to take care of the patient during or outside normal office hours.

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

PHYSICIANS PRESENTED AT THE SEPTEMBER 2011 BOARD MEETING

Abboy, Chandar Raja
Abern, Michael Ryan
Abraham, Edward
Abumostafa, Yousef Shokry
Agarwal, Akash Deep
Akhter, Natasha Salim
Albala, Maurizio Zeki
Alexander, Annetta Cheryl
Alexander, Johnny Octavious
Alvarez, Manrique
Amara, Ashvin Kumar
Appelgren, Kristie Elizabeth
Asevedo, Maria Regina
Ash, Lorraine Marjorie
Ashburn, Joseph Charles
Aultman, William Andrew
Bardy, Lea Lynne
Barkoe, David Jason
Bataller Alberola, Ramon
Bates, Michael Devon
Bean, Michael John
Beaupied, Earl Francis
Becerra, Gonzalo Daniel
Beck, Joel Brian
Belizaire, Kikelomo
Bestard, Jose Fernando
Biggs, Holly Marie
Black, Richard Robin
Boghara, Hareshkumar Dhirajlal
Botti, John Joseph
Bowe, Crystal Cornelia
Bowman, Amber Leigh
Bradford, William Tate
Brady, David Allen
Brannin, Sandra Shumate
Brendle, David C
Bridges, Charles R.
Brill, Jason Bradley
Briscoe, Kim Kouch
Brodie, Mark Francis
Budenz, Donald Lyle
Budin, Robert Earl
Burns-Booth, Keri Leigh
Cagle Richardson, Nicole Alexandria
Calaycay, Regulo
Carattini-Eley, Francine Louise
Carnes, Jason Anthony
Carroll, Pauline Clare
Caulfield, John Justin
Chang, Weili
Chhabra, Ravi
Chin, Matthew Steven
Choudry, Shazia Amber
Coates, Kevin Emerson
Cobb, Kathryn Watson
Colin, Brian Joseph
Conlee, Aimee Christine
Cornelius, Lala Arnoldovna
Correa, Candace Rebecca
Covey, Shannon Amber
Cox, Alan Lee
Crichlow, Lya Carol
Cuddapah, Deepak
Daluvoy, Melissa Beth
Daubert, Melissa Anne
Dean, Andrea Renata
Devon, Eric
Dhital, Pradeep Prasad
Do, Thi Khoa
Dolz, Mark Stephen
Donoghue, Kristin Lynn
Douglass, Cara Shoshana
Douglass, Samuel James
Drimalla, Richard Brian
Drummond, Shaina Marie
Durojaiye, Babatola Adeagbo
Dyrsen, Molly Elizabeth
Edwards, Landon Shay
Ehrlich, Roy Edward
Erami, Cauveh
Erb, David Richard
Esanakula, Swarupa Rani
Etukuru, Kasturi
Evans, James Warren
Evans, Samantha Renee
Evans-Hoeker, Emily A
Fakiris, Achilles John
Fan, Rongrong
Farah, Ramez
Farahi, Narges
Feiner, Alyssa Michelle
Ference-Valenta, Mary Jean
Files, Daniel Clark
Fink, Ryan Jeffrey
Folkner, Brie Michele
Fox, Bryan Alan
Fox, Curtis Elvin
Freeman, Patrick Scott
Gamez, Ruben
Garikiparthy, Venkataramana Pradeep
Gettys, Edna Katherine Gantt
Ghaderi, Iman
Ghanem, Mario Tadros
Goncalves, Rod Manuel
Gopal, Purva
Gorantla, Venkatesan Ramaswamy
Gorrey, Purushotham
Greiner, Jennifer Lynn
Groves, Nicole Kristine
Gupta, Deepa Rajshree
Gupta, Pushpender
Gustafson, Sarah Lucille
Harnish, Stephen Norman
Harrison, Natasha Faye
Hartsell, Fletcher Lee
Hawkes, Kristin DeVonne
Hayden, Gregory Lee
He, Jun
Heasley, Diane Dawn
Heller, Michael
Hemby, Katherine Anne
Hemingway, Diane R
Hemphill, Shane Donald
Hinson, Ashley Rebekah Presar
Hollowell, Kerry Lynn
Horvath, Jeffrey John
Howard, Neva Margaret
Hutton, Kimberly Kay
Igboeli, Ifeoma Jacqueline
Ikele, Stephen Akhi
Indulkar, Shalaka Dayarum
Irani, Katayun
Ivanova, Daniela Todorova
Jackson, Arthur Timothy
Jain-Spangler, Kunoor
Jameson, Kathleen Meagher
Jasani, Nirav Manubhai
Johnson, Daryih Lindsay
Jones, Blaise Vincent
Jones, Kamlyn
Jooste, Edmund Hilton
Joyner, Makesha Ann
Jurnecka, Jan Steven
Kalra, Sumit
Kang, Melissa Rahhyung
Kansagra, Sujay Mansukhlal
Kapur, Seema
Kessler, Brian Arthur
Khazanchi, Arthi Kachru
Kidd, Jason Michael
Kiefer, Todd
Klausner, Brian Thomas
Kolb, Terence William
Konig, Matthias Werner
Koul, Pulin Behari
Kumaran, Karthic Rajasekaran
Kumaria, Tanya
LaBoone, Laura Mesa
Lachiewicz, Anne Monica
Lagos, Jaime Andres
Lagvankar, Seema Ashok
Laney, Ronald Buren
Larzo, Cristoforo Raymond
Lewin, Marc Roy
Libertin, Mark
Logan, Ashley Fitzgerald
Loganathan, Amritraj Ganesh
Lynch, James Henry
Marder, Scott David
Marsh, Robert Anthony
Martin, Patricia
Mastrangelo, John Armand
Mcall, Kate Laura
McClanahan, Darbye Suzanne
McCrary, Bradford Scott
McDonell, Anne Ashley
McGill, Dennis Lucas
McNeill, Elena
Mikkilineni, Haritha
Miller, Susan Ney
Milowsky, Matthew Ivan
Moffatt, Lawrence Strong
Monnell, Kimberly Anne
Mozingo, Willis Scott
Muhammad, Chalak Najat
Mumpower, Rebecca Yvonne
Munoz, Lesli Casten
Nayak, Deepa
Newman, Barbara Anne
Nguyen, Chuck Thaichuong
Nickel, Marshall Scott
Nikfarjam, Iraj
Nissman, Kathleen Williams
Njapa, Jacqueline Masale
Ogbulu, Shamusideen Olayibo
Okumu, Wycliffe Okatch
Olivere, Joseph Wendell
Onuma, Kalu Ireke
Orlando, Giuseppe
Overton, Dolphin Henry
Palaniswamy, Guhapriya
Palit, Shyamal Kanti
Palliser, Alisha Marie
Parada, Stephen Arthur
Pasula, Smitha Reddy
Patel, Gaurav Jirajbhai
Patel, Hiren Rohit
Paya, Alejandro
Shaw, Steven James  
Shealy, Michael James  
Shendarkar, Nitin  
Sheth, Pragna Dhimant  
Silbiger, Adam Michael  
Singh, Abhay A  
Singh, Gajendra  
Singh, Paramjeet  
Singh, Prashant Kumar  
Skarupa, David Joseph  
Smithson, Sarah Elizabeth  
Sonberg, Arthur Robert  
Soundarapandian, Usha  
Sparks, David Parker  
Spellman, Keith Michael  
Spencer, Stephen Andrew  
Stein, Elisa Anne  
Stirparo, Joseph James  
Stolldorf, Sarah Alyce  
Syed, Salma Sultana  
Tabrizi, Elnaz Nassehzadeh  
Tatum, Christina Jackson  
Tatum, Philip Michele  
Teppara, Nikhil  
Thattaliyath, Bijoy Damodaran  
Theiling, Brent Jason  
Theune, Brian Thomas  
Thomas, Christopher Yancey  
Thompson, Zachary Moss  
Tiley, Stephen Gerard  
Trapp, Benjamin Allen  
Turinsky, Andrew Jaroslav  
Turner, Lee Leatherwood  
Turton, Robert Lawrence  
Tye, Grace Anlon  
Udeozo, Chidebe  
Vadaparampil, John Annjos  
Vaheesan, Kirubahara  
Vaidya, Neel Kumarpal  
Van De Ven, Thomas John  
Vaughan, Suzanne  
Versnick, Mark Anthony  
Wadie, George Michel
Walker, John Rishel
Watson, Brian Wesley
Watson, Larry Irving
Wayne, James Allen
Webster, Megan Aileen
Werle, David Michael
Werner, Jordana Gaylen
Whigham, Amy Shibley
Whitbeck, Matthew Gail
Widner, Aimee Elizabeth
Williams, Carey Campbell
Williams, Gethin
Williams, Malcolm Beverley
Wilson, Martha Louise
Wobker, Sara Elizabeth
Wolske, Kristy Marie
Wright, Eric Hamilton
Wright, Scott Jeffrey
Wright, Thamrah Rhoxyana
Yaar, Ron
Yerubandi, Vijay
Yirenkyi, Emmanuel Awuku
Youssef, Hany Lotfy
Yuan, Xiang
APPENDIX F

RESIDENT TRAINING LICENSES ISSUED IN 2011

Willis, Winston James  Blue Ridge Healthcare
Lynn, Jesse Harrison  Blue Ridge Healthcare
Miller, Gina  Blue Ridge Healthcare
Meador, Shannon Brown  Blue Ridge Healthcare
Shelton, Randal Curtis  Blue Ridge Healthcare
Bekal, Karthik Rao  Blue Ridge Healthcare
Vail, Chadwell Brandon  Blue Ridge Healthcare
Buchanan, Craig Andrew  Blue Ridge Healthcare
Jansen, Curtis Lee  Blue Ridge Healthcare
Svendsen, Torben  Blue Ridge Healthcare
Prieto, Jose Luis  Blue Ridge Healthcare
Blahovec, Lyndanne Whalen  Blue Ridge Healthcare
Joshi, Anand  Cabarrus Family Medicine
Poetta, Robert Patrick  Cabarrus Family Medicine
Paul, Timothy Evan  Cabarrus Family Medicine
Patterson, Jonathan Ryan  Cabarrus Family Medicine
Mekhael, Mina Saher  Cabarrus Family Medicine
Scott, Robert Eugene  Cabarrus Family Medicine
Thomas, Matthew Robert  Cabarrus Family Medicine
Thomas, Jenna Searcy  Cabarrus Family Medicine
Scott, Jennifer King  Cabarrus Family Medicine
Jarrett, Benjamin Paul  Carolinas Medical Center
Hanlon, Christopher Thomas  Carolinas Medical Center
Alexander, Justin Jacob  Carolinas Medical Center
Pierce, Tyler Cox  Carolinas Medical Center
Roach, Michael Charles  Carolinas Medical Center
Van Meter, Charles Jackson  Carolinas Medical Center
Carey, Christopher William  Carolinas Medical Center
Bustin, Devin James  Carolinas Medical Center
Lewis, Suzanne Wesley  Carolinas Medical Center
Gaffney, Vandy Theodore  Carolinas Medical Center
Day, Brendan Francis  Carolinas Medical Center
Keller, Stephen Michael  Carolinas Medical Center
Hart, Gavin  Carolinas Medical Center
Vogel, Kimbre Lee  Carolinas Medical Center
Dellinger, Matthew Blair  Carolinas Medical Center
Dahlquist, Robert Thomas  Carolinas Medical Center
Keller, Meaghan Elisabeth  Carolinas Medical Center
Mercer, Stephen Joseph  Carolinas Medical Center
Ramanathan, Dinesh  Duke University Hospital
Kushlaf, Hani Abdussalam  Duke University Hospital
Lynch, Martin Joseph  Duke University Hospital
Yang, Julian P  Duke University Hospital
Edwards, Meredith Hardy  Duke University Hospital
Prats, Lauren Ashley  Duke University Hospital
Kartha, Lakshmi Devi  Duke University Hospital
Chung, Jennifer Marshall  Duke University Hospital
Halbe, Jeremy Andrew  Duke University Hospital
Plummer, Sarah Tyler  Duke University Hospital
Pradhan, Anupam Kumar  Duke University Hospital
Miller, Mark Daniel  Duke University Hospital
Rutherford, Richard Woodson  Duke University Hospital
Poster, Craig Steven  Duke University Hospital
Sung, Anthony  Duke University Hospital
Bengali, Rayomand R  Duke University Hospital
Patel, Sandip Pravin  Duke University Hospital
Hauck, Jennifer Nowak  Duke University Hospital
Pickens, Charlie  Duke University Hospital
Vickers, Laura Ann  Duke University Hospital
Hooten, Joanna N  Duke University Hospital
Mauritz, Amy Amenawon-Ohen  Duke University Hospital
Evans, Christopher Scott  Duke University Hospital
Dude, Ann Melissa  Duke University Hospital
Kaysin, Alexander  Duke University Hospital
Hale, Brittani Ann  Duke University Hospital
Williams, Katherine Anne  Duke University Hospital
Patel, Kavita Dali  Duke University Hospital
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Parker Cote, Jennifer Lynne
Borden, Zachary Stephen
Watkins, John Ryan
Graves, Helen Gaskins
Saucerman, Adam Wesley
Aslam, Nazia
Paine, Matthew Stephen
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Leonard, Kenji Lawrence
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Butala, Mitul  
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Greene, Elizabeth Eve  UNCUnc Hospitals
Smetana, Brandon Shane  UNCUnc Hospitals
Rodgers, Brittny Page  UNCUnc Hospitals
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MEMO TO: NCMB Licensing Committee

FROM: Nancy Hemphill

DATE: September 8, 2011

SUBJECT: Emergency Physician Deployment and Licensure

The purpose of this memo is to discuss the federal and state laws regarding the licensing of physician and physician assistant volunteers following a natural or man-made disaster in North Carolina. The state’s plans for responding to disasters or emergencies which require volunteer medical personnel are extensive, intertwined, and well organized.

I. Authority at the national level:

A. All fifty states and US territories participate in the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP). ESAR-VP has been in existence since 2002; it now is administered by the Office of the Assistant Secretary for Preparedness and Response in the US Department of Health and Human Services. With this program, the federal government works with states to establish a national network of state-based programs for pre-registration of a broad range of volunteer health professionals. Under ESAR-VHP, volunteers' identities, licenses, credentials, accreditations, and hospital privileges are all verified both in advance and at the time of deployment of a public health or medical disaster or emergency. In NC, this program is called “ServNC”, the state emergency registry of volunteers. Most state programs have similar names.

There are several new ESAR-VP plans being created at the federal level with continued input from the states. When these are finalized, they will be shared with the states for adoption if they so choose. The NC Department of Emergency Management (NC DEM) believes that the relevant ESAR-VP will be adopted as a supplementary agreement (as permitted by N.C. Gen. Stat. § 166A-47) rather than as a new statute or administrative rule. The new ESAR-VP plans are being developed to deal with the diversity of programs across the states. Some state programs have more robust staffing and quality than others. States also differ in how they handle issues of professional liability and workers compensation. Generally speaking, professional liability insurance continues to provide coverage to a volunteer in another state, if their current employer agrees. In some states, workers' compensation is available to a volunteer from another state who is injured while serving, as though that volunteer were employed by state in the disaster zone. This is a contentious area and the NC law on this is unsettled.
B. Most of the fifty states and US territories are members of EMAC (Emergency Management Assistance Compact). This is a congressionally-ratified organization that provides form and structure to interstate mutual aid. Through EMAC, a disaster-impacted state can request and receive assistance from other member states quickly and efficiently, resolving two key issues upfront: liability and reimbursement. The EMAC provides for the requesting state to reimburse the rendering state (and hospitals, etc) for expenses incurred in responding. This funding goes through federal channels and can be very slow in processing. The EMAC is activated when a Governor declares a State of Emergency.

C. One of the lessons learned from Katrina is the importance of state and local response to a disaster or emergency. While the federal government (through FEMA) can play an important role financially, it is better to maximize the use of state and local knowledge, coordination, and personnel.

4. To the greatest extent possible, valuable personnel should be retained in their communities rather than encouraging outsiders to respond. In Katrina, when LA and MS hospitals and clinics were destroyed, many LA and MS physicians relocated out of state. It would have been better to create mobile hospitals or provide interim housing so those local physicians could continue working with their same teams, patient population, and cultural connections. A role for government is to have Disaster Medical Assistance Teams (DMATs) available, and also to provide temporary housing, if necessary, so local providers can stay in their communities.

5. Although most teams will come with their own resources for up to 72 hours, when unaffiliated outside volunteers come to the scene of a disaster, their need for food, water, and shelter can strain already scarce resources.

6. Retaining local medical professionals alleviates the need for state medical boards to create and execute temporary licensing protocols for incoming physicians and others.

II. Organization at the State Level

A. ServNC, North Carolina’s ESAR- VP program, provides a structure to recruit, inform, mobilize and track health care providers and other volunteers to respond to a crisis. This is true both for internal disasters (for example, a hurricane hits the coast and Charlotte physicians respond) and for situations that call for assistance from out of state (Kentucky gets hit with an ice storm and asks North Carolina to assist.)

B. Physicians, other health care providers and other volunteers register on-line. NCMB licensees may be drawn to it by a link on the NCMB annual renewal page.
It takes about 10 minutes to register. In addition to demographic information, the licensee lists specialty, occupation, certifications, medical history, and geographic areas to which he/she would be willing to respond. The licensee also lists the best way to be contacted, i.e., email or cell phone. Volunteers often are deployed in teams; if a person wishes to be assigned to team, ServNC can facilitate that process.

C. Other emergency response resources:

1. There are eight trauma regions in North Carolina, designated as Regional Advisory Committees (RACs). Each RAC has a State Medical Assistance Team (SMAT II). They each have the ability to set up a small field hospital. The SMAT was formed following 9/11/01, primarily to respond to biological and terrorism events which include chemical agents. Each RAC/SMAT is anchored by a major hospital: Mission (Asheville); Carolinas Medical Center (Metrolina); WFUBMC (Triad); Duke (Durham); UNC (Central Carolina); WakeMed (Capital); Pitt County Memorial (Eastern); and New Hanover Regional (Southeastern).

2. The state also has four mobile hospitals which can be set up in a matter of hours. The state also has mobile pharmacies and 29 SMAT III which have decontamination capabilities. They are spread out across the state and are run by the local EMS agencies.

III. What if there was a disaster in NC?

D. The NC Governor would declare a State of Emergency under N.C. Gen. Stat. §166A.

E. Requests for Assistance (RFAs) would come from local counties and municipalities to the NC DEM, who would aggregate those needs. The State Office of Emergency Medical Services (OEMS) would in turn determine what medical providers were needed. The OEMS would coordinate with the State Medical Asset Resource Tracking Tool (SMARTT). (OEMS also works with the NC EMS Advisory Council, of which Dr. Liz Kanof is a member.)

F. The OEMS would formulate a specific mission request: X doctors, X nurses, X paramedics, plus specified equipment and other resources. The mission request would be relayed to the ServNC program. The first approach would be for NC DEM/ServNC to compile teams of responders of North Carolina volunteers.

G. If the extent of the crisis were larger than could be dealt with using NC personnel alone, the Governor could authorize an EMAC/Request for Assistance (RFA), which would be posted to the EMAC network. The request would be very specific, asking for particular numbers and skill types of personnel and equipment. One or more states would respond to that request, offering NC a
team and itemizing the cost of that team. The NCEM could then accept one or more of these proposals.

H. The responding state’s ESAR-VP program would check the credentials of physicians and other licensees requested by NC’s RFA. If North Carolina had an agreement with the responding state covering this term, the NC OEMS would not check incoming physicians’ credentials, however, but would rely on the other state’s diligence in doing so. States differ in their protocols and the robustness of their programs, but in general, each state checks:

a. Federal ESAR VP database
b. Active state license with state medical or osteopathic board (Volunteers whose licensees are close to renewal or have other licensing issues may be rejected.)
c. FSMB databank
d. AMA and AOA databanks
e. ABMS for specialty board certification
f. DEA
g. OIG for improper use of federal funds

F. The North Carolina EMAC is codified in Article 4 of Chapter 166A, the Emergency Management Act. Among other things, the EMAC gives the Governor plenary powers in the event of a declared emergency or disaster, and the authority to declare that professionals from other participating states have reciprocal authority to practice in this state, subject to any limitations or conditions placed by the Governor. Specifically, N.C. Gen. Stat. § 166A-45 states:

Whenever any person holds a license, certificate, or other permit issued by any party state evidencing the meeting of qualifications for professional, mechanical, or other skills, and when assistance is requested by the receiving party state, the person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving skill to meet a declared emergency or disaster, subject to any limitations and conditions the governor of the requesting state may prescribe by executive order or otherwise. (1997-152, s. 1.)

I. The state Emergency Management Director would look to the NCMB if their office ran into any problems verifying the credentials of a physician. The NCMB would also be involved in licensing under emergency conditions if a physician intended to practice here for an extended period of time. However, the general rule is that the NCMB would not issue emergency licenses; incoming physicians vetted by another state would enter NC and practice medicine without any authority by the NCMB. The Governor, by Executive Order, might
place geographic, time, and other restrictions on the practice of the incoming volunteer physicians.

J. The state discourages anyone (whether licensed in NC or not) from simply arriving at a disaster zone. They feel it is unlikely that a hospital would extend privileges to physicians who simply showed up. As to physicians who do express willingness to serve at the last minute, the best thing is to direct them to register through ServNC. That way, their information is included in the central database. The state would provide “Just in time Training” before deploying them, and would keep track of volunteers who have been mobilized.

K. The recommendation from the state Emergency Management office is that the NCMB continue to promote ServNC by providing the link to it during the online renewal process, and including references to it on the NCMB website, The Forum or other media, to encourage physicians, PAs, and other licensees to register.

IV. What if there were a disaster in another state, and NC licensees were willing to assist?

A. If the Governor of another state filed a RFA through EMAC, to which NC responded, the ServNC program would compile a group of volunteers who agreed to serve in that time and place. OEMS would check their credentials against the roster which Hari provides each month. The NC EMS also has access to, and checks, the credentials of nurses, pharmacists, veterinarians, social workers, EMS, Respiratory Therapist and a few other professions.

B. The ServNC program would provide immediate training about the mission, and would mobilize the team for their specific mission. Again, the NC DEM would contact the NCMB if it had questions about a particular NC licensee’s credentials.

V. Key state statutes are attached.

   (a) The existence of a state of disaster may be proclaimed by the Governor, or by a resolution of the General Assembly if either of these finds that a disaster threatens or exists.
   (a1) If a state of disaster is proclaimed, the Secretary shall provide the Governor and the General Assembly with a preliminary damage assessment as soon as the assessment is available. Upon receipt of the preliminary damage assessment, the Governor shall issue a proclamation defining the area subject to the state of disaster and proclaiming the disaster as a Type I, Type II, or Type III disaster. In determining whether the disaster shall be proclaimed as a Type I, Type II, or Type III disaster, the Governor shall follow the standards set forth below.
   (1) A Type I disaster may be declared if all of the following criteria are met:
       a. A local state of emergency has been declared pursuant to G.S. 166A-8, and a written copy of the declaration has been forwarded to the Governor;
b. The preliminary damage assessment meets or exceeds the criteria established for the Small Business Administration Disaster Loan Program pursuant to 13 C.F.R. Part 123 or meets or exceeds the State infrastructure criteria set out in G.S. 166A-6.01(b)(2)a.; and
c. A major disaster declaration by the President of the United States pursuant to the Stafford Act has not been declared.

A Type I disaster declaration may be made by the Governor prior to, and independently of, any action taken by the Small Business Administration, the Federal Emergency Management Agency, or any other federal agency. A Type I disaster declaration shall expire 30 days after its issuance unless renewed by the Governor or the General Assembly. Such renewals may be made in increments of 30 days each, not to exceed a total of 120 days from the date of first issuance. The Joint Legislative Commission on Governmental Operations shall be notified prior to the issuance of any renewal of a Type I disaster declaration.

(2) A Type II disaster may be declared if the President of the United States has issued a major disaster declaration pursuant to the Stafford Act. The Governor may request federal disaster assistance under the Stafford Act without making a Type II disaster declaration. A Type II disaster declaration shall expire six months after its issuance unless renewed by the Governor or the General Assembly. Such renewals may be made in increments of three months each, not to exceed a total of 12 months from the date of first issuance. The Joint Legislative Commission on Governmental Operations shall be notified prior to the issuance of any renewal of a Type II disaster declaration.

(3) A Type III disaster may be declared if the President of the United States has issued a major disaster declaration under the Stafford Act and:
   a. The preliminary damage assessment indicates that the extent of damage is reasonably expected to meet the threshold established for an increased federal share of disaster assistance under applicable federal law and regulations; or
   b. The preliminary damage assessment prompts the Governor to call a special session of the General Assembly to establish programs to meet the unmet needs of individuals or political subdivisions affected by the disaster.

A Type III disaster declaration shall expire 12 months after its issuance unless renewed by the General Assembly.

(a2) Any state of disaster declared before July 1, 2001, shall terminate by a proclamation of the Governor or resolution of the General Assembly. A proclamation or resolution declaring or terminating a state of disaster shall be disseminated promptly by means calculated to bring its contents to the attention of the general public and, unless the circumstances attendant upon the disaster prevent or impede, promptly filed with the Secretary of Crime Control and Public Safety, the Secretary of State and the clerks of superior court in the area to which it applies.
(b) In addition to any other powers conferred upon the Governor by law, during a state of disaster, the Governor shall have the following powers.

1. To utilize all available State resources as reasonably necessary to cope with an emergency, including the transfer and direction of personnel or functions of State agencies or units thereof for the purpose of performing or facilitating emergency services;

2. To take such action and give such directions to State and local law-enforcement officers and agencies as may be reasonable and necessary for the purpose of securing compliance with the provisions of this Article and with the orders, rules and regulations made pursuant thereto;

3. To take steps to assure that measures, including the installation of public utilities, are taken when necessary to qualify for temporary housing assistance from the federal government when that assistance is required to protect the public health, welfare, and safety;

4. Subject to the provisions of the State Constitution to relieve any public official having administrative responsibilities under this Article of such responsibilities for willful failure to obey an order, rule or regulation adopted pursuant to this Article.

(c) In addition, during a state of disaster, with the concurrence of the Council of State, the Governor has the following powers:

1. To direct and compel the evacuation of all or part of the population from any stricken or threatened area within the State, to prescribe routes, modes of transportation, and destinations in connection with evacuation; and to control ingress and egress of a disaster area, the movement of persons within the area, and the occupancy of premises therein;

2. To establish a system of economic controls over all resources, materials and services to include food, clothing, shelter, fuel, rents and wages, including the administration and enforcement of any rationing, price freezing or similar federal order or regulation;

3. To regulate and control the flow of vehicular and pedestrian traffic, the congregation of persons in public places or buildings, lights and noises of all kinds and the maintenance, extension and operation of public utility and transportation services and facilities;

4. To waive a provision of any regulation or ordinance of a State agency or a political subdivision which restricts the immediate relief of human suffering;


6. To perform and exercise such other functions, powers and duties as are necessary to promote and secure the safety and protection of the civilian population;

7. To appoint or remove an executive head of any State agency or institution the executive head of which is regularly selected by a State board or commission.

a. Such an acting executive head will serve during:
1. The physical or mental incapacity of the regular office holder, as determined by the Governor after such inquiry as the Governor deems appropriate;
2. The continued absence of the regular holder of the office; or
3. A vacancy in the office pending selection of a new executive head.

b. An acting executive head of a State agency or institution appointed in accordance with this subdivision may perform any act and exercise any power which a regularly selected holder of such office could lawfully perform and exercise.

c. All powers granted to an acting executive head of a State agency or institution under this section shall expire immediately:
   1. Upon the termination of the incapacity as determined by the Governor of the officer in whose stead he acts;
   2. Upon the return of the officer in whose stead he acts; or
   3. Upon the selection and qualification of a person to serve for the unexpired term, or the selection of an acting executive head of the agency or institution by the board or commission authorized to make such selection, and his qualification.

(8) To procure, by purchase, condemnation, seizure or by other means to construct, lease, transport, store, maintain, renovate or distribute materials and facilities for emergency management without regard to the limitation of any existing law.

(d) In preparation for a state of disaster, with the concurrence of the Council of State, the Governor may use contingency and emergency funds as necessary and appropriate for National Guard training in preparation for disasters. (1951, c. 1016, s. 4; 1955, c. 387, s. 4; 1959, c. 284, s. 2; c. 337, s. 4; 1975, c. 734, ss. 11, 14; 1977, c. 848, s. 2; 1979, 2nd Sess., c. 1310, s. 2; 1993, c. 321, s. 181(a); 1995, c. 509, s. 125; 2001-214, s. 3.)

§ 166A-43. Party state responsibilities.

(a) It shall be the responsibility of each party state to formulate procedural plans and programs for interstate cooperation in the performance of the responsibilities listed in this Article. In formulating the plans, and in carrying them out, the party states, insofar as practicable, shall:

(1) Review individual state hazards analyses and, to the extent reasonably possible, determine all those potential emergencies the party state might jointly suffer, whether due to natural disaster, technological hazard, man-made disaster, emergency aspects of resource shortages, civil disorders, insurgency, or enemy attack.
(2) Review the party states' individual emergency plans and develop a plan that will determine the mechanism for the interstate management and provision of assistance concerning any potential emergency.

(3) Develop interstate procedures to fill any identified gaps and to resolve any identified inconsistencies or overlaps in existing or developed plans.

(4) Assist in warning communities adjacent to or crossing the state boundaries.

(5) Protect and assure uninterrupted delivery of services, medicines, water, food, energy and fuel, search and rescue, and critical lifeline equipment services, and resources, both human and material.

(6) Inventory and set procedures for the interstate loan and delivery of human and material resources, together with procedures for reimbursement or forgiveness.

(7) Provide, to the extent authorized by law, for temporary suspension of any statutes or ordinances that restrict the implementation of the above responsibilities.

(b) The authorized representative of a party state may request assistance of another party state by contacting the authorized representative of that state. The provisions of this Compact shall only apply to requests for assistance made by and to authorized representatives. Requests may be verbal or in writing. If verbal, the request shall be confirmed in writing within 30 days of the verbal request. Requests shall provide the following information:

(1) A description of the emergency service function for which assistance is needed, including fire services, law enforcement, emergency medical, transportation, communications, public works and engineering, building inspection, planning and information assistance, mass care, resource support, health and medical services, and search and rescue.

(2) The amount and type of personnel, equipment, materials and supplies needed, and a reasonable estimate of the length of time they will be needed.

(3) The specific place and time for staging of the assisting party's response and a point of contact at that location.

(c) There shall be frequent consultation between state officials who have assigned emergency management responsibilities and other appropriate representatives of the party states with affected jurisdictions and the federal government, with free exchange of information, plans, and resource records relating to emergency capabilities. (1997-152, s. 1.)

§ 166A-45. Licenses and permits.

Whenever any person holds a license, certificate, or other permit issued by any party state evidencing the meeting of qualifications for professional, mechanical, or other skills, and when assistance is requested by the receiving party state, the person shall be deemed licensed, certified, or permitted by the state requesting assistance to render aid involving skill to meet a declared emergency or disaster, subject to any limitations and conditions the governor of the requesting state may prescribe by executive order or otherwise. (1997-152, s. 1.)
APPENDIX H

Nurse Practitioner & Clinical Pharmacist Practitioner Approvals Issued
September 2011

List of Initial Applicants

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Clinical Pharmacist Practitioners

Lee, Ruth-Ann Mariko
Putt, Sally Renea
Anesthesiologist Assistant, Perfusionist & Provisional Perfusionist Licenses Issued
September 2011

Perfusionists:
None

Provisional Perfusionists:
None

Anesthesiologist Assistants:
Adams, John Clay
## Initial PA Applicants Licensed 07/01/11 – 08/31/11

### PA-Cs

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# Initial PA Applicants Licensed  07/01/11 – 08/31/11

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## PA-Cs Reactivations/Reinstatements/Re-Entries

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