

MINUTES

North Carolina Medical Board

January 19-21, 2011

**1203 Front Street
Raleigh, North Carolina**

General Session Minutes of the North Carolina Medical Board Meeting held January 19-21, 2011.

The North Carolina Medical Board met January 19-21, 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; Ms. Thelma Lennon; John B. Lewis, Jr., LLB; Peggy R. Robinson, PA-C; Paul S. Camnitz, MD; Karen R. Gerancher, MD and Eleanor E. Greene, MD.

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 November 17, 2010 Board Minutes and the December 17, 2010 Hearing Minutes.

Announcements

1. Dr. Huff presented the following resolution to Representative Bobby Flay England, MD, on behalf of the Board:

Resolution

In Recognition of the Distinguished Service Rendered by
The Honorable Bobby Flay England, M.D.
House of Representatives
North Carolina General Assembly

WHEREAS, The Honorable Bobby Flay England, M.D., of Ellenboro, North Carolina, was born in Spindale, North Carolina, and served his country as a Staff Sergeant in the United States Air Force in the years 1951 through 1955 before graduating from Wofford College and the Medical University of South Carolina; and

WHEREAS, Dr. England began caring for the people of North Carolina as a licensee of this Board and as a family medicine physician in 1963, a practice which he continues to this day. He has further served as a member of the North Carolina Institute of Medicine and on the Rutherford-Polk-McDowell Board of Health; and

WHEREAS, Dr. England served the people of Cleveland and Rutherford Counties as District 112's legislator in the House of Representative of the North Carolina General Assembly for four terms, an office to which he was elected in 2003 and from which he retired in 2010; and

WHEREAS, quality healthcare and patient safety were primary objectives of Dr. England's service in the North Carolina House. He served as Chairman and Vice-Chairman of the House Committee on Health as well as Chairman of the House Appropriations Subcommittee on Health and Human Services. Dr. England was instrumental in adopting numerous improvements to the Medical Practice Act to ensure the North Carolina Medical Board remains a strong and effective guardian of patient safety. Moreover Dr. England provided effective leadership in improving the appointment process for Medical Board members and allowing the public increased access to information concerning physicians and other health care professionals. He also served as an able champion in safeguarding the Medical Board from measures that threatened the Board's ability to protect patients from harm by weakening its investigative and disciplinary processes; and

WHEREAS, Dr. England exemplifies the best aspects of public service and of the medical profession in that he serves the people of North Carolina tirelessly, selflessly and effectively and does so with great joy.

NOW, THEREFORE, BE IT RESOLVED that the North Carolina Medical Board extends its deepest appreciation to Dr. England for his support and publicly recognizes the wisdom, leadership, and dedication he has demonstrated during his years of public service on behalf of citizens, patients, and the medical profession.

BE IT FUTHER RESOLVED that Dr. England be declared an Honorary Member of the North Carolina Medical Board and be presented an official NCMB lapel pin.

BE IT FURTHER RESOLVED that this Resolution be made part of the minutes of the Board and that a formal copy be presented to Dr. England.

Approved by acclamation this the Twenty-first day of January, 2011.

2. Ms. Joy Cooke, Director of Licensing, recognized Ms. Quanta Williams on her 5-year anniversary with the NCMB.

Proposed Rules

The Board considered the following rules which are before the Board for final approval:

Adopt:

- 32A.0114 Suspension of Authority to Expend Funds
- 32B.1370 Reentry of Active Practice
- 32B.1501 Scope of Practice Under Medical School Faculty Limited License
- 32B.1502 Application for Medical School Faculty Limited License

Amend:

- 32B.1301 Definitions
- 32B.1303 Application for Physician License
- 32M.0109 Prescribing Authority

- 32V.0103 Qualifications for License (Perfusionist)
- 32S.0202 Qualifications for Requirements for License (Physician Assistants)
- 32W.0102 Qualifications for License (Anesthesiologist Assistant)
- 32F.0103 Fees
- 32X.0104 Publishing Certain Misdemeanor Convictions

Repeal:

- 32B.0801 Definition of Practice
- 32B.0802 Eligibility Requirements
- 32B.0803 Application
- 32B.0804 Fee
- 32B.0805 Certified Photograph and Certificate of Graduation
- 32B.0806 Verification of Medical Licensure
- 32B.0807 Letters of Recommendation
- 32B.0808 Personal Interview
- 32B.0601 Application and Limitation
- 32B.0602 Certification of Graduation

Board Action: Approve all rules as presented

EXECUTIVE COMMITTEE REPORT

The Executive Committee of the North Carolina Medical Board was called to order at 1:05 pm, Thursday January 20, 2011, at the offices of the Medical 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 November 2010

Mr. Celentano, CPA, presented the November 2010 compiled financial statements. November is the first month of fiscal year 2011.

Committee Recommendation: The Committee recommends accepting the financial statements as reported.

Board Action: The Board accepted the Committee recommendation.

b. Year-end Audit (Boyce, Furr & Company, CPA's)

Ms. Sandy Newell, CPA, an audit partner with the firm Boyce, Furr & Company, CPAs ("Boyce Furr") presented the financial statements for the fiscal year ended October 31, 2010. Ms. Newell explained to the Committee that the statements are presented fairly and in accordance with generally accepted accounting principles. An unqualified opinion has been made on the report. Boyce Furr issued a management letter dated January 20, 2011, in which a recommendation has been made to insure staff makes all adjusting journal entries prior to the audit.

After Dr. Huff excused the staff, Ms. Newell spoke directly to the Committee and indicated there were no concerns that arose while performing the audit.

Committee Recommendation: The Committee recommends adopting the financial statements as presented by Boyce Furr.

Board Action: The Board accepted the Committee recommendation.

c. Investment Summary Review

Mr. Johns Ellington, Sterling Capital Management, gave a presentation to the Board involving proposed changes to our investment portfolio account.

Committee Recommendation: The Committee recommends staff obtain proposals from other investment advisors in order to determine if there are other options available to the Board. The staff will present proposals at the March Executive Committee meeting.

Board Action: The Board accepted the Committee recommendation.

2. Old Business

a. Proposed Changes to Corporation Rules (21 NCAC 32C .0102-.0108 and adoption of Rule 21 NCAC 32C .0109)

Staff presented to the Committee an updated draft of proposed changes to the Board's corporation rules as follows:

21 NCAC 32C .0102 NAME OF PROFESSIONAL CORPORATION

The following requirements must be met regarding the name of a professional corporation to practice medicine:

(1) The name shall not include any adjectives or other words not in accordance with ethical customs of the medical profession.

(2) The professional corporation may not be identical or substantially similar in name to an existing professional corporation.

(23) The professional corporation may not use any name other than its corporate name.

(34) The professional corporation shall specify its corporate structure in the public domain by the use of the designation "P.C." or "P.A."

(45) A shareholder may authorize the retention of his surname in the corporate name after his retirement or inactivity because of age or disability, even though he may have disposed of his stock. The estate of a deceased shareholder may authorize the retention of the deceased shareholder's surname in the corporate name after the shareholder's death.

(56) If a living shareholder in a professional corporation whose surname appears in the corporate name becomes a "disqualified person" as defined in the Professional Corporation Act, the name of the professional corporation shall be promptly changed to eliminate the name of the shareholder, and the shareholder shall promptly dispose of his stock in the corporation.

*History Note: Authority G.S. 55B-5; 55B-7; 55B-12;
Eff. February 1, 1976;
Amended Eff. July 1, 1993; May 1, 1989.*

21 NCAC 32C .0103 PREREQUISITES FOR INCORPORATION

(a) Before filing the articles of incorporation for a professional corporation with the Secretary of State, the incorporators shall file with the ~~Executive Director of the Board~~:

- (1) the properly executed original articles of incorporation;
- (2) ~~an additional executed copy of the articles of incorporation;~~
- (3) ~~a copy of the articles of incorporation;~~
- (4) a registration fee of ~~fifty dollars (\$50.00 set by Rule .008 of this Section in the maximum allowable amount set forth in N.C.G.S. 55B-10;~~
- (5) a signed certificate (N.C.M.B.-P.C. Form 1) certified by all incorporators shareholders, setting forth the names and addresses of each person who will be employed by the corporation to practice medicine for the corporation, and stating that all persons employed by the corporation to practice medicine such persons are duly licensed to practice medicine in North Carolina, and representing that the business of the corporation will be conducted in compliance with the Professional Corporation Act and the rules in this Subchapter;
- (6) a signed certificate (N.C.M.B.-P.C. Form 2) for the Executive Director or the Director of Finance/Operations/Human Resources of the Board to sign certifying that at least one of the incorporators and each of the persons named as original shareholders is licensed to practice medicine in North Carolina. certifying that all shareholders are duly licensed to practice medicine in North Carolina or are otherwise qualified to own shares pursuant to N.C.G.S. 55B-6, 55B-14(c) or 55B-16.

(b) ~~The Executive Director or Director of Finance/Operations/Human Resources Board~~ shall review the articles of incorporation for compliance with the laws relating to professional corporations and with these Rules. If they comply, the ~~Executive Director or Director of Finance/Operations/Human Resources Board~~ shall sign approve N.C.M.B.-P.C. Form 2 and return the original articles of incorporation and the copy to the incorporators for filing with the Secretary of State. The executed copy of the articles of incorporation shall be retained in the office of the Board. If the articles of incorporation are subsequently changed before they are filed with the Secretary of State, they shall be re-submitted to the Board and shall not be filed with the Secretary of State until approved by the Board.

History Note: Authority G.S. 55B-4; 55B-10; 55B-12;

Eff. February 1, 1976;

Amended Eff. September 1, 1995; July 1, 1993; May 1, 1989; November 1, 1985.

21 NCAC 32C .0104 CERTIFICATE OF REGISTRATION

A Certificate of Registration for a professional corporation shall remain effective until December 31 of each ~~odd-numbered~~ year. A Certificate of Registration may be renewed ~~biennially~~ annually thereafter ~~for years in which licensees are required to register~~ upon written application (N.C.M.B.-P.C. Form 4) to the ~~Executive Director Board~~, certifying the names and addresses of all licensed officers, directors, shareholders and employees of the corporation and representing that the corporation has complied with the rules in this Subchapter and the Professional Corporation Act. The application shall be accompanied by a renewal fee of ~~twenty-five dollars (\$25.00) set by Rule .0008 of this Section in~~

the maximum allowable amount set forth in N.C.G.S. 55B-11 established under N.C.G.S. 55B-11.

*History Note: Authority G.S. 55B-10; 55B-11;
Eff. February 1, 1976;
Amended Eff. September 1, 1995; May 1, 1989; November 1, 1985.*

21 NCAC 32C .0105 STOCK AND FINANCIAL MATTERS

The regulation and control of stocks in a professional corporation shall be as follows:

- (1) The chief executive officer of the corporation shall be a person duly licensed to practice medicine in North Carolina.
- (2) The corporation may acquire and hold its own stock.
- (3) No person other than a licensee of the Board shall exercise any authority whatsoever over professional matters.
- (4) Subject to the provisions of G.S. 55B-7, the corporation may make such agreement with its shareholders or its shareholders may make such agreement between themselves as they deem just for the acquisition of the shares of a deceased or retiring shareholder or of a shareholder who becomes disqualified to own shares under the Professional Corporation Act or under these Rules.
- (5) There shall be prominently displayed on the face of all certificates of stock in the corporation a legend that any transfer of the shares of stock is subject to the provisions of the Professional Corporation Act and the Rules of the Board.
- (6) All shareholders must be licensed to practice medicine in North Carolina or must otherwise be qualified to own shares pursuant to N.C.G.S. 55B-6, 55B-14(c) or 55B-16.
- (7) Any interest in the corporation belonging to a deceased shareholder shall be acquired by the corporation, or shall be acquired by one or more persons licensed by the Board. Failure to comply with this requirement within one year after the date of the death of a deceased shareholder shall be grounds for the suspension or revocation of the corporation's certificate of registration. The corporation shall report to the Board within 30 days after its occurrence the death of any shareholder.
- (8) The corporation shall render medical services only by or through individuals licensed by the Board.
- (9) The corporation shall not engage in any business other than rendering professional medical services and related services.

*History Note: Authority G.S. 55B-6 to 55B-8;
Eff. February 1, 1976;
Amended Eff. May 1, 1989; November 1, 1985.*

21 NCAC 32C .0106 CHARTER AMENDMENTS AND STOCK TRANSFERS

The following general provisions shall apply to all professional corporations to practice medicine:

- (1) All changes to the articles of incorporation of the corporation shall be filed with the Board for approval before being filed with the Secretary of State. A copy of the changes filed with the Secretary of State shall be sent to the Board within 10 days after filing with the Secretary of State.

(2) The ~~Executive Director or Director of Finance/Operations/Human Resources Board~~ shall issue the certificate (N.C.M.B.-P.C. Form 5) required by G.S. 55B-6 when stock is transferred in the corporation. N.C.M.B.-P.C. Form 5 shall be permanently retained by the corporation. The stock books of the corporation shall be kept at the principal office of the corporation and shall be subject to inspection by the Executive Director or his designee during business hours.

*History Note: Authority G.S. 55B-6; 55B-12;
Eff. February 1, 1976;
Amended Eff. September 1, 1995; July 1, 1993; May 1, 1989.*

21 NCAC 32C .0107 DOCUMENTS

The following documents regarding professional corporations may be obtained from or are issued by the Board:

- (1) Rules of the Board regarding Professional Corporations;
- (2) N.C.M.B.-P.C. Form 1 - Application for a Certificate of Registration for a Professional Corporation for the Practice of Medicine;
- (3) N.C.M.B.-P.C. Form 2 - Certification of Shareholders;
- (4) N.C.M.B.-P.C. Form 3 - Certificate of Registration of a Professional Corporation for the Practice of Medicine;
- (5) N.C.M.B.-P.C. Form 4 - Application for ~~Biennial~~ Renewal of Certificate of Registration;
- (6) N.C.M.B.-P.C. Form 5 - Certificate Authorizing Transfer of Stock in Professional Corporation Organized to Practice Medicine.

*History Note: Authority G.S. 150B-11;
Eff. February 1, 1976;
Amended Eff. May 1, 1989.*

21 NCAC 32C .0108 FEES

~~The initial registration fee for a professional corporation is fifty dollars (\$50.00). The fee for renewal of a Certificate of Registration is twenty five dollars (\$25.00). The initial registration fee for a professional corporation and the renewal fee for renewal of a Certificate of Registration shall be the maximum allowable amount under N.C.G.S. 55B-10 and 55B-11.~~

*History Note: Authority G.S. 55B-10; 55B-11;
Eff. February 1, 1976;
Amended Eff. May 1, 1989.*

New 21 NCAC 32C .0109 Registration of Foreign Professional Corporation

In addition to the foregoing, foreign professional corporations applying for registration—a Certificate of Authority to Transact Business must meet the following requirements:

- (1) provide proof that shareholders licensed in other states are currently licensed and in good standing with their respective licensing boards;
- (2) at least one shareholder must be currently licensed and in good standing with the Board;

(3) no person other than a licensee of the Board shall exercise any authority whatsoever over professional matters within the State.

*History Note: Authority G.S. 55B-16
Eff.*

Committee Recommendation: The Committee recommends staff file the proposed changes of Rule 21 NCAC 32C .0102-.0108 and adoption of Rule 21 NCAC 32C.0109 with the Rules Review Commission.

Board Action: The Board accepted the Committee recommendation.

b. Proposed Adoption to CME Rule (21 NCAC 32R .0106)

The Committee discussed adoption of CME Rule 21 NCAC 32R .0106 that would exempt NCMB licensees who are members of the NC General Assembly.

21 NCAC 32R .0106 WAIVER FOR LICENSEES SERVING AS MEMBERS OF
THE GENERAL ASSEMBLY

The Board shall waive the continuing education requirements set forth in Rule .0101 of this Section for an individual who is:

- (1) currently licensed by and in good standing with the Board;
- (2) serving as a member of the General Assembly; and
- (3) is engaged in activities as a member of the General Assembly requiring the study and analysis of issues related to the practice of medicine in North Carolina.

History Note: Authority; G.S.90-5.1, G.S. 90-14(a)(15)

Committee Recommendation: The Committee recommends staff file the proposed new Rule 21 NCAC 32R .0106 with the Rules Review Commission.

Board Action: The Board accepted the Committee recommendation.

c. Proposed Disciplinary Rules

Mr. Thomas Mansfield discussed with the Committee a draft of the disciplinary rules.

Committee Recommendation: The Committee recommends Mr. Mansfield share this draft with Rules Review Commission staff and continue to solicit feedback from other stakeholders and report back to the Committee in March.

Board Action: The Board accepted the Committee recommendation.

d. Legislative Update

Mr. Mansfield discussed with the Committee potential legislative agenda items.

Committee Recommendation: The Committee recommends Mr. Mansfield continue to update the Committee regarding legislative matters.

Board Action: The Board accepted the Committee recommendation.

3. New Business

a. Letter from the American Academy of Dermatology Association

The Committee discussed a letter from the American Academy of Dermatology Association which expresses concerns that some dermatology practices are permitting medical assistants to perform complex surgical procedures that could jeopardize patient safety.

Committee Recommendation: The Committee recommends staff advise the Association that the Board will investigate any cases regarding specific physicians brought to its attention.

Board Action: The Board accepted the Committee recommendation.

b. Electronic Death Registration

The Board continues to receive complaints regarding the delay in physicians completing death certificates. One impediment is the current system of paper death certificates. Most states have adopted an electronic system for completing and filing death certificates.

Committee Recommendation: The Committee recommends staff determine the status of electronic death registration in North Carolina and report back to the Committee in March.

Board Action: The Board accepted the Committee recommendation.

c. Electrolysis Board Nomination

Dr. Gary Slaughter, a dermatologist from Charlotte, recently resigned from the NC Board of Electrolysis Examiners. The North Carolina Dermatology Association recommends Dr. Girish Munavalli, a dermatologist from Charlotte, for this position.

Committee Recommendation: The Committee recommends staff prepare a letter on behalf of the Board nominating Dr. Girish Munavalli to the NC Board of Electrolysis Examiners.

Board Action: The Board accepted the Committee recommendation.

POLICY COMMITTEE REPORT

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

Staff: Todd Brosius, Christina Apperson, Nancy Hemphill and Wanda Long

1. Old Business

a. Position Statement Review

i. – Office Based Procedures (Attachment “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.

9/2010 Committee Recommendation: Table this issue to allow comments from the full Board to be received. All comments will be considered at the November Committee meeting.

9/2010 Board Action: Adopt the Committee recommendation

11/2010 Committee Recommendation: Table this issue. Request input from standard distribution list, as well as, plastic surgeon speciality, dermatology speciality, OBGYN speciality, GI speciality, and insurance companies.

11/2010 Board Action: Adopt Committee recommendation.

1/2011 Committee Discussion: The Committee discussed comments received from various parties. The Committee agreed that the position statement is lengthy, but included important and useful information. The Committee instructed the staff to inquire about the inclusion of language addressing “expenses of accreditation.” The Committee also suggested that language may be added to better explain what the Board views as “reasonable proximity.”

1/2011 Committee Recommendation: Table issue until the March 2011 meeting. Legal will wordsmith the position statement to incorporate suggested changes and attempt to reorganize the position statement to make it more accessible.

1/2011 Board Action: Adopt Committee recommendation.

1. Old Business

a. Position Statement Review continued

ii. Medical, Nursing, Pharmacy Boards: Joint Statement on Pain Management in End-of-Life Care (Attachment “B”)

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.

5/2010 Committee Discussion: The Committee discussed whether changes should be made to specify that the position statement applies to other licensees as well. It was

suggested that, since the position statement was initially propounded as a joint statement, it might be helpful to discuss this matter with the other licensing boards.

5/2010 Committee Recommendation: Mr. Brosius to contact the Pharmacy Board and the Nursing Board to determine if they object to the proposed changes and if they will join in those changes.

5/2010 Board Action: Adopt the Committee recommendation.

7/2010 Committee Recommendation: Mr. Brosius to contact the Pharmacy Board and the Nursing Board to determine if they object to the proposed changes and if they will join in those changes.

7/2010 Board Action: Adopt Committee recommendation.

9/2010 Committee Discussion: The Committee will wait for a response from the Pharmacy Board and Nursing Board.

9/2010 Committee Recommendation: No action is necessary.

9/2010 Board Action: Adopt the Committee recommendation.

11/2010 Committee Discussion: Information has been received from the Pharmacy Board.

11/2010 Committee Recommendation: Table issue until the Board receives a response from the Nursing Board.

11/2010 Board Action: Adopt the Committee recommendation.

1/2011 Committee Discussion: The Committee reviewed its previous decision to make all position statements consistent by substituting "physician" with "licensee" when appropriate. The Committee agreed to move forward with these changes.

1/2011 Committee Recommendation: Substitute "physician" with "licensee" to be consistent with previous changes made to Position Statements. No further changes are recommended. Provide amended position statement to the Nursing Board indicating changes.

1/2011 Board Action: Adopt Committee recommendation.

2. New Business:

a. Position Statement Review (Attachment "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.

i. HIV/HBV Infected Health Care Workers (Attachment “D”)

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.

1/2011 Committee Discussion: The Committee reviewed the position statement and deemed it appropriate as currently written.

1/2011 Committee Recommendation: Deem Position Statement appropriate. No changes are suggested.

1/2011 Board Action: Adopt Committee Recommendation.

ii. Writing of Prescriptions (Attachment “E”)

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.

1/2011 Committee Discussion: The Committee discussed the current position statement. It was pointed out that many practitioners currently do not spell out the quantity but simply write the numerical amount on prescriptions. Additionally, many practices and hospitals have computer systems that only use the numerical amount. The Committee considered whether the sentence in question was useful, and decided to bring it to the full Board for discussion.

1/2011 Committee Recommendation: Present for full Board discussion for consideration regarding changing: “Quantities should be indicated in both numbers AND words, e.g., 30 (thirty).”

1/2011 Board Action: Table issue for Committee to do further research.

b. Practice Drift Committee

1/2011 Committee Discussion: Nancy Hemphill reviewed the executive summary (Attachment “F”) of the Special Committee on Practice Drift with the Policy Committee. The Committee discussed the struggle of holding licensees accountable and also allowing for professional growth. The Committee also discussed the need for access to care. The Committee agreed that licensees should be held to the prevailing standards of practice relevant to the area of specialty or modality in which they are practicing regardless of the area in which they received their formal training.

1/2011 Committee Recommendation: Adopt proposed Position Statement. (Attachment “G”)

1/2011 Board Action: Table issue until it can be determined if the final version of the proposed Position Statement was reviewed by the Special Committee prior to being

presented to the Board. The Board would like the Policy Committee to consider editing the last sentence of the third paragraph of the proposed position statement.

CONTINUED COMPETENCE COMMITTEE REPORT

The Continued Competence Committee of the North Carolina Medical Board was called to order at 2:30pm January 20, 2011, at the office of the Medical Board. Members present were: Paul S. Camnitz, MD, Chair; Peggy R. Robinson, PA-C; John B. Lewis and Eleanor E. Greene, MD. Also present were: Karen R. Gerancher, MD; Michel Sheppa, MD; Janelle Rhyne, MD; John Mangum, MD; Nancy Hemphill and Maureen Bedell.

1. Old Business

- a. There is no old business to discuss.

2. New Business

- a. Dr. Rhyne gave the Committee an update/overview on the FSMB Maintenance of Licensure initiative.
- b. Dr. Sheppa gave a brief summary regarding the 2010 Institute of Medicine report on "Redesigning Continuing Education in the Health Professions".
- c. Dr. Sheppa presented and asked the Committee for approval to use the SPEX exam as another tool in the NCMB re-entry plan.

Committee Recommendation: To accept Dr. Sheppa's request.

Board Action: Declined the recommendation and sent it back to the Committee for further refining. Refinements were to address concerns that the SPEX exam might not be appropriate for applicants who had recently obtained ABMS certification, and that requiring a passing score on all sections of the SPEX exam might inappropriately subject applicants to unnecessary further assessments.

LICENSING COMMITTEE REPORT

The Licensing Committee of the North Carolina Medical Board was called to order at 12:30 p.m., January 19, 2011, at the office of the Medical Board. Members present were: Thomas Hill, MD, Chair, Donald Jablonski, DO, Karen Gerancher, MD, and Mr. John Lewis. Also present was: Janice Huff, MD, Scott Kirby, MD, Thom Mansfield, Patrick Balestrieri, Carren Mackiewicz, Joy Cooke, Michelle Allen, and Kim Chapin

Open Session

Old Business

1. Pre-populating the application form

Issue: There was discussion during the September Board meeting about new applications being “pre-populated” with information from old applications with regard to misdemeanors, felonies, malpractice, privileges and regulatory Board actions. This affects licensees who have previously been licensed by NCMB; applicants who applied in the past and were denied, expired or withdrew. The general consensus of staff was to not pre-populate this information. However, because the data for LI (License Information) page, applications and renewals is stored in one place a majority of the information is pre-populated. The instructions for these pages are currently being reviewed for necessary modification. Also, pre-populating this information has been one of the things applicants have requested through our survey.

Committee Recommendation: Have staff provide an update at the January meeting regarding the status of changing the instructions.

Board Action: Have staff provide an update at the January meeting regarding the status of changing the instructions.

1/2011 Update: Staff meeting has been scheduled to update instructions. Update will be provided at Licensing Committee meeting.

Committee Recommendation: Task to Hari to implement. Provide updated information to licensing committee at May meeting.

2. Medical School Faculty Limited License (MSFL)

Issue: Physicians holding a current medical school faculty license of more than one year duration (109 physicians of a total 133 MSFL holders) were sent the following letter: The purpose of this letter is to request information regarding your North Carolina medical license. Our records indicate you currently hold a Medical School Faculty License (MSFL). North Carolina Administrative Code (21 NCAC 32B .0801 & .0802) requires that physicians with a MSFL have a full time appointment as either a lecturer, assistant professor, associate professor, or full professor at one of the following medical schools:

- Duke University School of Medicine
- University of North Carolina at Chapel Hill School of Medicine
- Bowman Gray School of Medicine
- East Carolina University School of Medicine

The MSFL also limits the physician’s practice to the confines of their employment as a member of the medical faculty. This license may not be used to engage in a practice outside the realm of a medical school. Based on the criteria noted above please provide the Board:

- a. A letter or other document confirming you have an existing full-time faculty appointment to one of the medical schools listed and are limiting your practice as required.
- b. Verification and details of the appointment signed by the Dean or Acting Dean of the Medical School at which you currently practice. If you are unable to provide confirmation of your current eligibility for a MSFL you are requested to make your license inactive (form enclosed). You may apply for a full and unrestricted license if you are eligible (requirements available on the Board's website at: www.ncmedboard.org/licensing).

Please respond to this letter by July 15, 2010. If you believe you have received this letter in error, or if you have any questions on this matter, please feel free to call or email me. Thank you in advance for your cooperation.

Physicians with a MSFL of less than one year duration, and who had thus just recently provided documentation of eligibility for the MSFL were not included in mailing list. I did not determine the order of medical school listing. It is copied directly from NCAC.

Responses have been received, one way or another, several only after multiple requests, from 108 physicians.

83 physicians confirmed their current eligibility for continued MSFL

- Duke University School of Medicine – 39
- University of North Carolina at Chapel Hill School of Medicine - 25
- Bowman Gray School of Medicine – 14
- East Carolina University School of Medicine – 5

25 physicians requested inactive status. Physicians who requested information about later re-activation or application for a full and unrestricted license were advised that both processes would require completion of an essentially new application. 1 physician did not respond and could not be located. Duke University confirmed this physician was no longer at Duke (gastroenterology) and did not have a faculty appointment. Graph represents total number of current MSFL holders at each medical school. Total adds to more than 109 because this is all MSFL, including those not sent letters requesting confirmation of status (those with MSFL of less than 1 year).

Miscellaneous Observations:

Mean age of physicians with MSFL – 45 years old (Range 30 – 71 years old).

Mean years since initial MSFL issue date – 5 years (range 1 – 14 years).

Department with largest number of MSFL – Duke Anesthesiology – 19 physicians

Number of MSFL physicians graduated from US medical schools – 21 physicians.

Committee Recommendation:

- a. All applications for MSFL should be screened to determine if applicant is eligible for full and unrestricted license (FUL). Physicians eligible for FUL should not be allowed to apply for MSFL.
- b. The following statement should be added to MSFL yearly renewal: "I certify that I remain eligible for continued medical school faculty limited licensure, that I have a full time faculty appointment at a North Carolina medical school, and that I am limiting my practice to the confines of my employment as a member of the medical school faculty".

Board Action:

a. All applications for MSFL should be screened to determine if applicant is eligible for full and unrestricted license (FUL). Physicians eligible for FUL should not be allowed to apply for MSFL.

b. The following statement should be added to MSFL yearly renewal: "I certify that I remain eligible for continued medical school faculty limited licensure, that I have a full time faculty appointment at a North Carolina medical school, and that I am limiting my practice to the confines of my employment as a member of the medical school faculty".

Tasked to Operations 1/5/2011

3. It is suggested that the following rule be amended as indicated in (b)(9)

21 NCAC 32B .1350 REINSTATEMENT OF PHYSICIAN LICENSE

(a) Reinstatement is for a physician who has held a North Carolina License, but whose license either has been inactive for more than one year, or whose license became inactive as a result of disciplinary action (revocation or suspension) taken by the Board. It also applies to a physician who has surrendered a license prior to charges being filed by the Board.

(b) All applicants for reinstatement shall:

- (1) submit a completed application, attesting under oath that information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
- (2) submit documentation of a legal name change, if applicable;
- (3) supply a certified copy of applicant's birth certificate if the applicant was born in the United States or a certified copy of a valid and unexpired US passport. If the applicant does not possess proof of U.S. citizenship, the applicant must provide information about applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;
- (4) If a graduate of a medical school other than those approved by LCME, AOA, COCA or CACMS, shall furnish an original ECFMG certification status report of a currently valid certification of the ECFMG. The ECFMG certification status report requirement shall be waived if:
 - (A) the applicant has passed the ECFMG examination and successfully completed an approved Fifth Pathway program (original ECFMG score transcript from the ECFMG required); or
 - (B) the applicant has been licensed in another state on the basis of a written examination before the establishment of the ECFMG in 1958;
- (5) submit reports from all state medical or osteopathic boards from which the applicant has ever held a medical or osteopathic license, indicating the status of the applicant's license and whether or not any action has been taken against the license;
- (6) submit the AMA Physician Profile; and, if applicant is an osteopathic physician, also submit the AOA Physician Profile;
- (7) submit a NPDB/HIPDB report dated within 60 days of the application's submission;
- (8) submit a FSMB Board Action Data Bank report;
- (9) submit documentation of CME obtained in the last three years, upon request;

- (10) submit two completed fingerprint cards supplied by the Board;
 - (11) submit a signed consent form allowing a search of local, state, and national files to disclose any criminal record;
 - (12) provide two original references from persons with no family or material relationship to the applicant. These references must be:
 - (A) from physicians who have observed the applicant's work in a clinical environment within the past three years;
 - (B) on forms supplied by the Board;
 - (C) dated within six months of submission of the application; and
 - (D) bearing the original signature of the author.
 - (13) pay to the Board a non-refundable fee pursuant to G.S. 90-13.1(a), plus the cost of a criminal background check;
 - (14) upon request, supply any additional information the Board deems necessary to evaluate the applicant's qualifications.
- (c) In addition to the requirements of Paragraph (b) of this Rule, the applicant shall submit proof that the applicant has:
- (1) within the past 10 years taken and passed either:
 - (A) an exam listed in G.S. 90-10.1 (a state board licensing examination; NBME; NBOME; USMLE; FLEX; COMLEX; or MCCQE or their successors);
 - (B) SPEX (with a score of 75 or higher); or
 - (C) COMVEX (with a score of 75 or higher); or
 - (2) within the past ten years obtained certification or recertification of CAQ by a speciality board recognized by the ABMS, CCFP, FRCP, FRCS or AOA; or
 - (3) within the past 10 years completed GME approved by ACGME, CFPC, RCPSC or AOA; or
 - (4) within the past three years completed CME as required by 21 NCAC 32R .0101(a), .0101(b), and .0102.
- (d) All reports must be submitted directly to the Board from the primary source, when possible.
- (e) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.
- (f) An application must be complete within one year of submission. If not, the applicant shall be charged another application fee, plus the cost of another criminal background check.

Committee Recommendation: Accept proposed change to 21 NCAC 32B .1350 by adding "upon request" in (b)(9).

Board Action: Accept proposed change to 21 NCAC 32B .1350 by adding "upon request" in (b)(9).

Amend 21 NCAC 32B .1350 (b)(9) as follows: submit documentation of CME obtained in the last three years, upon request;

Amend 21 NCAC 32B .1350 (c) as follows:

In addition to the requirements of Paragraph (b) of this Rule, the applicant shall submit proof ~~that the applicant has~~ of one of the following:

Notify Rules Review that the word "specialty" in (c) (2) is misspelled.

(2) within the past ten years obtained certification or recertification of CAQ by a ~~specialty~~ specialty board recognized by the ABMS, CCFP, FRCP, FRCS or AOA; or

1/2011 Update: Tasked to Legal 1/5/2011

4. Requiring examinations for a resident training license

Issue: During the Fall RTL debriefing session with DIOs and House Staff representatives there was a discussion regarding the NCMB requiring physicians to pass USMLE Steps 1 & 2 or COMLEX 1 & 2 to be eligible for a training license and whether any GME office would object to this. David advised GME offices to check around and let the Board know if there would be any issues with their institutions if the NCMB required this. Dr. Gerancher suggested that before the NCMB implements this rule the Dean of Students at the medical schools be notified. Dr. Baker (CMC) suggested that plenty of notice be given to the GME offices and the physicians applying for a training license. David advised since there was no rush to implement this rule, the Board would try to make this effective 1/1/2012.

Committee Recommendation: Implement a rule requiring USMLE 1&2 (CK and CS) or COMLEX 1&2 (CK and CS) for a resident training license.

Board Action: Implement a rule requiring passage of USMLE 1&2 (CK and CS) or COMLEX 1&2 (CK and CS) for a resident training license.

1/2011 Update: Rule has been drafted and will be presented for approval to Rules Review with ample advance notice to interested parties for a 2012 effective date.

New Business

1. Privileges Suspended Section of License Applications

Issue: Recently the Board reviewed a physician license application in which the physician had been fired by her group practice for cause and then “voluntarily resigned” from the hospital staff before any action was taken by the hospital (related to the same incident which caused the physician to be fired from her group practice). This physician did not list any “Privileges suspended”; essentially answering the question “No”. The Board has previously determined, for the purposes of this question, that a group practice or employer should properly be considered a “health care institution”. It is an organization that does “issue credentials” to physicians. Nevertheless, in order to clarify the intent of the *Privileges Suspended* question Dr. Kirby proposes the definitions of “Actions” and “Health Care Institutions” be amended to include specific reference to physician group practices or employers.

Privileges Suspended/Authority to Practice Interrupted

Have you ever had an action taken against you by a health care institution, including employers or group practices? If so, list each occurrence.

Actions include warnings, censures, discipline, admissions monitored, privileges limited, ~~privileges~~ privileges suspended, or revoked; remediation, probation, withdrawals/resignations of privileges, suspension or termination of employment or a resignation under threat of investigation or disciplinary action or denial of staff membership.

Health care institutions include hospitals, health maintenance organizations, ~~or~~ preferred provider organizations, any facility in which you trained, any group practice, or any other ~~provider~~ organizations that issue credentials to physicians.

Committee Recommendation: Change question to read:

Privileges/Authority to Practice

Have you ever had an action taken against you by a health care institution, including employers or group practices? If so, list each occurrence.

Actions include:

- Warnings
- Censures
- Discipline
- Admissions monitored
- Privileges limited, suspended or revoked;
- Remediation
- Probation
- Withdrawals/resignations of privileges,
- Suspension or termination of employment or a resignation under threat of investigation or disciplinary action or denial of staff membership

Health care institutions include:

- Hospitals
- Health maintenance or preferred provider organizations
- Any facility in which you trained
- Any group practice
- Any other organization that issues credentials to physicians.

Board Action: Change the Privileges Section to read as outlined above.

2. 21 NCAC 32B.1303(a)(14) & (15)

Issue: It has been noted that we have a latent ambiguity in our physician licensing rules on the 3-tries-per step (or level) and get a 75 issue. It is recommended that the rule be cleaned up to make it stronger and clearer, although no different in application.

Committee Recommendation: Amend the rule as outlined below.

21 NCAC 32B .1303 APPLICATION FOR PHYSICIAN LICENSE

(a) In order to obtain a Physician License, an applicant shall:

- (14) if applying on the basis of the USMLE, submit:
 - ~~(A) a transcript from the FSMB showing a score of at least 75 on USMLE Step 1, both portions of Step 2 (clinical knowledge and clinical skills) and Step 3;~~
 - (A) a transcript from the FSMB showing a two-digit score of at least 75 on USMLE Step 1, Step 2 clinical knowledge examination, and Step 3, as well as passage of the Step 2 clinical skills assessment;
 - (B) proof that the applicant has passed each step within three attempts. However, the Board shall waive this requirement if the applicant has been certified or recertified by an ABMS, CCFP, FRCP, FRCS or AOA approved specialty board within the past 10 years.
- (15) if applying on the basis of COMLEX, submit:
 - ~~(A) a transcript from the NBOME showing a score of at least 75 on COMLEX;~~
 - (A) a transcript from the NBOME showing a two-digit score of at least 75 on COMLEX Level 1, Level 2 cognitive evaluation and Level 3, as well as proof of passage of the Level 2 performance evaluation;
 - (B) proof that the applicant has passed COMLEX within three attempts. However, the Board shall waive this requirement if the applicant has been certified or recertified by an ABMS, CCFP, FRCP, FRCS or AOA approved specialty board within the past 10 years.

History note: Authority G.S. 90-8.1; 90-9.1; 90-9.2; 90-13.1; Eff. August 1, 2010.

Board Action: Amend 21 NCAC 32B.1303 (a)(14) (A) and (15) (A) as follows:

(a) In order to obtain a Physician License, an applicant shall:

- (14) if applying on the basis of the USMLE, submit:
 - (A) a transcript from the FSMB showing a passing score ~~of at least 75~~ on USMLE Step 1, both portions of Step 2 (clinical knowledge and clinical skills) and Step 3;
- (15) if applying on the basis of COMLEX, submit:
 - (A) a transcript from the NBOME showing a passing score ~~of at least 75~~ on COMLEX Level 1, both portions of Level 2 (cognitive evaluation and performance evaluation) and Level 3;

3. Guidelines for Reporting Withdrawal and Denial of Applications to NPDB, HIPDB and FSMB

Issue: There has been discussion regarding exactly what license application “withdrawals and denials” should be reported to FSMB, NPDB and HIPDB. We have contacted all three entities and recently received guidance and direction regarding the reporting issues. See bookmarked copy of Mr. Balestrieri’s January 4, 2011 memorandum outlining the reporting guidelines.

Committee Recommendation: Continue discussion at May meeting. Patrick to provide update.

Board Action: continue discussion at May meeting. Patrick to provide update.

4. Letters of Advice

Issue: Senior Staff Review Committee request that a letter of advice be sent to applicants who are applying to NC for their initial full license in any jurisdiction and have less than 2 years PGT. The letter will provide advice regarding appropriately limiting the applicant's scope and practice in accordance with their training and expertise.

Committee Recommendation: Letters of advice to be done on a case by case basis.

Board Action: Letters of advice to be done on a case by case basis.

5. Medical School Faculty License

Issue: There has been discussion about whether it is appropriate to have a time limitation on Medical School Faculty Licenses. The proposed rule implements an expiration date after three years. Dr. Kirby will address this issue and whether the three year expiration date is appropriate.

Proposed Rules:

21 NCAC 32 BB.0800 SCOPE OF PRACTICE UNDER MEDICAL SCHOOL FACULTY LIMITED LICENSE

A physician holding a Medical School Faculty Limited License may practice only within the confines of the medical school or its affiliates. "Affiliates" shall mean the primary medical school hospital(s) and clinic(s), as designated by the ACGME.

History Note: G.S. 90-12.3

21 NCAC 32BB .0801 APPLICATION FOR MEDICAL SCHOOL FACULTY LIMITED LICENSE

The Medical School Faculty License is limited to physicians who have expertise which can be used to help educate North Carolina medical students, post-graduate residents and fellows but who do not meet the requirements for Physician licensure.

(A) In order to obtain a Medical School Faculty License, an applicant shall:

1. submit a completed application, attesting under oath that the information on the application is true and complete, and authorizing the release to the Board of all information pertaining to the application;
2. submit the Board's form, signed by the Dean or his appointed representative, indicating that the applicant has received full-time appointment as either a lecturer, assistant professor, associate professor, or full professor at a medical school in the state of North Carolina.
3. submit documentation of a legal name change, if applicable;
4. submit a recent photograph, at least two inches by two inches, affixed to the oath, and attested by a notary public;
5. submit proof on the Board's Medical Education Certification form that the applicant has completed at least 130 weeks of medical education. The applicant's date of graduation from medical school shall be written in the designated space, and the school seal shall be stamped on the form; the dean or other official of the applicant's medical school shall sign this form, verifying the information;

6. supply a certified copy of applicant's birth certificate or a certified copy of a valid and unexpired US passport if the applicant was born in the United States. If the applicant does not possess proof of US citizenship, the applicant must provide information about the applicant's immigration and work status which the Board will use to verify applicant's ability to work lawfully in the United States;

7. submit proof of satisfactory completion of at least one year of GME approved by ACGME, CFPC, RCPSC, or AOA; or evidence of other education, training or experience, determined by the Board to be equivalent;

8. submit reports from all medical or osteopathic boards from which the applicant has ever held a medical or osteopathic license, indicating the status of the applicant's license and whether or not any action has been taken against the license;

9. submit an AMA Physician Profile; and, if applicant is an osteopathic physician, submit an AOA Physician Profile;

10. submit a NPDB report, HIPDB report, dated within 60 days of applicant's oath;

11. submit a FSMB Board Action Data Bank report;

12. submit two completed fingerprint record cards supplied by the Board;

13. submit a signed consent form allowing a search of local, state, and national files to disclose any criminal record;

14. provide two original references from persons with no family or marital relationship to the applicant. These letters must be:

(a) from physicians who have observed the applicant's work in a clinical environment within the past three years;

(b) on forms supplied by the Board;

(c) dated within six months of the applicant's oath; and

(d) bearing the original signature of the writer.

15. pay to the Board a non-refundable fee of \$350.00, plus the cost of a criminal background check;

16. upon request, supply any additional information the Board deems necessary to evaluate the applicant's competence and character.

(B) All reports must be submitted directly to the Board from the primary source, when possible.

(C) An applicant may be required to appear in person for an interview with the Board or its agent to evaluate the applicant's competence and character.

(D) An application must be completed within one year of the date of the applicant's oath.

(E) This license is valid for the shorter of three years or the duration of the holder's appointment to the academic staff of the school.

(F) This rule shall apply prospectively.

History Note: G.S 90-12.3; 90-13.2

Committee Recommendation: Remove the 3 year time limit.

Board Action: Remove the 3 year time limit.

6. Fines

Issue: There has been some discussion regarding implementation of fines. Additional information will be forthcoming following 1/13/11 conference call.

Committee Recommendation: Staff will be coming forward with a recommendation to deal with administrative fines that will not be posted on the licensee information page as opposed to fines associated with public disciplinary actions which will be posted on the licensee information page permanently.

Board Action: Table until March or May Board meeting.

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.

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

A motion passed to return to open session.

PHYSICIANS PRESENTED AT THE JANUARY 2011 BOARD MEETING

Abdul, Makunda	Brown, Doris Renee
Adams, Van Lee	Bryant, Craig
Afsharchi, Foroozan	Cammarata, Michael Wesley
Amrhein, Timothy James	Chapman, David Brandon
Anand, Amritpal Singh	Chastain, Cody Allan
Anderson, Rahel	Chhetri, Bhaskar Kunwar
Babiss, Paula Towne	Chism, David Dewayne
Bailen, Erica Lane	Chow, Lillian Chu
Bajillan, Hendren Akram	Claus, Steven Duane
Balouch, Jamal Abdul Yasser	Cline, Matthew Todd
Banks, Gretchen	Cooper, James Anthony
Barbour, Sarah Ray	Croitoru, Claudia Mirela
Bartels, Karsten	Croitoru, Mihai
Beck, Aaron John	Crozier, Joseph Charles
Benitez Concepcion, Lourdes Teresa	Dalieh, Sadi Daoud
Bennett, Jennifer Millicent	Dalton-Etheridge, Yvonne Christine
Benson, Jessica Dawn	Daniels, Mary Leigh Anne
Bhattacharjee, Pradip	Davit, Rajesh Kumar
Bhatti, Sokun Ky	Del Grosso, Edward Anthony
Bomeli, Steven Richard	Demirci, Sukru Serdar
Bone, Leslie Ann	Demorest, Rebecca Anne
Bream, John David	DePeralta, Edgar Tugaoen
Bronitsky, Carl	Dibas, Basema Ismail

Doskey, Richard Michael
Downing, Brian Elliott
Dusabe-Ziherambere, Liliane
Ergas, Heath Brian
Ezeihuaku, Christopher Chukwuemeka
Farooq, Umar
Flack, Jessica Lynn
Floyd, Virginia Taylor
Freccia, Colin David
French, Kevin Michael
Fylstra, Leigh Rachele
Galey, Timothy Michael
Garland, Jeffrey Scott
Gault, Irina Ellen
Gaznabi, Ak M
Gershenbaum, Bart Keith
Gordon, Charles Alan
Griffin, Richard Madison
Gurpinar, Ediz Ibrahim
Gwynn, Matthews Weber
Harley, Garth Howland
Harpole, Joseph Hunter
Harris, Brenda Fagan
Harrison, Jeremy Don
Hart, Lora Lee
Heacock, Timothy Ryan
Helman, Joshua Bennett
Hicks, Jacqueline Michele
Hill, Keith Daniel
Horst, James
Hossain, Sayeed
Howell, Gregory Allen
Howell, Robert Spencer
James, Kimone Monet
Janjua, Rashid Mazhar
Josiah-Howze, Dara Anita
Kapuram, Miranda
Kearns, Stephen Cameron
Kenyherz, Gregory Edward
Kiely, James Matthew
Kim, Betty Shin Wun
Kulbersh, Jonathan Sol
Lake, Leena Kulkarni

Lambert, Christopher Thomas
Lari, Steven Jud
Lazarus, John Michael
Linnan, Brigid Mary
Lohrbach, Bonnie Lyn
Lohri, Joshua Mark
Lois, John Peter
Lutterman, Joel
Lwin, Phyu Thwe
Macron, Donald Scott
Manzanero, Philip Laurence
Maples, William James
Marin, Daniele
Mark, Ron Yaacov
Martel, Thomas
Martin, Jeremiah Thomas
Mathew, Rajesh
Mazzarulli, Anthony Andrew
McCulloch, Scott Vandervort
McCutcheon, Monica Smoak
McGill, Dennis L
Miller, Leona Arica
Mitchell, Michael Scott
Montgomery, Sean Paul
Moran, Timothy Paul
Morgan, Christopher Ashley
Morsek, John Robert
Mudipalli, Vasudeva Ranjit Soundararaja
Murphy, Lindsey Thomas
Neiner, James Richard
Nevin, Daniel Thomas
Northam, Meredith Cates
O'Connor, Rory Vincent
Odulana, Adebowale Ayoola
Ortiz, Veronica
Padula, Anthony
Pandya, Sunil Ramesh
Papadonikolakis, Anastasios
Passaretti, Catherine Louise
Paszek, Matthew Robert
Patalay, Madhu Kumar
Patino, Willmar Davison
Perez, Jose Eduardo

Peters, Shirin Sabina
Phillips, Earl Lynn
Plonk, Drew Patterson
Plummer, Stephanie Jean
Poetter, Vivian Ruth
Pope, Brian Owen
Pyle, Jeremy William
Racharla, Sushma
Ramnath, Ravi Richard
Rashidzada, Wahid
Rau, James Gerard
Raustol, Ole Anton
Ray, Christi Renee
Rees, Stephen Gregory
Richey, Luther Merritt
Richter, James Thomas
Ritchey, Christopher Paul
Roberts, Jared Tyler
Royster, Robert Allyn
Ryan, Patrick Keith
Sandler, Aaron James
Schmitt, Richard Alan
Schwertschlag, Ullrich Steven
Sedwick, Joseph Lee
Seh Achu, Edwin
Seiders, Christopher David
Seikel, Stacy Elizabeth
Sharon, Elliott Arnold
Shaw, Eva Nicolene Proescholdt
Shea, Christa
Shim, Inbo
Shutter, Jamie David
Singh, Poonam
Sisneros, Silver Cree
Smith, Stephen Brooks
Starr, Shane Randal
Strasser, Nicholas Lee
Sweezer, William Penn
Tamar, Kyron Collin
Tang, Christopher Ming Tai
Tasa, Laura Ann
Tennant, Joshua Neal
Toma, Sabah Salman

Torres, Jomari Sheila
Tran, Boi Phuong
Trivette, Evan Thomas
Ulzen, Thaddeus Patrick Manus
Van Scriver, Kimberly Pauline
Varley, Rebecca Jane
Varrell, James Ronald
Vining, Suzanne Strandhoy
Vohra, Ameet
Waintrub, Mauricio Luder
Wallace, Monica Lauren
Ward, Kendria Valencia
WeirCox, Kaylene Daryl
White, Nzingha Jaunita
Wilds, Caroline Lee
Williams, Daniel Mark
Williams, Eric Rashad
Winecoff, William Franklin
Wong, Matthew Harry
Yoder, Grant Leo

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.

Nurse Practitioner & Clinical Pharmacist Practitioner Approvals

Issued as of the Last Board Meeting

Peggy Robinson, PA-C, Chair; William Walker, MD; and Pamela Blizzard

List of Initial Applicants

	NAME	PRIMARY SUPERVISOR	PRACTICE CITY
NP	AROCENA, MARIETTA	FLOWE, KENNETH	GREENSBORO
	BALLARD, MELISSA	LAMOND, DAVID	HENDERSONVILLE
	BERNDT, APRIL	DIRSCHL, DOUGLAS	CHAPEL HILL
	BRACKETT, REBECCA	VINCENT, MARK	CHARLOTTE
	BRUEHL, HOLLY	KANN, JOEL	KNIGHTDALE
	BURD, WENDY	KANN, JOEL	DURHAM
	BYNUM, SHAN	FLOWE, KENNETH	GREENSBORO
	COCONIS, PHYLLIS	FLOWE, KENNETH	GREENSBORO
	CUTLER, JANET	COOK, ELISABETH	WASHINGTON
	DAVIS, TRAVONIA	FLOWE, KENNETH	GREENSBORO
	DAVIS, KATHRYN	BALLARD, HARRY	NEW BURN
	EDWARDS, LAURA	WILLIAMS RAMIREZ, CARLOS	SOUTH HILL
	HENSLEY, MEGAN	BERNSTEIN, DANIEL	HENDERSONVILLE
	KLEIN, SUSAN	MANLY, DAVID	HENDERSONVILLE
	LANIER, CHRISTIAN	JOHN, JOHN	KINSTON
	LIVINGSTON-GREEN, DEBRA	GODWIN, CHARLES	NEW BERN
	LOCKE, CAROL	WAIVERS, LEO	GREENVILLE
	LU, CINDY	REARDON, DAVID	DURHAM
	MCLAMB, TARA	MAYO, PHILIP	GOLDSBORO
	MEDINA-VARGAS, MONINA	ROBSON, MICHAEL	GREENSBORO
	MITCHELL, SHARON	CROCKER, DANIEL	WILSON
	MOORE, TANYA	PISCITELLI, JOANNE	DURHAM
	NORTON, CHRISTINE	SCHROER, BRADY	HENDERSONVILLE
	ROBERTS, ALICE	MCGRATH, JAMES	YADKINVILLE

January 19-21, 2011

RUSSO, REBECCA
SOCHA, LAUREL
SQUIRES, KIMBERLY
TAYLOR, JULIE
VOCI, CATHERINE
WATTS, ROXIE
WENGER, JENNA
WHITEHEAD, KAREN
ZILIUS, MARIE
ZIMBELMAN, BRANDI
ALLEN, ANGELA
BEVERLY-HOWARD, LASHAWN
DEL RIO, AMANDA
DOHERTY, DIANNE
EVANS, KAREN
FARMER, NEDA
HARRINGTON, JULIE
HEGLAR, CAROL
JONES, LAUREN
KAY, DANA
MAVELLIA, HELEN
MYHAND, MARIE
NEWKIRK, LUCRETIA
OSBORNE, HEATHER
PARKER, TAMRAH
QUEEN, STACY
RICHARDSON, FELICIA
RIDENHOUR, JAMIE
SMITH, CHERI
STEWART, CATHERINE
TARLTON, NINA
VEBBER, SUSAN
WEATHERFORD, KARA
WOLFE, DANA
BEATTY, LATONYA
COLMER, SARA
CONNORS, SUNAH
CORBETT, ELIZABETH
HILL, RHONDA
LATORRE, CAROL
PERKINS, JENNIFER
SALINAS, PEDRINA
SUTTON, BESSIE
AUSTIN, LEIGH-TAYLOR
BENTLEY, MONICA
CHRISTY, LARA

GUHA, SUBRATA
CHEIFETZ, IRA
SUNDERLAND, BRENT
GOODNIGHT, WILLIAM
RICHTER, STEPHANIE
CZUBA, KAREN
IGHADE, ANDREW
YOUNG, RICHARD
SHERRINGTON, BRIAN
SEAGLE, ROGER
HARTMAN, EDWIN
HARRIS, DIANE
MATTHEWS, CHARLES
LANGSTON, BERNARD
WATSON, RICKY
PEARSON, DAVID
O'SHEA, THOMAS
BLACKMAN, CAMERON
HALL, SANDRA
EDGERTON, THOMAS
NAZER, KARIM
GIROUARD, MICHAEL
DAMBECK, ALLYN
BERNSTEIN, DANIEL
ZERVOS, EMMANUEL
FERRELL, WILLIAM
JAMES, ROBERT
STOUDMIRE, JONATHAN
MORESCHI, RAFAEL
VARGAS, CARLOS
SHAW, ANDREW
MILLET, ROBERT
KAHAI, JUGTA
GAMBINO, JOHN
CORNELIO FLORES, OSCAR
SINGH, PARAMJEET
NTIMBA, FRANCIS
FLEURY, ROBERT
BRYAN, ANGELA
SARANTOU, TERRY
KANN, JOEL
HUFFMON, GEORGE
CARRERAS, JORGE
MORTON, TERRENCE
KLASING, DONALD
WELLS, ROBERT

WILSON
DURHAM
CHARLOTTE
RALEIGH
CHARLOTTE
SPARTANBURG
CHARLOTTE
WASHINGTON
SOUTHERN PINES
MORGANTON
SMITHFIELD
WILMINGTON
RALEIGH
CHARLOTTE
SNOW HILL
CHARLOTTE
WINSTON-SALEM
CONCORD
WILMINGTON
PINEHURST
DALLAS
HUNTERSVILLE
WALLACE
MT. AIRY
GREENVILLE
RALEIGH
GREENVILLE
CONCORD
CARY
ASHEVILLE
SPARTA
DURHAM
SOUTHPORT
HUNTERSVILLE
WHITEVILLE
CARY
ST. LOUIS
RALEIGH
MARION
CHARLOTTE
CARY
WILMINGTON
SYLVA
HUNTERSVILLE
GASTONIA
ASHEVILLE

DAVIS, JENEL
DUNBAR, SASHA
JACOBS, LISA
LE, THANH TANA
MURRAY, CAROL
NEAL, JENNIFER
NORBURY, AMY
WELCH, DINAH
WHITE, RENE
WITHEROW, WENDY

MAYES, BRUCE
BLACKBURN, WARREN
CHEIFETZ, IRA
SONG, QILIN
VINCENT, MARK
BOYETTE, CHARLES
LAWRENCE, MICHAEL
LANDERS, MARK
MILLER, MICHAEL
EDWARDS, ANGELA

CHARLOTTE
LOUISBURG
DURHAM
WASHINGTON
MONROE
BELHAVEN
GREENVILLE
PINEHURST
DURHAM
WINSTON-SALEM

NP ADDITIONAL SUPERVISOR LIST

ALBANO, DENISE
ANDERSON, MEREDITH
ARIWODO, UDO
BAGNULO, ELSA MAE
BASKIN, ROBIN
BOROUGHES, BETHANY
BUTLER, CAROL
CARPENTER, KELLI
CHURCH, THOMAS
CUDDY, SHERRI
CUDDY, SHERRI
DAVIS, CAROLYN
DIXON, KELLY
DRINKARD, SUE
FOHR, CRISSY
FULLAR, SUZANNE
GILLIAM, KAREN
GUARINI, ELEANOR
HAIRSTON, TAWANNA
HANOBECK VERVILLE, SUSAN
HARDCASTLE, LAURA
HEDRICK, DIANN
HENRY ROSS, DOROTHY
HILL, DORIS
JOHNSON, ALMAZ
KEITH, BARBARA
KENDALL, KELLIE
KING, PAULA
LALIBERTE, SALLY
LATTA, JOANNE
LINDSEY, KIMBERLEY
MANG, MELISSA
MANG, MELISSA
MASSON, MICHELLE

HYLER, JAMES
UGAH, NWANNADIYA
HASSAN, SAMI
COCKRELL, WILEY
LOWE-HOYTE, CHARMAINE
HALL, TIMOTHY
GRAHAM-HOSKINS, PEARLY
SPIVEY, DAVID
BELL, JOSEPH
HANSEN, TODD
BUCHANAN, SONYA
WILSON, ROBERT
DORN, HENRY
SOUTH, STEPHEN
WILSON, ROBERT
MCKAY, JUDYTHE
ERLANDSON, STEPHEN
SCHMIDT, BRIAN
HUSSEY, MICHAEL
VINCENT, MARK
MOORE, BARRY
KUCH, JEFFREY
SAAD, MAGED
GROSS, THOMAS
PATEL, SUBHASH
MOO YOUNG, KARL
WANDER, JOHN
LAMBETH, WILLIAM
JEFFERSON, HENRY
JONES, LAWRENCE
SANTIN, AMY
BYRON, JOHN
WASHINGTON, RAYMOND
RUDYK, MARY

STATESVILLE
PEMBROKE
GREENSBORO
WHITAKERS
ASHEVILLE
CHARLOTTE
COUNCIL
WINSTON SALEM
BOONE
CHARLOTTE
MOUNT HOLLY
MOORESVILLE
HIGH POINT
GREENSBORO
MOORESVILLE
ASHEVILLE
ELKIN
CONCORD
HIGH POINT
CHARLOTTE
WILMINGTON
HICKORY
GARNER
MOORESVILLE
CHARLOTTE
ST. PAULS
ASHEVILLE
MOREHEAD CITY
CARY
ASHEVILLE
HENDERSONVILLE
SOUTHERN PINES
PINEHURST
WILMINGTON

January 19-21, 2011

MASTERS, TASSIE
MCCORMICK, TERESA
MIKULANINEC, CLAUDIA
MIXON, SUSAN
MUELLER, CAROLYN
MURRAY, JANIS
NEW, PAULA
NORMAN, TONJA
OSSNER, CHRISTINA
PERKINS, JUANITA
PHARR, AMY
PROPST, DAVID
PURVIS, LATASHA
RETIS, LIZETTE
RODRIGUEZ-LENNON, LUZ
ROGERS, JOAN
RUSSO, FRANK
SCISM, ELIZABETH
SHARPE, ROSE
SILVERNALE, MAUREEN
SMALL, ADRIENNE
SMITH, JERICA
SPENCER, BROOKE
STANSBURY-ROLLACK, KATHRYN
SULLIVAN, PATRICIA
SWANSON, PAMELA
VALDIVIEZO, AUXILIADORA
VALDIVIEZO, AUXILIADORA
VERCIO, MARGARET
VINSON, LYNNE
WALLACE, REBECCA
WEKONY, MELINDA
WILLARD, FAWN
WILLIAMS, SHANA
WOJCIECHOWSKI, COLLEEN
WRIGGELSWORTH, KATHRYN
YARBOROUGH, KELLY
YEBOAH, MAVIS
ADAMS, JESSICA
BOURDON, DINAH
BRITTAI, TISHA
BROWN, ESTELLE
CAVILEER, DENISE
CRUM, SHARON
DAUGHERTY, DECEMBER
DISALVO, LINDA

WELLS, ROBERT
TUCCI, KEITH
CHEWNING, JOHN
EASLEY, RONALD
COVINGTON, VALENCIA
BARTLETT, KATHLEEN
MCGHEE, JAMES
COVINGTON, VALENCIA
WALTER, KAREN
JOHNSON, DAVID
CHOWDHURY, SHABBIR
KELLY, JONATHAN
COVINGTON, VALENCIA
BOWEN, SAMUEL
FLOWE, KENNETH
WHITLOCK, GARY
COVINGTON, VALENCIA
STALLINGS, MARTIN
FALK, RONALD
LONG, THOMAS
FLOWE, KENNETH
GUHA, SUBRATA
PEELER, RONALD
HOIDAL, CHARLES
TAIT, DAVID
MONTEITH, CHARLES
PETERSON, DAVID
ALLGOOD, SARA
CROOK, JANET
ALEJANDRO, LUIS
HOLT, LAWRENCE
FLOWE, KENNETH
MACGILVRAY, PHYLLIS
CHAMBERS, JEFFREY
CUTSON, TONI
MAROOF, SHAHEDA
PEARSON, DAVID
SPELLS, ROSALIND
LANDVATER, LANCE
BENFIELD, EDWARD
IQBAL, JAVED
NOLL, BRUCE
PRIDGEN, JAMES
RODRIGUEZ, LUIS
WATLING, BRADLEY
SANDER, MARGIE

ASHEVILLE
GREENVILLE
WS
FAYETTEVILLE
WILMINGTON
DURHAM
HOLLY RIDGE
WILMINGTON
ASHEVILLE
RALEIGH
FAYETTEVILLE
WINSTON SALEM
WILMINGTON
HICKORY
KERNERSVILLE
NEW BERN
WILMINGTON
SHELBY
CHAPEL HILL
YADKINVILLE
MORRISVILLE
WILSON
CHARLOTTE
ELIZABETH CITY
CHARLOTTE
CHAPEL HILL
CHARLOTTE
CHARLOTTE
CHARLOTTE
GREENSBORO
MYRTLE BEACH
KERNERSVILLE
CAMP LEJEUNE
DURHAM
DURHAM
RALEIGH
CHARLOTTE
HIGH POINT
RALEIGH
CHARLOTTE
MORGANTON
CHARLOTTE
SNEADS FERRY
GREENVILLE
CANTON
CHARLOTTE

FECIK, CONNIE
FITZPATRICK, KATHRYN
FRANKLIN, VICTORIA
GONDER, ANGELA
GREEN, ANGELA
GREEN, LORI
HAYWOOD, ANTONIA
HINSON, KRISTEN
HURKA RICHARDSON, KAREN
IKEAKANAM, ROSELINE
JENKINS, DAWN
JESSE, MELISSA
JOHNSON, CAMILLE
JOHNSTON, DENISE
KOZAR, DOROTHY
KOZAR, DOROTHY
KRIEGLER, TANIA
LAKE, ANNE
MILLER, NORMA
MONGER-CAWTHON,
ELIZABETH
MORROZOFF, JR, WILLIAM
MURRAY, SARAH
NADEAU, RANDINE
NOELL, REBECCA
NOSER, PATRICIA
NUR ID-DIN, SHAHEERAH
ORMOND, MARY
OWENS, REBECCA
PAYNE, BILLEE
PERKINS, JUANITA
RICCI, LINDSEY
RUSSO, REBECCA
SCACCIA, NICOLE
SHANKAR, ANN
SHINE, ANNE
SHUMATE, WENDY
SKAKEY, JOSETTE
SMITH, CLAUDIA
STARR, TAMARA
STRAYHORN, CHRISTINE
TEAGUE, MARLYN
VERSEN-RAMPEY, STACI
VOCI, CATHERINE
WHISNANT ROPER, REGINA
WILSON, KAREN
WOODARD, CHARLSIE

CAHILL, JOHN
LASTER, ANDREW
GOLDMAN, STEVEN
DAILEY, TIMOTHY
ISAACS, ROBERT
SIMS, WILLIAM
KEAN, VICTORIA
KERSTEN, BRIAN
SHEA, THOMAS
LEWIS, MARVIN
POWELL, EDDIE
SUNDERLAND, THERESA
COWARD, KAREN
HUBBARD, LAURA
MARTERRE, WILLIAM
FULLER, STANLEY
WALTER, KAREN
MCCANTS, DEIDRA
KALALA, JAMAL

STEPHENSON, ANNE
CHAVIS, HERMAN
FLOWE, KENNETH
MURRAY, MICHAEL
REICHOW, KAREN
WELLS, ROBERT
KANN, JOEL
LAWRENCE, MARK
KNAPP, EVE
ADAMI, JOHN
POLANCO, LEONARD
JORGE, CARLOS
REHFIELD, AMY
MILLARD, JONATHAN
NOLL, BRUCE
GRAHAM, MARK
CRANSTON, JAY
MORTON, TERRENCE
ADEDIRAN, ABAYOMI
THOMPSON, MYRNA
BALOCH, MOHAMMAD
LORIMER, WILLIAM
FASSLER, JOHN
SHULSTAD, ANDREW
STROTHER, BYRON
HINES, MARCONO
GARRETT, JAMES

GREENVILLE
CHARLOTTE
CHARLOTTE
BOONE
DURHAM
SYLVA
GREENVILLE
CHARLOTTE
CHAPEL HILL
ANGIER
DUNN
CHARLOTTE
TARBORO
FERGUSON
WINSTON-SALEM
WINSTON-SALEM
ASHEVILLE
BURLINGTON
TAYLORSVILLE

BUTNER
RED SPRINGS
DURHAM
ASHEVILLE
WILMINGTON
ASHEVILLE
DURHAM
WAYNESVILLE
GREENSBORO
KITTY HAWK
GRAHAM
CORNELIUS
KNIGHTDALE
CHARLOTTE
CHARLOTTE
CARY
BOONE
HUNTERSVILLE
WARSAW
CHARLOTTE
RALEIGH
DURHA,
ROCK HILL
CHARLOTTE
MORGANTON
ALLIANCE
JACKSONVILLE

January 19-21, 2011

BAKER, KRISTINE
BARKLEY, VICKIE
BARNHARDT, CYNTHIA
BENTON, JENNIFER
BRACK, LAURA
CHILDERS, PATRICIA
COMER, ZOE
CONRAD, SHARYN
CROSSMAN, MOLLY
DUGAN, ERIN
EARLY, CARMALINDA
EVERETT, ARNETTE
GRENINGER, LINDA
HINNANT, CONNIE
LATTA, CYNTHIA
LAVENBURG, ALEXANDRA
LEFAIVE, MICHAEL
MACDONALD, KERI
MCCARTHY, BRIAN
MCMAHAN, REBECCA
MEDINA-VARGAS, MONINA
MILLS, MICHELLE
MULHOLLAND, ANDREA
NWOKO, AGNES
PARKER, DIANE
PARRIS, CHRISTOPHER
PATEL, SWATIBEN
POWELL, LESLIE
PRESLEY, MELISSA
RUSSELL, AKIMYO
SCHROEDER, CAROL
SHARPE, ANGELA
SHULER, PAMELA
SMITH, LOIS
SUDDRETH, LISA
TERRY, JEVITA
TERRY, JEVITA
TOMAN, LAURIE
VAUGHN, ASHLEY
VERNON, ANN
WELSH, EILEEN
WHITE, SONJA
WILKS, KANZENNER
BAKER, NANCY
BARKER, GARY
BATES, AMANDA

GOUDAS, LEONIDAS
HOOPER, JEFFREY
HOPPER, KELLY
OLATIDOYE, CONSTANCE
STEPP, KEVIN
CZUBA, KAREN
VINCENT, MARK
LORD, RICHARD
WASHINGTON, JOHN
MISTRY, KSHITIJ
SALTZ, JAMES
WOODALL, HAL
BALLANTINE, CAROLYN
MESSEC, HARRY
MONACO, JULIE
PERCIACCANTE, JAMES
OATES, ELIZABETH
MONACO, JULIE
MONROE, YVONNE
KIMBERLY, GEORGE
GREEN, ARTHUR
MOFFET, CYNTHIA
MONACO, JULIE
FLEURY, ROBERT
POLLOCK, HOKE
MUNOZ, PAUL
AUSTIN, DEMETRIA
GIBSON, KEISHA
SEWARD, DANIEL
MORTON, TERRENCE
VICKERY, DAVID
RUPE, CAROL
HOCH, MARK
NOVAK, ALBERT
MCNABB, JAMES
WILLIAMS-WOOTEN, ADA
COWARD, KAREN
GOUDAS, LEONIDAS
SHUKLA, NILIMA
JORGE, CARLOS
MONACO, JULIE
RHOADES, ALAN
RHOADES, ALAN
ROSE, JOHN
HAQUE, IMRAN
SCOBAY, MARTIN

VALDESE
ASHEBORO
KANNAPOLIS
ROSE HILL
CHARLOTTE
KINSTON
CHARLOTTE
WINSTON SALEM
BURLINGTON
CHARLOTTE
SNOW HILL
KENLY
RALEIGH
JACKSONVILLE
HILLSBOROUGH
RALEIGH
WILMINGTON
HILLSBOROUGH
CHAPEL HILL
MOCKSVILLE
GREENSBORO
NEWTON
CHAPEL HILL
PINEHURST
WILMINGTON
SHELBY
GASTONIA
CHAPEL HILL
CHARLOTTE
CHARLOTTE
ASHEVILLE
CHARLOTTE
ASHEVILLE
BOILING SPRINGS
MOORESVILLE
TARBORO
TARBORO
VALDESE
GASTONIA
WINSTON SALEM
CHAPEL HILL
WINSTON SALEM
WINSTON-SALEM
GREENVILLE
RAMSEUR
CHARLOTTE

BENSON, INGA	HONGALGI, ANAND	GREENSBORO
BRONSON, KIMBERLY	BARNES-DURITY, MONICA	DUNN
CARLTON, MELISSA	DUBOW, RONALD	LENOIR
CEPONIS, EILEEN	SCHNEYER, BARTON	SOUTHPORT
CHAPPELL, NICOLE	PETERSON, MATTHEW	BOONE
CHRISTY, EDANA	BASHORE, THOMAS	DURHAM
COOMBE, COURTNEY	MORAN, JOSEPH	STATESVILLE
DEGENNARO, LINDA	WILKINS, KENNETH	NEW BERN
DEITZ, SHEILA	MITTAL, MADHUR	JACKSONVILLE
DUDLEY, MARGARET	JOHNSON, LYNN	GREENVILLE
EDWARDS, JANE	SANDERSON, STEVEN	HICKORY
FERNALD, CARRIE	IRUELA, MARIA	WINSTON-SALEM
GAMEWELL, MARILYN	BATTS, MARK	LENIOR
HARRIS-COLEMAN, JUDITH	CORDER, JOHN	HICKORY
HAYES, CECILIA	ROUGEOU, GLENDON	MURPHY
HOUSER, PAIGE	JOSEPH, DAVID	WILMINGTON
JINDAL, VINEETA	STEPHENSON, ANNE	BUTNER
JOHNSON, YOLANDA	EZEIGBO, WALTER	WALNUT COVE
LEDFORD, ELOISE	ROTHE, KELLY	SPRUCE PINE
LEDFORD, ELOISE	POLGAR, JEFFREY	BURNSVILLE
MARTIN, DORINE	TRIPP, HENRY	KERNERSVILLE
MERRITT JAMES, PHYLLIS	PARKER, JOSEPH	GREENVILLE
RYAN, LISA	CLARK, TERRENCE	ASHEVILLE
THOMAS, ALLISON	SMITH, ALMAZ	CARY
VANVIEGEN, MARK	BLUMLING, BRANDI	RALEIGH
WHITE, MARY	MANOUSOS, GEORGE	CHARLOTTE
WILLIAMS, SHANA	HARRIS, HERBERT	MORRISVILLE
YOUNG, SARA	ALEJANDRO, LUIS	GREENSBORO

Clinical Pharmacist Practitioners

No CPPs approved since last report

Anesthesiologist Assistant, Perfusionist & Provisional Perfusionist Licenses

Issued as of the Last Board Meeting

Peggy Robinson, PA-C, Chair; William Walker, MD; and Pamela Blizzard

Perfusionists:

Kinard, Michael Rhett

Scott, Chelsea Lee

Provisional Perfusionists:

None

Anesthesiologist Assistants:

None

January 19-21, 2011

Initial PA Applicants Licensed 11/01/10 – 12/31/10

PA-Cs

Name

Adamo, Ashley Dawn	12/27/2010
Alho, Jeana Angela	12/08/2010
Blankenship, Chad E	12/20/2010
Blevins, Joanie Beth	12/21/2010
Bone, Hans Erling	11/24/2010
Boos, Jennifer Ann	11/12/2010
Bryan, Daniel Justin	12/29/2010
Caceres, Catherine Mariel	12/01/2010
Cole, Daniel	11/16/2010
Crosson, Emily Erin	12/29/2010
Curran, Amy Leann	12/01/2010
Davidson, Robin Lynn	11/19/2010
Davis, Jeremiah Paul	12/01/2010
Dong, Fan	11/10/2010
Doyle, Michael Paul	11/16/2010
Elmore, Rebecca Anne	12/28/2010
Fetch, Julie	11/03/2010
Filipkowski, Andrea Bethäuser	12/21/2010
Flynn, Cheryl Galatian	12/10/2010
Fraser, Amanda Jean	11/29/2010
Hafiz, Sehr	11/10/2010
Hanley, Allison Bright	12/15/2010
Hanopole, Jennifer Pitts	12/29/2010
Harris, Amanda Darden	12/27/2010
Herrmann, Becky T.	12/21/2010
Herrmann, Erin Grey	12/30/2010
Hickman, William Luke	12/30/2010
Hill, Jana Jade R.	12/21/2010
Hilton, Meleah Greene	12/28/2010
Kalogerinis, Peter Theodoros	12/27/2010
LaClaire, Christa Joy	12/28/2010
Lee, Winnie Yuk-Fung	12/28/2010
Lewis, Elizabeth Sarah	11/10/2010
Like, Allison	12/08/2010
Linginfelter, Kristy Rae	12/28/2010
Louis, Guerlande	11/03/2010
Mathis, Grace Nicole	12/28/2010
McBryde, James Anthony	12/27/2010
McCall, Tanya Susann	12/27/2010
Montanez, Melissa	12/21/2010
Nodeland, Heather Ann	11/22/2010

Pandiscia, Joseph D	12/10/2010
Parchuk, Anna	12/13/2010
Price, Alice Diane	12/15/2010
Riddick, Ashli Lauren	12/28/2010
Rudolf, Christine Michelle Kuuualoha	12/28/2010
Schaefer, Elizabeth Kathrine	11/10/2010
Schmidlin, Christine Marie	12/29/2010
Sebastian, Sarah Danielle	11/01/2010
Shorten, James	12/28/2010
Sigmon, Emily Manda	12/08/2010
Simmons-Valenzuela, Claire Elizabeth	12/27/2010
Steck, Cassie Kay	11/16/2010
Suarez, Joseph Jonathan	11/24/2010
Teague, Kristin Alicia	12/30/2010
Thompson, Luke Kenan	12/13/2010
Timm, Margaret Elizabeth	12/20/2010
Urso, Michelle	11/01/2010
Wells, Sarah	12/03/2010
Wood, Caitlin Elizabeth	11/29/2010
Wright, Eric R.	12/30/2010
Wright, James Christopher	12/29/2010
Wu, Jian	12/30/2010

PA-Cs Reactivations/Reinstatements/Re-Entries

Nowlan, Ashley Elizabeth	Reinstatement
Rosowski, Jeffrey Michael	Reinstatement

ALLIED HEALTH COMMITTEE REPORT-PA/EMS

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, Curt Ellis, Don Pittman, Mike Borden, and Jeffrey Katz, PA. Committee Members absent: None

Open Session Physician Assistants

1. Old business. PAs with Five or More Primary Supervising Physicians.

Issue: Follow-up update from the November, 2010 Board Action regarding the status of PAs with five or more primary supervising physicians and audits on these PAs. The Committee discussed PAs with five or more primary supervising physicians and audits on these PAs. M. Jimison discussed random audits vs. targeted audits. He will investigate audit information and report his findings back to the AHC at the March, 2011 meeting. The Committee also discussed PA Compliance Reviews and C. Ellis and D. Pittman gave a report on the 2010 PA Compliance Reviews. L. King informed the Committee that H. Gupta is working on adding PA audit information to the online PA registration/renewal process and that Ms. Fisher will add the PA 2010 Compliance Review Report to the Forum.

January 19-21, 2011

Committee Recommendation: Accept as information.

Board Action: Accept as information.

Open Session NC Emergency Medical Services

1. EMS – Patient Transportation and other Rules. Information received from Dr. Kanof 12/10/10.

Issue: EMS – Patient Transportation and other Rules adopted by the Commission on 11/19/10. Rules 10A NCAC 13P.0221 Patient Transportation between Hospitals, Section .0700 – Enforcement, 10A NCAC 13P.0701, 10A NCAC 13P.0702, 10A NCAC 13P.1501 Section 1500 Denial, Suspension, Amendment, or revocation, 10A NCAC 13P.1502 EMS Systems, 10A NCAC 13P.1503 Licensed EMS Providers, 10A NCAC 13P.1504 Specialty Care Transport Programs, 10A NCAC 13P.1505 Trauma Centers, 10A NCAC 13P.1506 EMS Educational Institutions, 10A NCAC 13P.1507 EMS Vehicle Permits, 10A NCAC 13P.1508 EMS Personnel Credentials, 10A NCAC 13P.1509 Summary Suspension.

Committee Recommendation: Accept as information.

Board Action: Accept as information.

2. EMS - Rules for Recovery and Rehabilitation of Chemically Dependent EMS Personnel and the Role of the NC EMS Disciplinary Committee. Information received from Dr. Kanof 12/30/10.

Issue: Utilizing the Rules for the Recovery and Rehabilitation of Chemically Dependent EMS Personnel and the Role of the NC EMS Disciplinary Committee. Rules 10A NCAC 13P.1402 Provisions for Participation in the Chemical Addiction or Abuse Treatment Program, 10A NCAC 13P.1403 Conditions for Restricted Practice with Limited Privileges.

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.

Two licensee applications 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.

ALLIED HEALTH COMMITTEE REPORT – LP/AA/CPP

The Allied Health Committee of the North Carolina Medical Board was called to order at 10:30 am, January 19, 2011 at the office of the North Carolina Medical Board. Members present were: Peggy Robinson, PA-C, Chair; William Walker, MD; and Pamela Blizzard. Also present were Marcus Jimison, Jane Paige, Lori King, Curt Ellis, Don Pittman, Katharine Kovacs, and Quanta Williams.

1. Open Session Anesthesiologist Assistants
 - a. AA Certification
 - i. Discuss certifying exam and exam for continued demonstration of qualifications for AAs.

Committee Recommendation: Accept as information

Board Action: Accept as information
2. Open Session Nurse Practitioners
 - a. No items for discussion
3. Open Session Clinical Pharmacist Practitioners
 - a. No Items for discussion
4. Open Session Perfusionists
 - a. Open session portion of the minutes of the November PAC meeting.
 - i. The open session minutes of the November PAC meeting have been sent to the Committee members for review.

PAC Recommendation: Approve minutes

Committee Recommendation: Accept as information

Board Action: Accept as information
 - b. Requests for reappointment
 - i. Mr. Shearer's and Dr. Hines's terms expired on October 31, 2010. They have requested reappointment to the PAC.

Committee Recommendation: Reappoint Ian Shearer, LP and Michael Hines, MD to the PAC.

Board Action: Reappoint Ian Shearer, LP and Michael Hines, MD to the PAC.
 - c. Proposed CME Rule
 - i. During the May PAC meeting, Mr. Jimison explained the Board's CME rule for PAs and suggested that the PAC may want to follow the same reporting procedure. The Committee approved the proposed rule.

Present Rule

21 NCAC 32V .0105 CONTINUING EDUCATION

The licensed perfusionist must maintain documentation of 30 hours of continuing education (CE) completed for every two year period. Of the 30 hours, at least 10 hours must be Category I hours as recognized by the American Board of Cardiovascular Perfusion (ABCP), the remaining hours may be Category II or III hours as recognized by the ABCP. CE documentation must be available for inspection by the Committee or Board or an agent of the Committee or Board upon request.

*History Note: Authority G.S. 90-685(3) and (8);
Eff. September 1, 2007.*

Proposed Rule

21 NCAC 32V .0105 CONTINUING EDUCATION

(a) The licensed perfusionist must maintain documentation of 30 hours of continuing education (CE) completed for every two year period. Of the 30 hours, at least 10 hours must be Category I hours as recognized by the American Board of Cardiovascular Perfusion (ABCP), the remaining hours may be Category II or III hours as recognized by the ABCP. CE documentation must be available for inspection by the Committee or Board or an agent of the Committee or Board upon request.

(b) A perfusionist who possesses a current certification with the ABCP will be deemed in compliance with the requirement of subparagraph (a) of this Rule. The perfusionist must attest on his or her biennial renewal that he or she is currently certified by the ABCP.

PAC Recommendation: Approve the proposed CME rule for perfusionists.

Committee Recommendation: Approve the proposed CME rule for perfusionists.

Board Action: Approve the proposed CME rule for perfusionists

d. Changes to Education Certification form

- i. The Medical School Certification form has been changed on the MD/DO application. In order to be consistent with the other applications, the Education Certification form in the perfusionist application will need to be revised. The changes were reviewed by the Committee. They also discussed the best way to make the perfusionist community aware of the change. Mr. Hodges is the president of the NC Perfusionist Society. He will have the NCPS send the information out.

PAC Recommendation: Approve changes to the form

Committee Recommendation: Accept as information

Board Action: Accept as information

e. ABCP Recertification

- i. Dr. Hines has drafted a letter to be sent to the American Board of Cardiovascular Perfusion addressing the requirements for certification renewal. He points out that perfusionist can currently maintain annual certification with the ABCP exclusively with ECMO shifts and other non-CPB cases. He suggests that the ABCP work to revise their requirements to allow no more than 10 ECMO "shifts" (25%) toward the minimum annual number of 40 perfusion cases, and also set a limit on the use of the other non-CPB categories. Dr. Hines would like for the ABCP to consider setting a minimum number of CPB (described as "Primary Bypass" by the ABCP) of at least 20 cases per year (50%), perhaps even averaged over two years (e.g. 15 year 1, 25 year 2).

The general consensus of the members present was that adding caseload requirements for certification may cause small community programs to have to shut down. The Committee viewed this as an awareness issue regarding competency and performance for individual employers to address.

Mr. Jimison will contact Dr. Hines to find out if the letter was sent to the ABCP. If the letter has been sent, the Committee would like to know what the response was.

PAC Recommendation: Defer this issue until Dr. Hines has been contacted. Mr. Jimison will share information from Dr. Hines with PAC members. Discuss at March PAC meeting.

Committee Recommendation: Accept as information

Board Action: Accept as information

f. PAC Vacancy

- i. Board staff has been in contact with Hugh Tilson at the NC Hospital Association. A replacement for Mr. Gannotta has not been named yet. David Henderson will be asked to contact NCHA. An update will be given at the March meeting.

PAC Recommendation: Accept as information

Committee Recommendation: Accept as information

Board Action: Accept as information

g. Late Fee Rule

- i. The PAC members reviewed the rules to determine whether there are rules they may want to see, or believes may need to be, changed. Subsequent to that meeting, the staff encountered an issue with the wording of the rule imposing a late fee for perfusionists who fail to renew his or her perfusion license on time.

Present Rule

21 NCAC 32V .0115 FEES

(a) A fee of three hundred and fifty dollars (\$350.00) is due at the time of application for a perfusion license and a fee of one hundred and seventy five dollars (\$175.00) is due at the time of application for a provisional perfusion license. No portion of the application fee is refundable.

(b) A fee of three hundred and fifty dollars (\$350.00) shall be paid to the North Carolina Medical Board for biennial renewal of a perfusion license and a fee of one hundred and seventy five dollars (\$175.00) for annual renewal of a provisional perfusion license.

(c) A late fee of one hundred dollars (\$100.00) shall be charged to those who fail to renew either a perfusion license or a provisional perfusion license within thirty days after the expiration date of the license.

History Note: Authority G.S. 90-685(7); 90-688; 90-689; 90-690; Eff. March 1, 2008.

Proposed Rule

21 NCAC 32V .0115 FEES

(a) A fee of three hundred and fifty dollars (\$350.00) is due at the time of application for a perfusion license and a fee of one hundred and seventy five dollars (\$175.00) is due at the time of application for a provisional perfusion license. No portion of the application fee is refundable.

(b) A fee of three hundred and fifty dollars (\$350.00) shall be paid to the North Carolina Medical Board for biennial renewal of a perfusion license and a fee of one hundred and seventy five dollars (\$175.00) for annual renewal of a provisional perfusion license.

(c) A late fee of one hundred dollars (\$100.00) shall be charged to those who fail to renew timely a perfusion license or a provisional perfusion license.

History Note: Authority G.S. 90-685(7); 90-688; 90-689; 90-690; Eff. March 1, 2008

PAC Recommendation: Adopt the proposed rule change

Committee Recommendation: Adopt the proposed rule change

Board Action: Adopt the proposed rule change

5. Open Session Polysomnography
 - a. No items for discussion

NURSE PRACTITIONER JOINT SUBCOMMITTEE

The Nurse Practitioner Joint Subcommittee (NPJS) was called to order at 1:00 pm January 19, 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); Sarah Griffith (NCBON); William Walker, MD (NCMB); and Pamela Blizzard (NCMB). Also present was: Jean Stanley (NCBON); Donna Mooney (NCBON); Eileen Kugler (NCBON); Jack Nichols (NCBON); Julie George (NCBON); Marcus Jimison (NCMB); David Kalbacker (NCBON); Don Pittman (NCMB); and Quanta Williams (NCMB).

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1. Approval of minutes of November 17, 2010
 - a. Motion: To approve the minutes of the November meeting. Passed.
2. Additions to agenda
 - a. None
3. New Business
 - a. Board Certification
 - i. Adoption of a statement requiring disclosure of the area of practice and the certifying agency.

NPJS Recommendation: The staff has been asked to collaborate on the wording of a position statement regarding board certification and bring a recommendation back to the NPJS.
 - b. Compliance Review Annual Report
 - i. Forty-three percent of NPs reviewed were in total compliance with NP rules in 2010 compared to 23% in 2009 and 48% in 2008.

NPJS Recommendation: Accept as information.
 - c. Information added to the Renewal Application
 - i. A dialog box containing common discrepancies found during compliance reviews has been added to the online renewal application. It was suggested that a link be added that the NPs would have to click on to confirm that they had read the statement. The Board of Nursing will check with their IT department about adding the link.
4. Report of any disciplinary actions, including Consent Agreements, taken by either Board since November 17, 2010
 - i. The Board of Nursing reported 8 actions taken against a nurse practitioner since the last meeting.
 - ii. The Medical Board didn't report any public actions taken against a nurse practitioner since the last meeting.
5. Revision of Compliance Review Process
 - i. The Medical Board has asked that the NPJS revise the Compliance Review Process so that it is not so taxing on staff time. Changes would be made to have all compliance reviews would be done by the Board of Nursing by mail. The audits would center on the rules that deal specifically with the collaborative practice agreement (CE requirements and QI meetings). Also, up to five site visits per year may be conducted jointly at the discretion of Board staff.

NPJS Recommendation: Approve the proposed changes to the compliance review process.

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.

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Four licensee applications 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.

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 43 complaint cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included 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 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 (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 36 cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

INFORMAL INTERVIEW REPORT

A motion passed to close the session 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.

Thirteen informal 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

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 (Investigative) Committee reported on 22 investigative cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

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 27 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 42 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.

RETREAT COMMITTEE

The Retreat Committee of the North Carolina Medical Board was called to order at 10:30am Wednesday January 19, 2011, at the office of the Medical Board. Members present were: Karen R. Gerancher, MD, Chair; Janice E. Huff, MD; Ms. Thelma Lennon; Thomas R. Hill, MD; and Ralph C. Loomis, MD. Also present were: David Henderson, Christina Apperson and Maureen Bedell.

1. Old Business
 - a. Approval of Minutes
The minutes of the November 2010 meeting were approved.
2. New Business
 - a. Date/Location of Retreat
The committee settled on September 23-24, 2011 at the Renaissance Hotel for the date and location of the Board Retreat. Board members will have several hours of personal time after the end of the September 2011 Board meeting before reconvening at the Renaissance Hotel for the retreat.
 - b. General Schedule of Events

Friday, September 23
3-5PM Opening Session
6-8PM Dinner
9-11PM Midnight Bowling

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Saturday, September 24

7-8 AM Breakfast

8-Noon Morning Session

Noon-1 Lunch

1-3 PM Closing Session

c. Topics for Discussion at Retreat

The committee discussed the following potential retreat topics:

i. Ways to assist medical residents in the transition from student to professional.

ii. Maintenance of licensure from the perspective of Dr. Bill Williams, NBME Chair.

iii. Members of the legislature including the House and Senate Health Committee chairs to recap the 2011 session of the General Assembly. The state Medicaid director could provide a recap of the session. It was decided that Thom Mansfield should be consulted about the viability of this option.

iv. Board processes, specifically, division of labor between full Board/committees/staff; hearing procedures; optimal use of committees; wisdom of expanding Board; use of Skype and teleconference for committee work, etc.

v. General long range planning

vi. General education on telemedicine

vii. Responsible prescribing of controlled substances

viii. "Peek behind the curtain" at a medical liability insurance company. Speaker from medical liability insurance company, such as claims manager, to describe med mal trial processes, considerations that go into settlement; trend analysis of the types of malpractice. Could be useful for public members, in particular, to better understand the medical malpractice system.

It was decided to bring these topics to the full Board to gauge the general level of interest.

d. Speakers/Funding

David Henderson identified the FSMB Foundation as a possible source of outside speakers. For example, Dr. Marty Crane has spoken in the past about a range of issues. In addition, there is some modest funding available to assist speakers with travel, lodging or honorariums.

ADJOURNMENT

This meeting was adjourned at 11:00am, January 21, 2011.

William A. Walker, MD
Secretary/Treasurer

OFFICE-BASED PROCEDURES

PREFACE

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

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

General Guidelines

The Physician's Professional and Legal Obligation

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

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

Exemptions

These guidelines do not apply to Level I procedures.

Written Policies and Procedures

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

Emergency Procedure and Transfer Protocol

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

All office personnel should be familiar with and capable of carrying out written emergency instructions. The instructions should be followed in the event of an emergency, any untoward anesthetic, medical or surgical complications, or other conditions making hospitalization of a patient necessary. The instructions should include arrangements for immediate contact of emergency medical services when indicated and when advanced cardiac life support is needed.

When emergency medical services are not indicated, the instructions should include procedures for timely escort of the patient to the hospital or to an appropriate practitioner.

Infection Control

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

Performance Improvement

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

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

Medical Records and Informed Consent

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

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

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

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

Credentialing of Physicians

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

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

1. state licensure;
2. procedure specific education, training, experience and successful evaluation appropriate for the patient population being treated (*i.e.*, pediatrics);
3. for physicians, board certification, board eligibility or completion of a training program in a field of specialization recognized by the ACGME or by a national medical specialty board that is recognized by the ABMS for expertise and proficiency in that field. For purposes of this requirement, board eligibility or certification is relevant only if the board in question is recognized by the ABMS, AOA, or equivalent board certification as determined by the Board;

4. professional misconduct and malpractice history;
5. participation in peer and quality review;
6. participation in continuing education consistent with the statutory requirements and requirements of the physician's professional organization;
7. to the extent such coverage is reasonably available in North Carolina, malpractice insurance coverage for the surgical or special procedures being performed in the office;
8. procedure-specific competence (and competence in the use of new procedures and technology), which should encompass education, training, experience and evaluation, and which may include the following:
 - a. adherence to professional society standards;
 - b. credentials approved by a nationally recognized accrediting or credentialing entity; or
 - c. didactic course complemented by hands-on, observed experience; training is to be followed by a specified number of cases supervised by a practitioner already competent in the respective procedure, in accordance with professional society standards.

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

Accreditation

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

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

Patient Selection

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

ASA Physical Status Classifications

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

Candidates for Level II Procedures

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

Candidates for Level III Procedures

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

Surgical or Special Procedure Guidelines

Patient Preparation

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

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

The physician performing the surgical or special procedure also should:

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

Discharge Criteria

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

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

Information to the Patient

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

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

Reportable Complications

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

1. physician's name and license number;

2. date and time of the occurrence;
3. office where the occurrence took place;
4. name and address of the patient;
5. surgical or special procedure involved;
6. type and dosage of sedation or anesthesia utilized in the procedure; and
7. circumstances involved in the occurrence.

Equipment Maintenance

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

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

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

Compliance with Relevant Health Laws

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

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

Patient Rights

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

Enforcement

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

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

Level II Guidelines

Personnel

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

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

Surgical or Special Procedure Guidelines

Intraoperative Care and Monitoring

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

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

Postoperative Care and Monitoring

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

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

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

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

Equipment and Supplies

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

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

Level III Guidelines

Personnel

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

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

Surgical or Special Procedure Guidelines

Intraoperative Monitoring

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

- an esophageal or precordial stethoscope should be utilized on the patient.

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

Postoperative Care and Monitoring

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

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

Recovery from a Level III procedure should be monitored by an ACLS certified (PALS or APLS certified when appropriate) health care professional using appropriate criteria for the level of anesthesia. At least one health care professional who is ACLS certified should be immediately available during postoperative monitoring and until the patient meets discharge criteria. Each patient should meet discharge criteria prior to leaving the operating or recovery area.

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

Equipment and Supplies

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

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

Definitions

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

AAAHC – the Accreditation Association for Ambulatory Health Care

ABMS – the American Board of Medical Specialties

ACGME – the Accreditation Council for Graduate Medical Education

ACLS certified – a person who holds a current “ACLS Provider” credential certifying that they have successfully completed the national cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the Advanced Cardiovascular Life Support Program.

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

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

Anesthesia provider – an anesthesiologist or CRNA.

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

AOA – the American Osteopathic Association

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

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

ASA – the American Society of Anesthesiologists

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

Board – the North Carolina Medical Board.

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

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

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

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

FDA – the Food and Drug Administration.

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

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

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

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

Immediately available – within the office.

JCAHO – the Joint Commission for the Accreditation of Health Organizations

Level I procedures – any surgical or special procedures:

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

Level II procedures – any surgical or special procedures:

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

Level III procedures – any surgical or special procedures:

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

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

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

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

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

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

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

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

OSHA – the Occupational Safety and Health Administration.

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

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

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

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

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

reaction, pneumothorax, allergic reaction to anesthesia, unintended hospitalization for more than twenty-four (24) hours, or death.

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

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

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

[A Position Statement on Office-Based Surgery was adopted by the Board on September 2000. The statement above (Adopted January 2003) replaces that statement.]

Joint Statement on Pain Management in End-of-Life Care
(Adopted by the North Carolina Medical, Nursing, and Pharmacy Boards)

Through dialogue with members of the healthcare community and consumers, a number of perceived regulatory barriers to adequate pain management in end-of-life care have been expressed to the Boards of Medicine, Nursing, and Pharmacy. The following statement attempts to address these misperceptions by outlining practice expectations for physicians and other health care professionals authorized to prescribe medications, as well as nurses and pharmacists involved in this aspect of end-of-life care. The statement is based on:

- the legal scope of practice for each of these licensed health professionals;
- professional collaboration and communication among health professionals providing palliative care; and
- a standard of care that assures on-going pain assessment, a therapeutic plan for pain management interventions; and evidence of adequate symptom management for the dying patient.

It is the position of all three Boards that patients and their families should be assured of competent, comprehensive palliative care at the end of their lives. Physicians, nurses and pharmacists should be knowledgeable regarding effective and compassionate pain relief, and patients and their families should be assured such relief will be provided.

Because of the overwhelming concern of patients about pain relief, the physician needs to give special attention to the effective assessment of pain. It is particularly important that the physician frankly but sensitively discuss with the patient and the family their concerns and choices at the end of life. As part of this discussion, the physician should make clear that, in some end of life care situations, there are inherent risks associated with effective pain relief. *The Medical Board will assume opioid use in such patients is appropriate if the responsible physician is familiar with and abides by acceptable medical guidelines regarding such use, is knowledgeable about effective and compassionate pain relief, and maintains an appropriate medical record that details a pain management plan.* Because the Board is aware of the inherent risks associated with effective pain relief in such situations, it will not interpret their occurrence as subject to discipline by the Board.

With regard to pharmacy practice, North Carolina has no quantity restrictions on dispensing controlled substances including those in Schedule II. This is significant when utilizing the federal rule that allows the partial filling of Schedule II prescriptions for up to 60 days. In these situations it would minimize expenses and unnecessary waste of drugs if the prescriber would note on the prescription that the patient is terminally ill and specify the largest anticipated quantity that could be needed for the next two months. The pharmacist could then dispense smaller quantities of the prescription to meet the patient's needs up to the total quantity authorized. Government-approved labeling for dosage level and frequency can be useful as guidance for patient care. Health professionals may, on occasion, determine that higher levels are justified in specific cases. However, these occasions would be exceptions to general practice and would need to be properly documented to establish informed consent of the patient and family.

Federal and state rules also allow the fax transmittal of an original prescription for Schedule II drugs for hospice patients. If the prescriber notes the hospice status of the patient on the faxed document, it serves as the original. Pharmacy rules also allow the emergency refilling of prescriptions in Schedules III, IV, and V. While this does not apply to Schedule II drugs, it can

be useful in situations where the patient is using drugs such as Vicodin for pain or Xanax for anxiety.

The nurse is often the health professional most involved in on-going pain assessment, implementing the prescribed pain management plan, evaluating the patient's response to such interventions and adjusting medication levels based on patient status. In order to achieve adequate pain management, the prescription must provide dosage ranges and frequency parameters within which the nurse may adjust (titrate) medication in order to achieve adequate pain control. Consistent with the licensee's scope of practice, the RN or LPN is accountable for implementing the pain management plan utilizing his/her knowledge base and documented assessment of the patient's needs. *The nurse has the authority to adjust medication levels within the dosage and frequency ranges stipulated by the prescriber and according to the agency's established protocols.* However, the nurse does not have the authority to change the medical pain management plan. When adequate pain management is not achieved under the currently prescribed treatment plan, the nurse is responsible for reporting such findings to the prescriber and documenting this communication. Only the physician or other health professional with authority to prescribe may change the medical pain management plan.

Communication and collaboration between members of the healthcare team, and the patient and family are essential in achieving adequate pain management in end-of-life care. Within this interdisciplinary framework for end of life care, effective pain management should include:

- thorough documentation of all aspects of the patient's assessment and care;
- a working diagnosis and therapeutic treatment plan including pharmacologic and non-pharmacologic interventions;
- regular and documented evaluation of response to the interventions and, as appropriate, revisions to the treatment plan;
- evidence of communication among care providers;
- education of the patient and family; and
- a clear understanding by the patient, the family and healthcare team of the treatment goals.

It is important to remind health professionals that licensing boards hold each licensee accountable for providing safe, effective care. Exercising this standard of care requires the application of knowledge, skills, as well as ethical principles focused on optimum patient care while taking all appropriate measures to relieve suffering. The healthcare team should give primary importance to the expressed desires of the patient tempered by the judgment and legal responsibilities of each licensed health professional as to what is in the patient's best interest.

(October 1999)

ATTACHMENT "C"

POSITION STATEMENT	ADOPTED	SCHEDULED FOR REVIEW	LAST REVISED/ REVIEWED/ ADOPTED	REVISED/ REVIEWED	REVISED/ REVIEWED	REVISED/ REVIEWED	REVISED/ REVIEWED
Medical, Nursing, Pharmacy Boards: Joint Statement on Pain Management in End-of-Life Care	Oct-99	Jan-11	Oct-99				
Office-Based Procedures	Sep-00	Jan-11	Jan-03				
HIV/HBV Infected Health Care Workers	Nov-92	Jan-11	Jan-05	May-96			
Writing of Prescriptions	May-91	Jan-11	Mar-05	Jul-02	Mar-02	May-96	Sep-92
Laser Surgery	Jul-99		Jul-05	Aug-02	Mar-02	Jan-00	
Self- Treatment and Treatment of Family Members and Others With Whom Significant Emotional Relationships Exist	May-91		Sep-05	Mar-02	May-00	May-96	
Prescribing Legend or Controlled Substances for Other Than Valid Medical or Therapeutic Purposes, with Particular Reference to Substances or Preparations with Anabolic Properties	May-98		Nov-05	Jan-01	Jul-98		
Sale of Goods From Physician Offices	Mar-01		Mar-06				
Competence and Reentry to the Active Practice of Medicine	Jul-06		Jul-06				
Availability of Physicians to Their Patients	Jul-93		Jul-06	Oct-03	Jan-01	May-96	
Referral Fees and Fee Splitting	Nov-93		Jul-06	May-96			
Sexual Exploitation of Patients	May-91		Sep-06	Jan-01	Apr-96		
Care of the Patient Undergoing Surgery or Other Invasive Procedure	Sep-91		Sep-06	Mar-01			
The Physician-Patient Relationship	Jul-95		Sep-06	Aug-03	Mar-02	Jan-00	Jul-98
The Retired Physician	Jan-97		Sep-06				
Physician Supervision of Other Licensed Health Care Practitioners	Jul-07		Jul-07				
Medical Testimony	Mar-08		Mar-08				
Advance Directives and Patient Autonomy	Jul-93		Mar-08	May-96			
End-of-Life Responsibilities and Palliative Care	Oct-99		Mar-08	May-07			
Drug Overdose Prevention	Sep-08		Sep-08				

Policy for the Use of Controlled Substances for the Treatment of Pain	Sep-96		Sep-08	Jul-05			
Medical Record Documentation	May-94		May-09	May-96			
Retention of Medical Records	May-98		May-09				
Capital Punishment	Jan-07		Jul-09				
Departures from or Closings of Medical	Jan-00		Jul-09	Aug-03			
Professional Obligations pertaining to incompetence, impairment, and unethical conduct of healthcare providers	Nov-98		Mar-10	Nov-98			
Unethical Agreements in Complaint Settlements	Nov-93		Mar-10	May-96			
What Are the Position Statements of the Board and To Whom Do They Apply?	Nov-99		May-10	Nov-99			
Telemedicine	May-10		May-10				
Contact With Patients Before Prescribing	Nov-99		Jul-10	Feb-01			
Guidelines for Avoiding Misunderstandings During Physical Examinations	May-91		Jul-10	Oct-02	Feb-01	Jan-01	May-96
Access to Physician Records	Nov-93		Sep-10	Aug-03	Mar-02	Sep-97	May-96
Medical Supervisor-Trainee Relationship	Apr-04		Nov-10	Apr-04			
The Treatment of Obesity	Oct-87		Nov-10	Jan-05	Mar-96		
Advertising and Publicity	Nov-99		Nov-10	Sep-05	Mar-01		

HIV/HVB infected health care workers

The North Carolina Medical Board supports and adopts the following rules of the North Carolina Department of Health and Human Services regarding infection control in health care settings and HIV/HBV infected health care workers.

10A NCAC 41A .0206: INFECTION CONTROL—HEALTH CARE SETTINGS

(a) The following definitions shall apply throughout this Rule:

- (1) "Health care organization" means hospital; clinic; physician, dentist, podiatrist, optometrist, or chiropractic office; home health agency; nursing home; local health department; community health center; mental health agency; hospice; ambulatory surgical center; urgent care center; emergency room; or any other health care provider that provides clinical care.
- (2) "Invasive procedure" means entry into tissues, cavities, or organs or repair of traumatic injuries. The term includes the use of needles to puncture skin, vaginal and cesarean deliveries, surgery, and dental procedures during which bleeding occurs or the potential for bleeding exists.

(b) Health care workers, emergency responders, and funeral service personnel shall follow blood and body fluid precautions with all patients.

(c) Health care workers who have exudative lesions or weeping dermatitis shall refrain from handling patient care equipment and devices used in performing invasive procedures and from all direct patient care that involves the potential for contact of the patient, equipment, or devices with the lesion or dermatitis until the condition resolves.

(d) All equipment used to puncture skin, mucous membranes, or other tissues in medical, dental, or other settings must be disposed of in accordance with 10A NCAC 36B after use or sterilized prior to reuse.

(e) In order to prevent transmission of HIV and hepatitis B from health care workers to patients, each health care organization that performs invasive procedures shall implement a written infection control policy. The health care organization shall ensure that health care workers in its employ or who have staff privileges are trained in the principles of infection control and the practices required by the policy; require and monitor compliance with the policy; and update the policy as needed to prevent transmission of HIV and hepatitis B from health care workers to patients. The health care organization shall designate a staff member to direct these activities. The designated staff member in each health care organization shall complete a course in infection control approved by the Department. The course shall address:

- (1) Epidemiologic principles of infectious disease;
- (2) Principles and practice of asepsis;
- (3) Sterilization, disinfection, and sanitation;
- (4) Universal blood and body fluid precautions;
- (5) Engineering controls to reduce the risk of sharp injuries;
- (6) Disposal of sharps; and
- (7) Techniques that reduce the risk of sharp injuries to health care workers.

(f) The infection control policy required by this Rule shall address the following components that are necessary to prevent transmission of HIV and hepatitis B from infected health care workers to patients:

- (1) Sterilization and disinfection, including a schedule for maintenance and microbiologic monitoring of equipment; the policy shall require documentation of maintenance and monitoring;
- (2) Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules;
- (3) Accessibility of infection control devices and supplies;
- (4) Procedures to be followed in implementing 10A NCAC 41A .0202(4) and .0203(b)(4) when a health care provider or a patient has an exposure to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV or hepatitis B.

History Note: Authority G.S. 130A-144; 130A-145; Eff. October 1, 1992; Amended Eff. December 1, 2003; July 1, 1994; January 4, 1994.

10A NCAC 41A .0207: HIV AND HEPATITIS B INFECTED HEALTH CARE WORKERS

(a) The following definitions shall apply throughout this Rule:

- (1) "Surgical or obstetrical procedures" means vaginal deliveries or surgical entry into tissues, cavities, or organs. The term does not include phlebotomy; administration of intramuscular, intradermal, or subcutaneous injections; needle biopsies; needle aspirations; lumbar punctures; angiographic procedures; endoscopic and bronchoscopic procedures; or placing or maintaining peripheral or central intravascular lines.
- (2) "Dental procedure" means any dental procedure involving manipulation, cutting, or removal of oral or perioral tissues, including tooth structure during which bleeding occurs or the potential for bleeding exists. The term does not include the brushing of teeth.

(b) All health care workers who perform surgical or obstetrical procedures or dental procedures and who know themselves to be infected with HIV or hepatitis B shall notify the State Health Director. Health care workers who assist in these procedures in a manner that may result in exposure of patients to their blood and who know themselves to be infected with HIV or hepatitis B shall also notify the State Health Director. The notification shall be

made in writing to the Chief, Communicable Disease Control Branch, 1902 Mail Service Center, Raleigh, NC 27699-1902..

(c) The State Health Director shall investigate the practice of any infected health care worker and the risk of transmission to patients. The investigation may include review of medical and work records and consultation with health care professionals who may have information necessary to evaluate the clinical condition or practice of the infected health care worker. The attending physician of the infected health care worker shall be consulted. The State Health Director shall protect the confidentiality of the infected health care worker and may disclose the worker's infection status only when essential to the conduct of the investigation or periodic reviews pursuant to Paragraph (h) of this Rule. When the health care worker's infection status is disclosed, the State Health Director shall give instructions regarding the requirement for protecting confidentiality.

(d) If the State Health Director determines that there may be a significant risk of transmission of HIV or hepatitis B to patients, the State Health Director shall appoint an expert panel to evaluate the risk of transmission to patients, and review the practice, skills, and clinical condition of the infected health care worker, as well as the nature of the surgical or obstetrical procedures or dental procedures performed and operative and infection control techniques used. Each expert panel shall include an infectious disease specialist, an infection control expert, a person who practices the same occupational specialty as the infected health care worker and, if the health care worker is a licensed professional, a representative of the appropriate licensure board. The panel may include other experts. The State Health Director shall consider for appointment recommendations from health care organizations and local societies of health care professionals.

(e) The expert panel shall review information collected by the State Health Director and may request that the State Health Director obtain additional information as needed. The State Health Director shall not reveal to the panel the identity of the infected health care worker. The infected health care worker and the health care worker's attending physician shall be given an opportunity to present information to the panel. The panel shall make recommendations to the State Health Director that address the following:

- (1) Restrictions that are necessary to prevent transmission from the infected health care worker to patients;
- (2) Identification of patients that have been exposed to a significant risk of transmission of HIV or hepatitis B; and
- (3) Periodic review of the clinical condition and practice of the infected health care worker.

(f) If, prior to receipt of the recommendations of the expert panel, the State Health Director determines that immediate practice restrictions are necessary to prevent an imminent threat to the public health, the State Health Director shall issue an isolation order pursuant to G.S. 130A-145. The isolation order shall require cessation or modification of some or all surgical or obstetrical procedures or dental procedures to the extent necessary to prevent an imminent threat to the public health. This isolation order shall remain in effect until an isolation order is issued pursuant to Paragraph (g) of this Rule or until the State Health Director determines the imminent threat to the public health no longer exists.

(g) After consideration of the recommendations of the expert panel, the State Health Director shall issue an isolation order pursuant to G.S. 130A-145. The isolation order shall require any health care worker who is allowed to continue performing surgical or obstetrical procedures or dental procedures to, within a time period specified by the State Health Director, successfully complete a course in infection control procedures approved by the Department of Health and Human Services, General Communicable Disease Control Branch, in accordance with 10A NCAC 41A .0206(e). The isolation order shall require practice restrictions, such as cessation or modification of some or all surgical or obstetrical procedures or dental procedures, to the extent necessary to prevent a significant risk of transmission of HIV or hepatitis B to patients. The isolation order shall prohibit the performance of procedures that cannot be modified to avoid a significant risk of transmission. If the State Health Director determines that there has been a significant risk of transmission of HIV or hepatitis B to a patient, the State Health Director shall notify the patient or assist the health care worker to notify the patient.

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

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

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

*History Note: Authority G.S. 130A-144; 130A-145;
Eff. October 1, 1992; Amended Eff. April 1, 2003.*

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

January 19-21, 2011

ATTACHMENT “E”

Writing of prescriptions

It is the position of the North Carolina Medical Board that prescriptions should be written in ink or indelible pencil or typewritten or electronically printed and should be signed by the practitioner at the time of issuance. Quantities should be indicated in both numbers AND words, e.g., 30 (thirty). Such prescriptions must not be written on pre-signed prescription blanks.

Each prescription for a DEA controlled substance (2, 2N, 3, 3N, 4, and 5) should be written on a separate prescription blank. Multiple medications may appear on a single prescription blank only when none are DEA-controlled.

No prescriptions should be issued for a patient in the absence of a documented physician-patient relationship.

No prescription should be issued by a practitioner for his or her personal use. (See Position Statement entitled “Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist.”)

The practice of pre-signing prescriptions is unacceptable to the Board.

It is the responsibility of those who prescribe controlled substances to fully comply with applicable federal and state laws and regulations. Links to these laws and regulations may be found on the Board’s Web site (www.ncmedboard.org).

(Adopted May 1991, September 1992) (Amended May 1996; March 2002; July 2002)
(Reviewed March 2005)

North Carolina Medical Board
Special Committee on Practice Drift
Public Meeting Wednesday, October 13, 2010
Executive Summary

Attendees: Committee members: Thomas Hill, MD, Chair; Karen Gerancher, MD; Thelma Lennon. Other Board members: Donald Jablonski, DO; Janice Huff, MD. Staff: Scott Kirby, MD; Christina Apperson; Nancy Hemphill; Maureen Bedell. Guests: Keith Neff and Julie Brightwell (The Doctors Company); Charles Bregier, Jr., MD (ER physician); Gerald Aronoff, MD (pain physician); Steve Herring, MD (cosmetic surgeon); Steve Keene and Amy Whited (NCMS); Sheila Elliot and Karen Still (MAG Mutual Insurance Company); Gregory Griggs (ED of the NCAFP); Brian Forrest, MD (family practice); Beverly Goode Kanawati, DO and Bill Kanawati (family practice); Sharon Mussellman (Medical Mutual Insurance Company); Rob Clark, MD (dermatology); Alan Skipper (NCMS specialty boards); John Fagg, MD (cosmetic surgery); John Foreman, MD (pediatric nephrology); Charles Willson, MD (pediatrics/ECU GME).

Practice drift (which differs from practice evolution) occurs primarily for economic reasons, as physicians seek new revenue sources while underestimating the inherent risks and additional training needed to successfully perform procedures for which they did not receive formal education. Industry also drives physicians into new lucrative areas. Other factors: necessity because of patients' limited access to specialists, whether geographic or monetary.

Practice drift occurs primarily outside of hospital settings or other peer review facilities, since hospitals have credentialing procedures which vet physicians' qualifications to perform certain procedures. Drift also occurs after a physician has been covered by professional liability insurance, because the liability carriers' underwriters also serve as a check on a physician's scope of practice. A related problem is inadequate supervision of allied health providers performing procedures into which the supervising physician may not be adequately trained. Sometimes drift can be positive: i.e., bringing retinal scans to the primary care setting so diabetic patients' eye care needs can be met.

Areas in which drift is prevalent:

Cosmetic procedures (Botox, liposuction, laser hair removal)
Pain management
Moh's surgery
Mental health (both for adults, and children being treated with off-label adult meds)
Hair restoration
Weight loss
Sleep issues
Urgent care
Hormone replacement therapy
Complex patients who are seen initially in tertiary centers and then must be followed by generalists in home community
Special situations where a patient or patient's family has developed a strong connection to a particular physician, such as pediatrician continuing to treat a mentally handicapped adult

Patient safety issues: inadequate knowledge of treating physician. Missed diagnoses; over testing or overexposure to X rays for follow up care; insurance companies may refuse to pay for duplicative testing.

Whose responsibility: mostly on the individual physician to consider whether practice is in the best interest of the patient, and whether the procedure can be done safely. Health and professional liability insurers also have a role to play.

Resource: Use of telemedicine to provide expertise to physicians in rural areas.

Board's role: create Position Statement that provides guidance to physicians. Allow practice evolution. Allow some leeway (look to Position Statement on Supervision of Other License Health Care Practitioners). Consider relying on objective sources which evaluate the validity and rigor of training (ACGME, AAAHC, etc.) if/when Board investigates a physician and reviews his/her CME resume.

PHYSICIAN SCOPE OF PRACTICE

This Position Statement is intended to guide physicians who undertake to perform new procedures, use new technologies, or migrate into areas of practice for which they have not received formal graduate medical education. The Board recognizes that medicine is a dynamic field that, along with individual practices, continues to evolve. Economic pressures, business opportunities, lifestyle considerations, and access to care are all reasons that physicians move into new areas of practice. However, patient harm can occur when physicians practicing outside areas in which they were trained are unable to meet accepted and prevailing standards of care in the new practice area.

The informed, prudent care of patients begins with adequate training and the selection of appropriate patients. Follow up care and the ability to address complications is paramount. Physicians intending to expand their practice to an area outside of their graduate medical education should ensure that they have acquired the appropriate level of education and training.

It is the Board's position that all physicians, irrespective of their training, will be held to the standard of acceptable and prevailing medical practice as set forth in N.C. Gen. Stat. § 90-14(a)(6).^{*} It also may be prudent for physicians to confirm that their liability insurance provides coverage for the procedures they intend to perform.

^{*} In some instances, the Board may have provided relevant guidance to particular practice areas. See for example the Board's position statements on Laser Surgery, Office-Based Procedures, Care of the Patient Undergoing Surgery or Other Invasive Procedure, and Advertising and Publicity.
