MINUTES

North Carolina Medical Board

May 16-18, 2007

1203 Front Street
Raleigh, North Carolina

Minutes of the Open Sessions of the North Carolina Medical Board Meeting May 16-18, 2007.

The May 16-18, 2007, meeting of the North Carolina Medical Board was held at the Board's Office, 1203 Front Street, Raleigh, NC 27609. The meeting was called to order at 8:05 a.m., Wednesday, May 16, 2007, by H. Arthur McCulloch, MD President (May 16 and 17 only). Board members in attendance were: Janelle A. Rhyne, MD, President Elect (May 16 and 17 only); George L. Saunders, III, MD, Secretary; Ralph C. Loomis, MD, Treasurer; Donald E. Jablonski, DO; John B. Lewis, Jr., JD; Robert C. Moffatt, MD, Michael E. Norins, MD; Peggy R. Robinson, PA-C; and Sarvesh Sathiraju, MD. Absent were E. K. Fretwell, PhD; and Andrea Bazan-Manson.

Staff members present were: R. David Henderson, JD, Executive Director; Nancy Hemphill, JD, Special Projects Coordinator; Thomas W. Mansfield, JD, Legal Department Director; Brian Blankenship, Board Attorney; Marcus Jimison, JD, Board Attorney; Katherine Carpenter, JD, Board Attorney; Todd Brosius, JD, Board Attorney; Ms. Wanda Long, Legal Assistant; Ms. Lynne Edwards, Legal Assistant; Ms. Cindy Harrison, Legal Assistant; Mr. Curtis Ellis, Investigative Department Director; Don R. Pittman, Investigator/Compliance Coordinator; Mr. Mike Wilson, Investigator; Mrs. Therese Dembroski, Investigator; Mr. Loy C. Ingold, Investigator, Mr. Bruce B. Jarvis, Investigator; Mr. Robert Ayala, Investigator; Mr. Richard Sims, Investigator; Mr. David Van Parker, Investigator; Mr. Vernon Leroy Allen, Investigator; Mr. David Allen, Investigator; Ms. Jenny Olmstead, Senior Investigative Coordinator; Ms. Barbara Rodrigues, Investigative Coordinator; Mr. Dale Breaden, Director of Public Affairs; Ms. Dena Konkel, Assistant Director, Public Affairs; Mrs. Joy D. Cooke, Licensing Director; Ms. Michelle Allen, Licensing Supervisor; Ms. Amy Ingram, Licensing Assistant; Ms. Ravonda James, Licensing Assistant; Ms. Lori King, Physician Extender Coordinator; Ms. Quanta Williams, Physician Extender Coordinator; Michael Sheppa, MD, Medical Director; Scott Kirby, MD, Assistant Medical Director; Ms. Judie Clark, Complaint Department Director; Mrs. Sharon Squibb-Denslow, Complaint Department Assistant; Ms. Sherry Hyder, Complaint Summary Coordinator; Ms. Carol Puryear, Malpractice/Medical Examiner Coordinator; Mr. Hari Gupta, Operations Department Director; Ms. Patricia Paulson, Registration Coordinator; Mrs. Janice Fowler, Operations Assistant; Mr. Peter Celentano, Comptroller; Ms. Mary Mazzetti, Receptionist; Ms. Barbara Gartside, Operations Assistant/Licensing Assistant; Mr. Donald Smelcer, Technology Department Director; Ms. Dawn LaSure, Human Resources Director; and Mr. Jeffery Denton, Executive Assistant/Verification Coordinator.

MISCELLANEOUS

Presidential Remarks

Dr. McCulloch commenced the meeting by reading from Governor Easley's Executive Order No. 1, the "ethics awareness and conflict of interest reminder." No conflicts were reported.

Dr. McCulloch noted that Dr. Fretwell had announced his intentions to resign effective Friday, May 18, 2007, due to health reasons.

Federation of State Medical Boards' Annual Meeting, May 3-5, 2007 (San Francisco)

Dr. McCulloch made the following announcements:

- Dr. Sathiraju was elected to a one-year term on the Nominating Committee.
- Dr Loomis was appointed to the Bylaws Committee.
- Mr. Ellis received the Ronald K. Williamson Memorial Award for Board Investigators.
- Mr. Henderson awarded the Medical Board Executive Certification.

Dr. Sathiraju made the following announcements regarding actions taken by the Federation Board of Directors on resolutions submitted by member boards:

- Did not adopt Resolution 07-1, submitted by the Oregon Board of Medical Examiners, requesting the House of Delegates amend its governing statutes to allow it, by unanimous consent of the delegates assembled, to accept for consideration any resolution submitted to the FSMB after the published deadline for such submission.
- Adopted Resolution 07-2, submitted by the Iowa Board of Medical Examiners, requesting the FSMB to develop a common definition for telemedicine to recommend to the FSMB House of Delegates.
- Did not adopt Resolution 07-3, submitted by the Nebraska Board of Medicine and Surgery, requesting the FSMB recommend the usage of the term "Board Certified" only when the physician has met the standards set by the American Board of Medical Specialties (ABMS) and its member boards for certification in that specialty, as well as the specialty exams of the American Osteopathic Association (AOA).
- Referred Resolution 07-4, submitted by the Minnesota Board of Medical Practice, to the FSMB Board of Directors for further study and report back to the House of Delegates in 2008. Resolution 07-4 requested the FSMB create a task force to define what is an adequate copy of a "complete medical record," and provide guidance for uniform content, form and format for such a record.
- Adopted a substitute resolution in lieu of Resolution 07-5, which was submitted by the Virginia Board of Medicine, requesting the FSMB develop methods and/or modules of information to be used to educate medical students, residents and practicing physicians regarding the identification of substance use disorders, intervention and the proper prescribing of controlled substances.

Robin N. Hunter Buskey, PA-C updated the Board regarding the concurrent meeting of the Federation Board of Directors.

Physician Assessment and Clinical Education Program (PACE)

Dr. Sheppa, Mr. Henderson and Mr. Mansfield visited PACE in San Diego, California on March 30, 2007.

Dr. Sheppa gave a brief summarized presentation of PACE followed by a comparison to CPEP. One difference is that PACE staff and their consultant pool are pulled from University of California at San Diego. Both are multiphase programs that have similar assessment programs. These provide health assessment of participants, incorporating information from referring boards, information from the participant's practice, chart review, and, oral and written testing. PACE may provide a slightly more comprehensive approach. Whether it is of significantly more benefit is uncertain. Phase II programs differ: CPEP outlines a structured learning and/or supervised retraining program utilizing participant identified mentors and is on site at the participant's practice. It includes CME, audits, reminders, individual study, and follow-up. PACE provides specialty specific integration into UCSD Medical Center fellowships or residencies with creation of remediation programs for participants to take back to their practice site, and then a 6-month follow-up. For a licensee with fundamental needs,

PACE is probably better, for a licensee who has fundamentals in place but needs better structured learning, CPEP may be acceptable.

Consumer Access to Physician Information (CAPI) Task Force Report

Dr. Norins, Chair, CAPI Task Force, recapped the task force's work and composition. He stated that in the interests of further discussion, the Medical Board adopted the recommendations only in principal in January 2007. He would like to see the Board now adopt the content as detailed below. Thus far, there have been no objections raised by other organizations like the North Carolina Medical Society.

One Board Member suggested we only post those malpractice cases where the care provided was below standards to provide the most reliable information and make it palatable to the rest of the medical community. A lengthy discussion of pros and cons ensued.

Motion: A motion passed to adopt the following content and details with the exception that PLIP information will be implemented by rule.

CAPI TASK FORCE RECOMMENDATIONS

COMPONENT	COMMENT
Demographic Information	**Information reported by the physician on their initial license application.**
Licensee Name	Changes require a legal document.
Gender	Changes require a legal document.
Business Address/Practice Site/Business Phone Number	Changes may be made by written request or on annual registration.
Birth Date	
Medical Education	**Information reported by the physician on their initial license application.**
Medical School	
Medical School Location	(City, State, Country)
Year of Graduation	
Approved Postgraduate Training	Only American Osteopathic Association (AOA), Accreditation Council of Graduate Medical Education (ACGME) and Royal College of Physicians and Surgeons of Canada (RCPSC) approved programs. Only fellowships approved by an ABMS constituent Board may be listed.
License and Certification Information	**Information taken from the Medical Board's data base, except Type of Practice and Board Certification. Board Certification comes from the initial license application or a renewal registration. Type of Practice is submitted by the physician.**
License Status	
License Number	(Current, not history.)
License Type	
Original License Date	

COMPONENT	COMMENT
License Renewal Date (Annual Registration)	
Type of Practice	Physicians will indicate their "area of practice." In addition, physicians will be allowed to insert a link to their practice website, if available. A disclaimer will inform consumers that the information was received from the physician and is not attested to by the Medical Board.
Board Certification	Only board certifications from a member board of the American Board of Medical Specialties (ABMS), American Osteopathic Association – Bureau of Osteopathic Specialists or Royal College of Physicians and Surgeons in Canada (RCPSC) will be included. Subspecialties board certification from the above member boards may also be listed.
Hospital Affiliation	(Collected via the annual registration questionnaire.)
Criminal Convictions	**Reported from the court having jurisdiction over the case or from the physician.**
Criminal Convictions	All criminal convictions for felonies. A person shall be deemed convicted of a felony if entering a plea of guilty or found or adjudged guilty by a court of competent jurisdiction, or having been convicted by the entry of a plea of nolo contendere. In the last ten years – all convictions for misdemeanors involving offenses against the person, offenses of moral turpitude, offenses involving the use of drugs or alcohol, and violations of public health and safety codes. A person shall be deemed to be convicted of a misdemeanor if pleading guilty, found guilty by a court of competent jurisdiction or entering a plea of nolo contendere.
Medical Malpractice	**This information is reported to the Medical Board by insurance companies, the National Practitioner Data Bank (NPDB) or by the physician on his or her license application and subsequent annual registrations.**
Medical Malpractice	All professional liability insurance payments (PLIPs) for the past ten years will be reported. For physicians practicing less than ten years, the data covers their total years of practice. Dollar amounts of awards, judgment and settlements will not be included for PLIPs. Physicians will have the opportunity to post a brief explanation regarding the PLIP in question. It will be considered unprofessional conduct to misconstrue the facts of the case. Information will also be provided to include: number of NC

COMPONENT	COMMENT
	physicians reporting this specialty, number of physician in this specialty who made medical malpractice payments within the past ten years, and total number of medical malpractice payments made by physicians within this specialty within the past ten years. An explanation on the website will include the following, or a similar, statement: "The Medical Board reviews all professional liability insurance payments (PLIPs) oftentimes requesting additional information, reviewing charts and sending for expert review."
Public Actions	**Taken from the Medical Board database, reported to the Board from other entities, or by the physician on his or her license application and subsequent annual registrations.**
Medical Board Actions	
Actions by Other State Medical Boards	
Disciplinary Actions by Hospitals	Revocations and suspensions (acknowledge exception for medical record suspensions).
Medicare, Medicaid, FDA and DEA	

MINUTE APPROVAL

Motion: A motion passed that the April 18-19, 2007, Board Minutes are approved as presented.

BEST PRACTICES AD HOC COMMITTEE REPORT

George Saunders, MD, Chair; Michael Norins, MD; EK Fretwell, PhD; Robert Moffatt, MD; Ralph Loomis, MD; Janelle Rhyne, MD; Donald Jablonski, DO

The Best Practice Ad Hoc Committee of the North Carolina Medical Board was called to order at 2:00 p.m., Thursday, May 17, 2007, at the office of the Board. Members present were: George Saunders, MD, Chair; Michael Norins, MD; Robert Moffatt; MD; Ralph Loomis, MD; Janelle Rhyne, MD; E. K. Fretwell, PhD (via telephone conference) and Donald Jablonski, DO. Also attending were: Al Walsh, Past Board Member (via telephone conference); David Henderson, JD, Executive Director (Staff); Thomas Mansfield, JD, Legal Director; Nancy Hemphill, Special Projects Coordinator; and Jeffery Denton, Recorder (Staff).

The April 2007 Committee Meeting Minutes were accepted as distributed.

Topics were discussed as follows:

Topic A: What is the function of the Board and where will it be in 5 to 10 to 15 years from now? (Saunders, Jablonski, Rhyne, Norins)

(1) Data Analysis for past three years – Work with Sheps Center and have done in the next six months. Look for trends. Then publish in *Forum* and on the website. Define what the issues are.
- Why are licenses denied?
- Identify major problem areas.
- How to track consistency
- Discipline for drugs, boundary violations, communications, etc.

Status: Due to Sheps involvement with gathering malpractice payments, this item will be tabled till further notice.

(2) Create list of best practices for staff and Board.
Status: Drs. Norins, Loomis and Saunders are working on this item.

(3) Appoint subcommittee to study communication issues:
- Educate the public about reasonable expectations,
- educate licensees about communication, and look into development of a physician communication course, and
- promote public relations.

Discussion: It was noted that Johns Hopkins University has such a course for physicians. They did a presentation at the Federation Annual Meeting in Boston. One member pointed out the cost of one of these courses is $7,000-10,000 plus a week out of work. Another member stated that this is more of a psychological barrier than a true barrier to continue to practice medicine in North Carolina (a small price to pay).
Status: (1) A resolution will drafted by Dr. Saunders for presentations to the Federation of State Medical Boards asking for support specifically with physician communications.
(2) This topic will be folded into the Reentry Task Force which is working with AHEC's and is a good remediation topic. They will work to develop this in North Carolina medical training institutions.

(4) Look at complaints and publish the quality of those complaints. Share this information with the medical school administrators, institutions, medical societies, etc. Share problems with others.
Status: Mr. Henderson will get this information from Mr. Gupta and Ms. Clark for presentation at the July committee meeting.

(5) Board needs to expand contact and interactive base. Reach out to other organizations, such as the Old North State Medical Society, the NC Osteopathic Medical Association, Institute of Medicine, and Carolinas Center of Clinical Excellence.
Consider appointing specific liaisons from key outside organizations to facilitate communication and cooperation with the Medical Board.
Status: All committee members are to prepare a list of key individuals in key organizations and bring for compilation at the July committee meeting.

<u>Topic B:</u> Hearings – is there a better way? (Rhyne, Loomis (& Legal Staff))

(1) Presiding Officer training for all Board Members.
Status: Mr. Mansfield will do more research on the feasibility of hiring professional trainers to do arbitrator-type training. He will also spearhead finding more resources. Will need 90 days to set up training.
Update: Work in progress.

(2) Put Bench Book on the Board Book CD and distribute hard copy to all Board Members.

Status: Mr. Henderson reported that the Bench Book is about 90% done. He will shoot to have it on the Board Book in May. He would prefer to have some discussion about it prior to putting it on the Board Book. Dr. Moffatt suggests having this finished before the presiding officer training.

Update: Drs. Loomis, Rhyne and Saunders have the current version for review. They will complete their reviews and give input to Mr. Henderson for compilation and presentation at the July Committee Meeting. A copy will be provided to Dr. Moffatt for review.

(3) Pre-presentation of briefs.

Status: Mr. Mansfield stated it may be possible to do the pre hearing stipulations sufficiently in advance that they could be included on the Board Book for the meetings the months that we do hearings.

A discussion ensued regarding whether the Board members should receive some or all of the documentary evidence prior to hearings so that they might review it in advance in order to make hearings go more quickly. Dr. Norins stated that in the normal process the jury is not given all the evidence in advance. Mr. Mansfield discussed how voluminous the documentary evidence is in some hearings. Dr. Saunders discussed the possibility of receiving a memorandum or some other shorter summary of the evidence along with the pre hearing stipulation.

Mr. Mansfield believes the presiding officer training is key to all of this. He is happy to put the pre hearing stipulation on the Board Book. He would like to revisit this issue in six months (post presiding officer training).

Update: Mr. Mansfield stated he had discussed this with the entire Legal Department. They liked providing a briefing of the case vs. the pre hearing statement. This would be more of a summary. He looks forward to doing this in either August or October.

(4) Panel Hearings – consideration of legal assistant to the Presiding Officer, consider professional judge as Hearing Officer.

Status: Mr. Mansfield recommends waiting on this idea. He will consider the possibility of a lawyer from the AG's office. The next level would be to bring in an ALJ for that function.

(5) Continue using Administrative Law Judge in those non-medicine cases (billing fraud, boundary violations, etc.).

Status: Reaffirmed the intention to use ALJ's when not about technical medical questions.

(6) Set criteria in which cases will still be considered at a Full Board hearing vs. a panel hearing.

Status: Mr. Mansfield stated that longer and more complex cases are ideal for a panel.

Cases for a Panel Hearing:

- Predicted for three hours or more
- Long and complex
- Generally not a summary suspension
- Generally not a license denial
- When hearing is to occur outside of Raleigh
- When there is not a quorum

Cases for a Full Board Hearing:

- Summary Suspension has occurred
- License denial hearing
- Shorter, less than three hours predicted
- Consent Order approvals
- When final decision is needed sooner due to patient safety
- When the hearing is otherwise "special"

Update: Above criteria affirmed.

Topic C: Proper division of responsibility between Board and staff. (Norins, Loomis)

(1) Appoint subcommittee to study empowerment of staff. This should be a priority. . Set specific protocols for staff under specific conditions such that staff can be empowered and yet the Board feels it has sufficient oversight that it is confident that the Board's wishes are being carried out. Appoint a subcommittee to look into and bring back to Board (Saunders and Moffatt volunteer to be on subcommittee). [As **Dr. Norins** so eloquently articulated the dynamic tension of this process, I would like to see him on this committee as well–GS]

(2) Licensing Committee to study the viability of using information, such as medical school completion, information already verified by another state where the applicant holds a license.

Status: Referred to Licensing Committee (March 2007)

Update: From Licensing Committee Report: It has been determined that this is not a viable option except in extreme circumstances. It is this Board's duty to primary source verify medical education of applicants.

(3) Licensing Committee to study a breakdown of the licensing process: where the most time is spent? What delays are there in the process? How could it be streamlined?

Status: Referred to Licensing Committee (March 2007)

Update: From Licensing Committee Report: This process has been studied and it has been determined that no changes will be made in the process at this time.

(4) Licensing Committee to study the concept of issuing a license after a Board Member reviews the application and approves the license without waiting till the next Board Meeting.

Status: Referred to Licensing Committee (March 2007)

Update: From Licensing Committee Report: Implemented March 2007 and working well.

(5) Do an internal analysis and self study looking at all the Board's functions to decide what the Board Members will hold onto and what will be delegated to the staff.

Status: There is a general consensus that that the Board is close to having the right balance. Full Board functions vs. committee functions will be reviewed on a continuing basis.

(6) Outside consultation to look at Board processes in relationship to how all operations can be streamlined, what work can be reasonably to staff, what staff tasks can be shortened/eliminated, what practices we can learn from other boards.

Discussion: Some Board Members have had bad experiences with outside consultants. Dr. Saunders would like to see how other boards are doing and get input from other boards.

Status: Mr. Henderson will send the Federation's Internal Audit Tool to Dr. Loomis and Dr. Norins to look at and consider at their next meeting.

Update: Copies of the Federation of State Medical Boards' Assessment Guide was

provided to Drs. Norins, Looms and Saunders. In the short time they had to review it Dr. Norins did point out several specific items that are mentioned in the guide that the North Carolina Medical Board does not do. Several discussions ensued and there was some question whether the Board should or should not be doing some of these things. **Action:** Mr. Henderson, Dr. Loomis and Dr. Norins will prepare a detailed recommendation for the Committee for presentation at the July Committee Meeting.

Full Board Motion: A motion passed that the following item is referred to the Executive Committee for a standard to be set – Board Members should attend a minimum of 75% of formal Board meetings per year.

Topic D: Public Members (Fretwell, Walsh)

Dr. Fretwell and Mr. Walsh provided the following:

Public Members of the Medical Board:

Must reside in the State and be persons of integrity and good reputation who have resided in the State for at least two years immediately preceding their appointment.

Must be citizens of the United States who have reached the age of majority as defined in the State statutes.

Should be drawn from different regions of the State, and must be selected without regard to sex, race, national or ethnic origin, creed, religion or lack thereof, or age above majority.

Should have proven leadership qualities demonstrated in experience acquired in employment or in civic or professional organizations. The member should have good judgment, the ability to communicate in small and large group situations, maintain appropriate demeanor under high pressure conditions, and be an effective team player.

Should be willing to commit the time and effort needed, both in board meetings, and in tasks assigned in committee activities between meetings, with fairness, objectivity, honesty and humor.

Should work toward mutual respect and good working relations with other Board Members. It is also incumbent on the public member to make other Board Members aware of the concerns of the people we represent.

Must always be aware of consumer advocacy role which is theirs. Consumer protection is the basis of regulation. Decisions related to purely clinical issues requiring the expertise of trained physicians should be guided by the physician members. Decisions related to all other issues – either in the same cases or other cases, without exception, should be shared equally by all members. Together they balance consumer interest with safe, competent service.

Should understand the confidentiality, open meeting requirements and other issues critical to assuring the integrity of the regulatory process.

May never been authorized to practice a health art, and shall not have had a substantial personal, business, professional, or financial connection with a health care or medical

education facility, except as patients or potential patients, for at least three years preceding their appointment.

When participating in rule making, or in the creation or revision of Board policies, procedures, or position statements, public member input should concentrate on whether these regulations address the public expectations for regulating medical practice.

Since public members represent the consumer perspective, contributing to Board decisions with the consumer interest in mind provides balance to a board.

May not be a registered lobbyist in any way involved in health care issues or related groups/organizations.

May not be an officer, board member, or employee of a statewide or national organization established for the purpose of advocating the interests of or conducting peer review of health care practitioners.

Any individual, organization, or group may suggest a potential nominee to the governor for consideration for appointment.

Mr. Walsh added that it appears that the consideration to increase the number of public members on the Board has left the agenda. He would like to see this taken back up by the Board, increasing the public members by three for a total of 15 Board Members.

Motion: A motion passed to accept the above Public Member structure report and also take into consideration the recommendation to expand the number of Public Members on the Medical Board.

Full Board Discussion: Judge Lewis opined that the Board is currently constituted at a workable size that allows for a quorum to be present without great strain. He continued that three additional public members without medical backgrounds could become a liability. Drs Norins, Loomis and Jablonski concurred in Judge Lewis' views.

Topic E: Board Officers and Composition (Moffatt, Loomis, Fretwell)

Appoint committee to study role of officers, Executive Committee, nomination process, also:

- Study internal governance of Board from top to bottom.
- Study structure, makeup and function of the Executive Committee.
- Look at officer structure of Executive Committee (chairman vs. president, etc.).
- Look at the current automatic accession system.
- Consider separate nominating and executive committees. Nomination input is desired from the entire body.
- Make current Executive Committee activities/functions both transparent and *inclusive*.

Update: Due to time restrictions and input from the Selection Process Ad Hoc Committee this item is tabled till the July Committee Meeting.

Topic F: Public Image – does the Board have a favorable public image, do we need to work on it, and what do we need to work on? (Saunders, Norins, Jablonski)

(1) Concentrate on having a positive influence on our licensees.
Status: Dr. Jablonski stated that the *Forum* is a very formal, austere journal. It is very threatening with articles that say "don't do this, don't do that." Why not us a positive attitude? For example, Dr.'s consults in hallways – the do's and don'ts (do see me in the office; do send for a pain evaluation/referral, etc). Turn the articles around and say what was done right, using a favorable/positive approach. Maybe a cartoon using "Dr. Right." He liked the previous idea of having a physician that has been disciplined/sanctioned write an article for the *Forum*, even if done anonymously.

Mr. Henderson encouraged Dr. Jablonski to sit down with the *Forum's* Editor, Dale Breaden, and convey his thoughts. Mr. Henderson will also sit down with Mr. Breaden. He thinks the whole issue of changing our perception of being an organization lying in wait to catch people should be shifted towards more proactive and educational.

Dr. Rhyne agrees. The Board has a list of ten things that will get a physician into trouble with the Board. There should be a list of things that will keep you out of trouble…….create positives.

Dr. Saunders encouraged all Board Members to write more (positive) articles for the *Forum*.

(2) Continue Board presentations at hospitals.

(3) Work with Public Affairs and look for other venues for presentations by Board Members (medical societies, etc).

(4) Revise mission statement based on Retreat discussion (competency, quality, etc).

(5) Prominently display the new mission statement in the lobby by the waterfall.

Discussion: Several members commented on recent articles written and in the works, presentations given and planned, etc.
Action: Mr. Breaden is tasked to write a Forum article regarding the numerous Federation appointments and elections that North Carolina currently holds within the Federation.

The next regular meeting of the Best Practice Ad Hoc Committee is tentatively set for Wednesday, July 18, 2007.

Motion: A motion passed to approve the Best Practices Ad Hoc Committee Report.

SELECTION PROCESS AD HOC COMMITTEE REPORT

John Lewis, JD, Chair; George Saunders, MD; Donald Jablonski, DO; Robert Moffatt, MD

The Selection Process Ad Hoc Committee of the North Carolina Medical Board was called to

order at 3:00 p.m., May 17, 2007, at the office of the Board. Members present were: John Lewis, JD, Chair; George Saunders, MD; Robert Moffatt; MD; and Donald Jablonski, DO. Also attending were: Nancy Hemphill, JD, Special Projects Coordinator (Staff), Thomas Mansfield, JD, Legal Director (Staff) and Wanda Long, Recorder (Staff).

A motion was made and passed to close the session pursuant to NCGS 90-8; 90-14, 90-16, 90-21.22 and 143-318(11) (a) in order to discuss pending litigation relevant to the Board member selection process.

Thom Mansfield reported to the Committee on the status of bills pending in the General Assembly related to the Board Member selection process.

A motion passed to return to open session.

The next meeting of the Committee will be scheduled during the June 2007 meeting of the NC Medical Board.

BOARD ACTION: Accept report as information.

ATTORNEY'S REPORT

A motion passed to close the session to prevent the disclosure of information that is confidential pursuant to sections 90-8, 90-14, 90-16, 90-21.22 and 143-318.11(a) of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and to preserve attorney/client privilege.

Written reports on 142 cases were presented for the Board's review. The specifics of this report are not included as these actions are not public information.

A motion passed to return to open session.

PUBLIC ACTIONS

Adkins, Paula Clark MD
Consent Order executed 4/18/07

Alford, Glen Ernest MD
Notice of Charges and Allegations; Notice of Hearing executed 4/16/07

Berger, Jeffrey Allen MD
Order Terminating Consent Order executed 4/19/07

Booker, James Judson MD
Public Letter of Concern executed 05/09/2007

Boyd, William Scott PA
Consent Order executed 03/22/2007

Brantley, Julian Chisolm MD
Consent and Waiver and Public Letter of Concern executed 4/5/07

Breiter, Katherine Lay
Re-Entry Agreement executed 05/16/2007

Councell, Richard Bruce MD
Public Letter of Concern executed 3/28/07

Cross, Harry Giles PA
Order Terminating Consent Order executed 5/10/2007

Crummie, Robert Gwinn MD
Notice of Charges and Allegations; Notice of Hearing executed 5/8/07

Dobson, Richard Carl MD
Consent Order executed 3/23/07

Fields, Jason Baker MD
Voluntary Surrender executed 4/24/07

Furr, Claudia Shawn PA
Re-Entry Agreement executed 04/05/2007

Gallucci, Richard Pat MD
Consent and Waiver and Public Letter of Concern executed 4/16/07

Greer, Gary Wayne MD
Notice of Charges and Allegations; Notice of Hearing executed 4/19/07

Grossling, Sergio Freudenburg MD
Consent Order executed 3/21/07

Haislip-Rambo, Carole Lynn, PA
Re-Entry Agreement executed 05/01/2007

Hope, Shelley-Ann Violet MD
Notice of Charges and Allegations; Notice of Hearing executed 4/20/07

Keller, Philip Arthur PA
Consent Order executed 4/18/07

Khawaja, Usman Anwar MD
Public Letter of Concern executed 03/23/2007

Lowe, James Edward MD
Notice of Charges and Allegations; Notice of Hearing executed

Mabe, Layla Myers NP
Consent Order executed 4/18/07

MacDonald, Carolyn MD
Amended Notice of Charges and Allegations; Notice of Hearing executed 04/30/2007

Martin, Michele I. MD
Notice of Charges and Allegations; Notice of Hearing executed 4/16/07

Mauskar, Anant Nilkanth MD
Notice of Charges and Allegations; Notice of Hearing executed 4/3/07

McLanahan, Gregory Allen MD
Public Letter of Concern executed 04/16/2007

Morter, Gregory Alan MD
Voluntary Surrender executed 4/5/07

Nascimento, Luiz MD
Consent Order executed 4/18/07

Oweida, Sami Joseph MD
Consent Order executed 4/5/07

Padua, Federico Pasudag MD
Notice of Charges and Allegations; Notice of Hearing executed 04/13/2007

Recine, Carl Albert MD
Public Letter of Concern executed 5/16/2007

Robinson, Lindwood Allen MD
Consent Order executed 04/30/2007

Sebhat, Berhan MD
Notice of Charges & Allegations; Notice of Hearing executed 4/20/07

Shanton, Gregory Damon PA
Order of Summary Suspension of License;
Notice of Charges and Allegations; Notice of Hearing executed 4/3/07

Shugarman, Richard Gerald MD
Public Letter of Concern executed 3/23/07

Skelton, Henry Grady MD
Notice of Charges and Allegations; Notice of Hearing executed 04/13/2007
Consent Order executed 5/17/2007

Sleeper, Arthur, MD
Notice of Charges and Allegations; Notice of Hearing executed 05/17/2007

Smith, Kathleen Jeanne MD
Notice of Charges and Allegations; Notice of Hearing executed 04/13/2007

Terry, Sandra Louise NP

Notice of Charges and Allegations; Notice of Hearing executed 04/25/2007

Thrift-Cottrell, Alesia Dawn MD
Consent Order executed 4/18/07

Tompkins, Kenneth James MD
Notice of Charges and Allegations; Notice of Hearing executed 4/3/07

Uretzky, Ira David MD
Termination Order executed 4/16/07

Washington, Clarence Joseph MD
Notice of Charges and Allegations; Notice of Hearing executed 5/1/07

Weiss, Allan Stuart MD
Public Letter of Concern executed 04/16/2007

Proposed Rules Changes for approval by Board:

21 NCAC 32B .0209 – EXAMINATION FEE
– Increase fee from $25.00 to $100.00

5/2007 BOARD ACTION: Approve rule. Proceed with filing with Rules Review Commission

21 NCAC 32B .0308 – FEE
- Increase fee from $250.00 to $350.00

5/2007 BOARD ACTION: Approve rule. Proceed with filing with Rules Review Commission

21 NCAC 32B .0213 – GRADUATE MEDICAL EDUCATION AND TRAINING LICENSURE
- To identify the correct program for approving training programs.

5/2007 BOARD ACTION: Approve rule. Proceed with filing with Rules Review Commission

21 NCAC 32B .0506 – FEE
- Increase fee from $25.00 to $100.00

5/2007 BOARD ACTION: Approve rule. Proceed with filing with Rules Review Commission

21 NCAC 32B .0507 – ECFMG CERTIFICATION
- To be consistent with 21 NCAC 32B .0302, which changed in July 2004 to require original EDFMG Certification Status report.

5/2007 BOARD ACTION: Approve rule. Proceed with filing with Rules Review Commission

21 NCAC 32R .0102 – APPRIOVED CATEGORIES OF CME

- To clarify categories that are approved for continuing medical education.

5/2007 BOARD ACTION: Approve rule. Proceed with filing with Rules Review Commission

2007 LEGISLATIVE TRACKING LIST

The following list was of pending Legislative bills was presented for the Board's information.

BILL NO	Description	Filed	Referred to Comm
H178	Require Supervision/Use of Lasers/Medicine	2/13/2007	2/14/2007
H311	Notice of Special/Emergency Mtgs	2/21/2007	2/22/2007
H442	Execution/Physician Assistance Authorized	3/1/2007	3/5/2007
H726	Amend Electrolysis Practice Act	3/14/2007	3/15/2007
H818	Amend Practice of Medicine Laws	3/14/2007	3/15/2007
H963	Elect Medical Board/Fees/Reports	3/21/2007	3/22/2007
H969	Naturopathic Physician Licensing Act	3/21/2007	3/22/2007
H1361	Increase Fees/Medical Records Copying	4/5/2007	4/9/2007
H1492	Anesthesiologist Assistants Licensure	4/16/2007	4/17/2007
H1794	Review Medical Records held By NCMB	4/18/2007	4/19/2007
S114	Execution/Physician Assistance Authorized	2/8/2007	2/12/2007
S662	Require Supervision/Use of Lasers/Medicine	3/8/2007	3/12/2007
S730	Increase Fee/Medical Records Copying	3/13/2007	3/14/2007
S864	Amend Practice of Medicine Laws	3/15/2007	3/19/2007
S1080	Naturopathic Physician Licensing Act	3/20/2007	3/22/2007
S1163	Amend Electrolysis Practice Act/Fees	3/20/2007	3/22/2007
S1210	Limitations/Med. Society Nominations	3/21/2007	3/26/2007

EXECUTIVE COMMITTEE REPORT

Arthur McCulloch, MD; Janelle Rhyne, MD; George Saunders, MD; Ralph Loomis, MD; Robert Moffatt, MD

The Executive Committee of the North Carolina Medical Board was called to order at 10:50 am, Wednesday May 16, 2007 at the offices of the Board. Members present were: Harlan A. McCulloch, MD, President; Ralph C. Loomis, MD; Robert C. Moffatt, MD; Janelle A. Rhyne, MD; and George L. Saunders, MD. Also present were R. David Henderson (Executive Director), Hari Gupta (Director of Operations), Thomas Mansfield (Director of Legal), Nancy Hemphill (Special Projects Coordinator), and Peter T. Celentano, CPA (Comptroller).

Financial Statements

Mr. Celentano, CPA, presented the March 2007 compiled financial statements. March is the fifth month of fiscal year 2007.

Mr. Celentano reviewed with the Committee our current cash position as of today and the amount on the Balance Sheet on March 31, 2007. The Statement of Cash Flows was reviewed and accepted as presented.

The March 2007 Investment Summary was reviewed and accepted as presented.

Dr. Moffatt made a motion to accept the financial statements as reported. Dr. Loomis seconded the motion and the motion was approved unanimously.

Old Business

Investment Update - BB & T: Mr. Celentano updated the Committee on the status of our new investment portfolio. The Board's CD matured on March 27, 2007. As previously directed by the Board, the staff liquidated the CD and invested those funds into an investment managed account with BB & T.

Mr. Celentano also asked the Committee to consider allowing the staff to make periodic transfers to the investment managed account when our cash position exceeds a certain level. Dr. Saunders made a motion to allow the staff the flexibility to transfer funds when the cash position exceeds the amount needed to meet monthly expenses. Dr. Loomis seconded the motion and the motion was approved unanimously.

The Committee would like to invite the Investment Management Team to the September Executive Committee Meeting to review the performance of the account.

Legislative Update: Mr. Mansfield reviewed with the Committee various bills pending in the legislature including H818 which includes possible changes to the Medical Practice Act.

Dr. McCulloch wished to recognize the excellent legislative work done by Mr. Mansfield and his staff on behalf of the Board.

Litigation Update: A motion passed to close the session to prevent the disclosure of information about pending litigation that is confidential pursuant to section 143-318.11(a) of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes.

Mr. Thomas Mansfield, Director of Legal Department, met with the Committee to discuss and advise the Committee regarding pending litigation.

A motion passed to return to open session.

New Business

Investment Policy: Mr. Celentano reviewed with the Committee a new draft of the Investment Policy. The Investment Policy of the North Carolina Medical Board was originally adopted by the Executive Committee in January 1996 and reaffirmed in January 1999 and March 2006. A copy of the draft was forwarded to BB & T which they have approved.

Several items in the current draft of the Investment Policy need to be amended including the sentence "Not more than five percent (5%) of the total reserve shall be invested in any one security." Mr. Celentano informed the Committee that he spoke with BB & T on May 16, 2007

and was informed that a single security would not comprise more than five percent (5%) of the reserve at any one time.

Dr. McCulloch made a suggestion to add language to the policy that the Investment Management Team at BB &T would reallocate the portfolio to stay in line with our 75% fixed income to 25% equity asset allocation.

The Committee also suggested adding language which would permit staff the flexibility to transfer funds into the investment account when the cash position exceeds $250,000 so long as sufficient funds remain in the checking account to meet monthly expenses.

Dr. Rhyne made a motion to accept the following Investment Policy as amended. Dr. Moffatt seconded the motion and the motion was approved unanimously.

Purpose
The purpose of this plan is to provide an understanding of the investment policy, guidelines and objectives for the management of liquid assets received and held by the North Carolina Medical Board.

Investment Objectives
The principal objective of the North Carolina Medical Board's investment program shall be to (1) maintain an adequate reserve, (2) maintain an adequate amount os short term cash to meet expenses, and (3) invest excess funds in a way that will maximize returns with minimal risk.

Amount of Reserve
The North Carolina Medical Board believes it is sound management practice to maintain a reserve equal to at least one year's operating budget. The reserve will be invested at all times.

Short Term Cash
Short term cash shall be deposited in a FDIC insured interest bearing account in amounts sufficient to meet all expenses in a timely manner as projected by estimated cash flow projections.

The staff will make transfers to the investment managed account described below when the cash exceeds $250,000. The staff will maintain a sufficient amount of cash in the interest bearing checking account to meet monthly expenses.

Intermediate and Long Term Cash
The North Carolina Medical Board will retain independent professional investment managers to assist the Board with the investment of intermediate and long term cash. The managers will be given appropriate discretion to buy and sell securities, reporting to the Medical Board's Executive Committee on a regular basis. At least once a year, the Executive Committee will review the manager's performance, investment objectives and strategies.

The following guidelines will direct allocation of funds:

Asset Category	Percentage
Fixed Income	75%
Equity	25%

From time to time, the Executive Committee will review the asset allocation and make changes it feels are appropriate. Unless approved by the Board, not more than five percent (5%) of the total reserve shall be invested in any one security.

The Investment Management Team at BB &T will reallocate the portfolio periodically to stay in line with the prescribed fixed income / equity asset allocation.

The manager may hold funds in cash when this strategy is wise but, generally, the funds should be fully invested.

Funding of Withdrawals/Distributions
Whenever the Board has requirements and expectations for periodic withdrawals to meet expenses, the investment managers will be made aware of these requirements and will assist in employing a strategy to meet these needs.

Checking Account: Mr. Celentano explained that BB & T has agreed to change our checking account into an interest bearing account. The account was modified by BB & T on May 15, 2007 and is currently earning 3%.

Online Registration: Mr. Henderson reviewed with the Committee a possible change to our renewal process. Currently, licensees have the option to renew their registrations either online or by paper. About 90% elect to register online. The staff is proposing the Board require all licensees to register online. Mr. Henderson will submit a proposal to the Executive Committee later this year.

The meeting was adjourned at 12:05pm.

Motion: A motion passed to approve the Executive Committee report.

POLICY COMMITTEE REPORT

George Saunders, MD, Chair; Janelle Rhyne; MD; Andrea Bazan-Manson

The Policy Committee of the North Carolina Medical Board was called to order at 1:10 p.m., Wednesday, May 16, 2007, at the office of the Board. Present were: George L. Saunders, III, MD, Chair; and Janelle A. Rhyne, MD. Also attending were: Todd Brosius, JD, Board Attorney; Nancy Hemphill, Special Projects Coordinator, NCMB; Dena Konkel, Assistant Director, Public Affairs, NCMB; and Wanda Long, Recorder.

March 2007 Policy Committee Meeting Minutes
The minutes from the March 21, 2007, Policy Committee were approved.

Review of Position Statements:
RETENTION OF MEDICAL RECORDS
MEDICAL RECORD DOCUMENTATION
Background: 11/2006 - Mr. Walsh stated that review of these two position statements has been temporarily postponed. Ms. Phelps stated that there has been a serious push regarding the issue of disposition of medical records of deceased physicians. This is a joint effort with the Medical Board and the Medical Society. A task force has been convened to study this area. 11/2006 Action: Postpone review of these two position statements until the above issue is resolved.

1/17/2006 – Brian Blankenship discussed new language that would give suggestions on a retention plan for records if a doctor retires, dies, etc. Basically it would be estate planning for records. He further stated that abandonment should be dealt with through rulemaking and legislation. Dr. Rhyne stated that MDs would welcome these suggestions. Todd Brosius suggested that the Committee should consider combining the position statements in an effort to provide useful information for doctors and patients in a central place. Also, addressed by Mr. Brosius and Mr. Blankenship was the question of what a medical record should contain. Mr. Blankenship pointed out that there are many misconceptions and this should also be addressed.

3/21/2007 – Todd Brosius presented the following draft for the Committee's consideration. Dr. Rhyne reminded the Committee that some MDs organize their medical records according to specific problems and that each individual problem may be addressed by the SOAP method. Dr. Rhyne stated that we should make sure that the position statement does not preclude the records from being problem oriented instead of general. Todd Brosius explained that they made an effort to put all our medical records issues into one position statement. He indicated that the position statements now show on the website in a list. Mr. Brosius suggested that the Board may want to consider grouping its position statements in a hierarchical format on the website. Dr. Saunders recommended numbering the position statements. Dr. Rhyne recommended a search option on the Board's website. Mr. Brosius would like to present a possible change in the organization of the Board's position statements for the committee's review at the May Board meeting.

3/2007 STAFF INSTRUCTION: Dr. Saunders will work with Todd Brosius to develop a proposal for the Committee to incorporate possible restructuring of the Board's website regarding Position Statements.

5/16/2007 – Dr. Rhyne indicated that the Federation is developing a statement and suggested that the Committee should table this issue until the Federation process is completed. Ms. Phelps suggested that the Committee consider updating the Retention of Patient Records position statement to conform to current law.

Proposed Comprehensive Revision of NCMB Medical Records Position Statement:

Patient Records

Introduction

Medical considerations and continuity of care are the primary purposes for maintaining adequate patient records. A patient record consists of medical records as well as billing information or "any item, collection, or grouping of information that includes protected health information and is maintained, collected, used, or disseminated" by a physician's practice.

Because of the importance of patient records, physicians should have clear policies in place regarding disclosure of, access to, and retention of patient records. These policies should be communicated to patients preferably in writing when the physician-patient relationship is established and when the policy changes.

Medical Record Documentation

Physician should maintain accurate patient care records of history, physical findings, assessments of findings, and the plan for treatment. The Board recommends the Problem Oriented Medical Record method known as SOAP.

SOAP charting is a schematic recording of facts and information. The S refers to "subjective information" (patient history and testimony about feelings). The O refers to objective material and measurable data (height, weight, respiration rate, temperature, and all examination findings). The A is the assessment of the subjective and objective material that can be the diagnosis but is always the total impression formed by the care provided after review of all materials gathered. And finally, the P is the treatment plan presented in sufficient detail to allow another care provider to follow the plan to completion. The plan should include a follow-up schedule.

Such a chronological document:

- records pertinent facts about an individual's health and wellness;
- enables the treating care provider to plan and evaluate treatments or interventions;
- enhances communication between professionals, assuring the patient optimum continuity of care;
- assists both patient and physician to communicate to third party participants;
- allows the physician to develop an ongoing quality assurance program;
- provides a legal document to verify the delivery of care; and
- is available as a source of clinical data for research and education.

Items that should appear in the medical record as a matter of course include:

- the purpose of the patient encounter;
- the assessment of patient condition;
- the services delivered--in full detail;
- the rationale for the requirement of any support services;
- the results of therapies or treatments;
- the plan for continued care;
- whether or not informed consent was obtained; and, finally,
- that the delivered services were appropriate for the condition of the patient.

The record should be legible. When the care giver does not write legibly, notes should be dictated, transcribed, reviewed, and signed within reasonable time. Signature, date, and time should also be legible.

All therapies should be documented as to indications, method of delivery, and response of the patient. Special instructions given to other care givers or the patient should be documented, and the record should indicate who received the instructions and whether the recipient of the instructions appeared to understand them.

All drug therapies should be named, with dosage instructions and indication of refill limits. All medications a patient receives from all sources should be inventoried and listed to include the method by which the patient understands they are to be taken. Any refill prescription by phone should be recorded in full detail.

The physician needs and the patient deserves clear and complete documentation.

Access to Patient Records

A physician's policies and practices relating to patient records under their control should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient's care. Such policies and practices should conform to applicable federal and state laws governing health information.

It is the position of the North Carolina Medical Board that notes made by a physician in the course of diagnosing and treating patients are primarily for the physician's use and to promote continuity of care. Patients, however, have a substantial right of access to their patient records and a qualified right to amend their records pursuant to the HIPAA privacy regulations.

Patient records are confidential documents and should only be released when permitted by law or with proper written authorization of the patient. Physicians are responsible for safeguarding and protecting the patient record and for providing adequate security measures.

Each physician has a duty on the request of a patient or the patient's representative to release a copy of the record in a timely manner to the patient or the patient's representative, unless the physician believes that such release would cause harm to the patient or another person. This includes patient records received from other physician offices or health care facilities. A summary may be provided in lieu of providing access to or copies of medical records only if the patient agrees in advance to such a summary and to any fees imposed for its production.

Physicians may charge a reasonable fee for the preparation and/or the photocopying of patient records. To assist in avoiding misunderstandings, and for a reasonable fee, the physician should be willing to review the records with the patient at the patient's request. Patient records should not be withheld because an account is overdue or a bill is owed (including charges for copies or summaries of medical records).

Should it be the physician's policy to complete insurance or other forms for established patients, it is the position of the Board that the physician should complete those forms in a timely manner. If a form is simple, the physician should perform this task for no fee. If a form is complex, the physician may charge a reasonable fee.

To prevent misunderstandings, the physician's policies about providing copies or summaries of medical records and about completing forms should be made available in writing to patients when the physician-patient relationship begins.

Physicians should not relinquish control over their patients' patient records to third parties unless there is an enforceable agreement that includes adequate provisions to protect patient confidentiality and to ensure access to those records.

When responding to subpoenas for patient records, unless there is a court or administrative order, physicians should follow the applicable federal regulations.

Retention of Patient Records

Physicians have an obligation to retain patient records which may reasonably be of value to a patient. The following guidelines are offered to assist physicians in meeting their ethical and legal obligations:

- Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes, chemotherapy records, and immunization records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.
- If a particular record no longer needs to be kept for medical reasons, the physician should check applicable state and federal laws to see if there is a requirement that records be kept for a minimum length of time including but not limited to:
  - Medicare and Medicaid Investigations (up to 7 years);
  - HIPAA (up to 6 years);
  - Medical Malpractice (varies depending on the case but should be measured from the date of the last professional contact with the patient)—physicians should check with their medical malpractice insurer);
  - North Carolina has no statute relating specifically to the retention of medical records;
- In order to preserve confidentiality when discarding old records, all documents should be destroyed; and
- Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.

Similarly, the Medical Board recognizes the need for, and importance of, proper maintenance, retention, and disposition of medical records. Accordingly, the Board recommends that physicians prepare written policies for the secure storage, transfer and access to medical records of the physician's patients. At a minimum, the Board recommends the policies specify:

- The procedure by which the physician will notify each patient in a timely manner if the physician terminates or sells his/her practice in order to inform the patient of the future location of the patient's medical records and how the patient can access those records;
- The procedure by which a physician may dispose of unclaimed medical records after a specified period of time during which the physician has made good faith efforts to contact the patient;
- How the physician shall timely respond to requests from patients for copies of their medical records or to access to their medical records;
- In the event of the physician's death, how the deceased physician's executor, administrator, personal representative or survivor will notify patients of location of their medical records and how the patient can access those records;
- The procedure by which the deceased physician's executor, administrator, personal representative or survivor will dispose of unclaimed medical records after a specified period of time;
- How long medical records will be retained; and
- The amount the physician will charge for copies of medical records and under what circumstances the physician will charge for copies of a patient's medical record.

5/2007 ACTION: Make minor changes to Retention of Patient Records position statement to reflect changes in the law without need of publication in the Forum. A more comprehensive review will be done after the Federation has completed its process.

Initial Review of Position Statements:

END-OF-LIFE RESPONSIBILITIES AND PALLIATIVE CARE
ADVANCE DIRECTIVES AND PATIENT AUTONOMY

Background: 11/2006 - Dr. Rhyne said that she and Ms. Phelps were working with the Bar Association and the Medical Society to improve and make these documents more user friendly and practical. 11/2006 Action: Postpone review.

1/17/2007 – Dr. Rhyne reported on the progress the Medical Society Committee and the Bar Association had made regarding this issue. The Medical Society Committee has created a MOST form (Medical, Orders, Scope, Treatment), and the Estate Section of the Bar Association is working on legislation.

1/2007 STAFF INSTRUCTION: Postpone until after Dr. Rhyne and Mrs. Phelps have had an opportunity to meet regarding these issues.

5/16/2007 – Dr. Rhyne and Melanie Phelps presented the following proposed changes for End-of-Life Responsibilities and Palliative Care position statement.

North Carolina Medical Board Position Statement

END-OF-LIFE RESPONSIBILITIES AND PALLIATIVE CARE

Assuring Patients

Death is part of life. When appropriate processes have determined that the use of ~~life-sustaining~~ life prolonging measurers or invasive interventions will only prolong the dying process, it is incumbent on physicians to accept death "not as a failure, but the natural culmination of our lives."*

It is the position of the North Carolina Medical Board that patients and their families should be assured of competent, comprehensive palliative care at the end of their lives. Physicians should be knowledgeable regarding effective and compassionate pain relief, and patients and their families should be assured such relief will be provided.

Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness, through the prevention and relief of suffering by means of early identification an impeccable assessment and treatment of pain and other physical, psychosocial and spiritual problems. Palliative care:

- **provides relief from pain and other distressing symptoms;**
- **affirms life and regards dying as a normal process;**
- **intends neither to hasten nor postpone death;**
- **integrates the psychological and spiritual aspects of patient care;**
- **offers a support system to help patients live as actively as possible until death;**
- **offers a support system to help the family cope during the patient's illness and in their own bereavement;**

- uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- [may be] applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.**

~~There is no one definition of palliative care, but the Board accepts that found in the Oxford Textbook of Palliative Medicine: "The study and management of patients with active, progressive, far advanced disease for whom the prognosis is limited and the focus of care is the quality of life." This is not intended to exclude remissions and requires that the management of patients be comprehensive, embracing the efforts of medical clinicians and of those who provide psychosocial services, spiritual support, and hospice care.~~

~~A physician who provides palliative care, encompassing the full range of comfort care, should assess his or her patient's physical, psychological, and spiritual conditions. Because of the overwhelming concern of patients about pain relief, special attention should be given 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 cases, there are inherent risks associated with effective pain relief in such situations.~~

Opioid Use

The 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. (See the Board's position statement on the ~~Management of Chronic Non-Malignant Pain~~ Policy for the Use of Controlled Substances for the Treatment of Pain for an outline of what the Board expects of physicians in the management of pain.) 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.

~~*Selected Guides*~~

~~To assist physicians in meeting these responsibilities, the Board recommends *Cancer Pain Relief: With a Guide to Opioid Availability*, 2nd ed (1996), *Cancer Pain Relief and Palliative Care* (1990), *Cancer Pain Relief and Palliative Care in Children* (1999), and *Symptom Relief in Terminal Illness* (1998), (World Health Organization, Geneva); *Management of Cancer Pain* (1994), (Agency for Health Care Policy and Research, Rockville, MD); *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain*, 4th Edition (1999)(American Pain Society, Glenview, IL); *Hospice Care: A Physician's Guide* (1998) (Hospice for the Carolinas, Raleigh); and the *Oxford Textbook of Palliative Medicine* (1993) (Oxford Medical, Oxford).~~

(Adopted 10/1999)

(Amended 5/2007)

***Steven A. Schroeder, MD, President, Robert Wood Johnson Foundation.**

**** Taken from the world Health Organization definition of Palliative Care (2002): (http:www.who.int/cancer/palliative/definition/en)**

5/2007 ACTION: Publish END-OF-LIFE RESPONSIBILITIES AND PALLIATIVE CARE position statement in the Forum for comments. The ADVANCE DIRECTIVES AND PATIENT AUTONOMY position statement is current and needs no updating at this time.

Physician Mobile Cardiac Catheterization Service:

3/21/2007 – The Committee heard from Mr. Luckey Welch, CEO and President Southeastern Regional Medical Center. Mr. Welch stated that patient safety was the central issue related to its letter from December 2006 in which it wrote about its concerns of a cardiac catheterization unit being used in a separate facility and not associated with any hospital. The matter was not merely physician versus hospital. When asked, Mr. Noah Huffstetler, Attorney for Southeastern Regional Medical Center stated that there are nine such mobile capacity units in North Carolina that were grandfathered in prior to the requirement of acquiring a certificate of need. Those units can be used either in a fixed or mobile capacity. The representatives from Southeastern Regional Medical Center indicated their concern that the mobile unit is being used at a physician's office and not a facility which is equipped to handle complications that might arise out of a cardiac catherization which may include cardiac surgery or emergency response.

Dr. Saunders questioned whether this could be a small facility versus large facility or a rural versus urban issue.

Mr. Huffstetler encouraged the Committee to review the 3/8/07 letter from Gaston Memorial Hospital supporting the recommendation of Southeastern Regional Medical Center.

Mr. Linwood Jones, Attorney for the NC Hospital Association encouraged the Committee to look into quality of care for patients and a safety perspective. Mr. Jones stated that the NC Hospital Association is concerned about patient care.

3/2007 ACTION: The Committee will present information to the full Board and continue to gather information.

5/16/2007 – Todd Brosius informed the Committee that he had spoken with Troy Smith, Attorney for the Mobile Cardiac Cath lab in question. Mr. Smith offered to meet with the Committee.

5/2007 ACTION: Mr. Brosius is to obtain written statements regarding safety from the hospital, Physician who the Mobile Cardiac Cath lab, CEO of NOVANT, and the manufacturer of the Mobile Cardiac Cath labs. Upon receipt of this information the Committee will review and consider further.

Expert Witness Testimony

Background: 11/2006 - Dr. McCulloch stated that this is a large and complex issue. He added that whether to adopt a Board policy as a position statement versus a rule is also a big issue. Mr. Mansfield suggested that the Board try to approach this through a position

statement. Superior Court judges reviewing cases coming from the Board expect licensees to be on notice of conduct that might result in disciplinary action. A position statement could express clearly the Board's opinion on the subject. If at the end of that process the Board has not accomplished their goal of putting licensees on notice, then they could look at rule-making. Mr. Brosius distributed a draft position statement. He explained that it is pretty basic, incorporating several guidelines from the American College of Surgeons and the applicable American Medical Association Code of Medical Ethics opinion. Mr. Mansfield went on to say that he wanted it to be clear that the Legal Department sees the draft position statement as applying equally to physician expert witnesses no matter which side of a legal matter engages the witness to appear. The issue of honesty as a witness goes to the character component of licensing and the Medical Practice Act permits the Board to take disciplinary action where a physician engages in dishonest conduct.

1/17/2007 – Dr. Saunders stated that telling the truth and giving a balanced view should be more clearly stated in the last paragraph of the statement.

3/2007 ACTION: Defer review at this time.

POSITION STATEMENT:

Medical Testimony Position Statement

The Board recognizes that medical testimony is vital to the administration of justice in both judicial and administrative proceedings. In order to provide further guidance to those physicians called upon to testify, the Board adopts and endorses the AMA Code of Medical Ethics Opinion 9.07 entitled "Medical Testimony." In addition to AMA Ethics Opinion 9.07, the Board provides the following guidelines to those physicians testifying as medical experts:

- **Physician expert witnesses are expected to be impartial and should not adopt a position as an advocate or partisan in the legal proceedings.**

- **The physician expert witness should review all the relevant medical information in the case and testify to its content fairly, honestly, and in a balanced manner. In addition, the physician expert witness may be called upon to draw an inference or an opinion based on the facts of the case. In doing so, the physician expert witness should apply the same standards of fairness and honesty.**

- **The physician expert witness is ethically and legally obligated to tell the truth. The physician expert witness should be aware that failure to provide truthful testimony may expose the physician expert witness to disciplinary action by the Board.**

[1] **The language of AMA Code of Medical Ethics Opinion 9.07 provides:**

> **In various legal and administrative proceedings, medical evidence is critical. As citizens and as professionals with specialized knowledge and experience, physicians have an obligation to assist in the administration of justice.**
>
> **When a legal claim pertains to a patient the physician has treated, the physician must hold the patient's medical interests paramount,**

including the confidentiality of the patient's health information, unless the physician is authorized or legally compelled to disclose the information.

Physicians who serve as fact witnesses must deliver honest testimony. This requires that they engage in continuous self-examination to ensure that their testimony represents the facts of the case. When treating physicians are called upon to testify in matters that could adversely impact their patients' medical interests, they should decline to testify unless the patient consents or unless ordered to do so by legally constituted authority. If, as a result of legal proceedings, the patient and the physician are placed in adversarial positions it may be appropriate for a treating physician to transfer the care of the patient to another physician.

When physicians choose to provide expert testimony, they should have recent and substantive experience or knowledge in the area in which they testify, and be committed to evaluating cases objectively and to providing an independent opinion. Their testimony should reflect current scientific thought and standards of care that have gained acceptance among peers in the relevant field. If a medical witness knowingly provides testimony based on a theory not widely accepted in the profession, the witness should characterize the theory as such. Also, testimony pertinent to a standard of care must consider standards that prevailed at the time the event under review occurred.

All physicians must accurately represent their qualifications and must testify honestly. Physician testimony must not be influenced by financial compensation; for example, it is unethical for a physician to accept compensation that is contingent upon the outcome of litigation.

Organized medicine, including state and specialty societies, and medical licensing boards can help maintain high standards for medical witnesses by assessing claims of false or misleading testimony and issuing disciplinary sanctions as appropriate. (II, IV, V, VII) Issued December 2004 based on the report "Medical Testimony," adopted June 2004.

5/2007 ACTION: Defer review at this time.

Supervision of Physician Assistants and Nurse Practitioners

Background: This item was referred from the Executive Committee. (1) Is it legal for NP's and/or PA's to employ their supervising physician? (2) What is the optimal number of PA's and NP's that a physician can supervise? Mr. Jimison gave his opinion that it would be inappropriate for a PA or NP to hire a physician as an employee of a practice owned entirely by the PA or NP. To do so would be an impermissible expansion of the scope of the PA license or NP approval to perform medical acts. Regarding supervision, several articles were reviewed, discussions with Ms. Hunter Buskey, PA-C, Board Member, NCMB, and representation of the NCPAP were present for the discussion.

7/2006 - Dr. McCulloch stated his opinion that the Board would be misguided if it were to try to create a formula for supervision based on specific numbers of providers supervised and

specific geographical distance limitations. He went on to say that specific number limitations should not be part of the equation as the Board determines whether supervision by a physician is appropriate or not appropriate.

9/2006 - Dr. McCulloch stated that it may be wise to spell out some factors that would constitute an appropriate quality assessment (chart reviews, educational topics discussed in detail, etc.). Dr. Rhyne agreed, stating that we need to articulate some general guidelines, yet be more specific. Dr. Norins noted that this position statement has no consequences.

11/15/2006 - Mr. Jeffery Katz stated that in consultation with Ms. Hunter Buskey it is felt that the words "quality of" should be removed from the ninth bullet. There are currently no standards for written protocols for PA's. In addition, his own protocols may be more vague since he has 25 years of experience, whereas a new licensee may appropriately require more specific protocols. He suggested that generic wording be used that will encompass all the supervision needs.

11/15/2006 - Ms. Adcock stated that the word "protocol" was removed from the nurse practitioner rules back in 2004. Therefore, it would be more appropriate in their case to replace the word protocol with "collaborative practice agreement." She stated that it is important to take experience into account, not only for the supervisee but the supervisor as well.

1/17/2007 – The Committee discussed whether to leave "protocol" in the statement. It was agreed that the Statement would better inform supervising physicians by leaving "protocol" in and expanding on it. Additionally, the Committee discussed removing the word "quality." Dr. Saunders suggested that it be left in, and Dr. Rhyne preferred that we leave it in and provide guidance. Todd Brosius suggested that if the Committee recommended providing specifics this would be better done with a rule or through the Joint Subcommittee. Dr. Saunders suggested that maybe guidelines or a template would be better and that the Committee might have the Licensing Committee look at it to provide something similar to what was done with the CPPs.

3/2007 ACTION: The following position statement was reviewed by the Committee and referred to the full Board with a recommendation that the position statement be published in *The Forum* for the purpose of giving notice and receiving comments.

5/16/2007 – The Board has received one written comment regarding the proposed position statement.

POSITION STATEMENT:

Physician Supervision

The physician who provides medical supervision of other licensed healthcare practitioners is expected to provide adequate oversight. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise the appropriate amount of supervision over a licensed healthcare practitioner which will ensure the maintenance of quality medical care and patient safety in accord with existing state and federal law and the rules and regulations of the North Carolina Medical Board. What

constitutes an "appropriate amount of supervision" will depend on a variety of factors. Those factors include, but are not limited to:

- **The number of supervisees under a physician's supervision**
- **The geographical distance between the supervising physician and the supervisee**
- **The supervisee's practice setting**
- **The medical specialty of the supervising physician and the supervisee**
- **The level of training of the supervisee**
- **The experience of the supervisee**
- **The frequency, quality, and type of ongoing education of the supervisee**
- **The amount of time the supervising physician and the supervisee have worked together**
- **The quality of the written collaborative practice agreement, supervisory arrangement, protocol or other written guidelines intended for the guidance of the supervisee**
- **The supervisee's scope of practice consistent with the supervisee 's education, national certification and/or collaborative practice agreement**

5/2007 ACTION: The Committee will continue to receive comments and should be prepared to vote at the July Committee meeting.

Request for permission to conduct health screenings for SC based employer

5/16/2007 – The Committee reviewed a letter from Health Works of Palmetto Health, a South Carolina based company, requesting permission to conduct health screenings for two companies located in North Carolina. After reviewing the specifics outlined in the request, the Committee determined that the screenings would be the practice of medicine. It was brought to the Committee's attention that Dr. Floyd has subsequently applied for a North Carolina medical license.

5/2007 ACTION: Communicate with Dr. Floyd that the Board is in receipt of his inquiry, has determined that this is the practice of medicine and would require a NC medical license. Indicate that the Board is happy he has applied for an NC medical license and emphasis that there should not be any interpretations until he has a full NC medical license.

21 NCAC 32R .0102 Approved Categories of CME – proposed language change

5/16/2007 – The Medical Board staff had requested that the Policy Committee consider a language change in 32R .0102(1)(c) to clarify what enduring materials were. Information and a resource contact was provided to the Medical Board staff by a representative of the Medical Society to clarify this issue.

5/2007 ACTION: Issue will be tabled until July for further discussion if needed.

Follow-up by Emergency Room physicians

5/16/2007 – The Committee reviewed a correspondence from Dr. Kirk Gulden, Chair of Wilkes Regional Medical Center's Bylaw Committee. Dr. Gulden inquired, if it would be acceptable to the Medical Board to notify patients seen in the emergency department without a local physician, that the treating ED physician is obligated for only one visit.

5/2007 ACTION: Notify Dr. Gulden that the patient must be seen in a follow-up visit, but may be immediately terminated per the Board's position statement. Dr. Saunders will write the letter.

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

ALLIED HEALTH COMMITTEE REPORT

Don Jablonski, DO ; Savesh Sathiraju, MD; Peggy Robinson, PA-C;

The Allied Health Committee of the North Carolina Medical Board met on Wednesday, May 16, 2007 at the office of the Board. Present: Dr. Jablonski, Chairperson, Dr. Sathiraju, Peggy Robinson, PA-C, Marcus Jimison, Legal, Lori King, CPCS, Licensing, Quanta Williams, Licensing, Jeffrey Katz, PA-C, Lisa Shock, PA-C, Scarlette Gardner, Mike Borden, CAE, Marc Katz, PA-C.

Requiring FCVS
Catchline: The Board recently passed a rule requiring physicians that have an established FCVS profile, have to apply "using FCVS" as part of the application process. Does the Board want to require the same for PA's?

Board Action: Require applicants for physician assistant license to use FCVS if they have an established profile with FCVS. Add requirement to PA application instructions sheet.

Board Member File Review
Catchline: The Board recently approved the following procedure regarding physician applications. Is it the desire of the Board to follow suit for physician assistants?
a) Issue licenses to those applicants with pristine applications once the application is approved by a Board member. A list of licensees will be presented to the Board for information, every month.
b) Continue having Board members review all applications.
c) If an applicant has one Professional Liability Insurance Payment (PLIP) – send file for Board member review; if more than one PLIP – have senior staff review and make a recommendation to a Board member or License Committee.

Board Action: a) Issue licenses to those applicants with pristine applications once the application is approved by a Board member. A list of licensees will be presented to the Board for information, every month.
b) Continue having Board members review all applications.
c) If an applicant has one PLIP – send file for Board member review; if more than one PLIP – have senior staff review and make a recommendation to a Board member or License Committee.

License Verifications
Catchline: Because the Board no longer requires verification of "other professional licenses" for physicians, does it want to eliminate verification of same for physician assistants? Revision of application questions reads as follows: "Are you aware of any complaint or investigation, past or present, regarding you that has been received or conducted by any governmental agency or any professional licensing board or agency?"

Board Action: Eliminate verification of other professional licenses. Remove requirement from PA application instructions sheet.

Certification of PA Degree
Catchline: Recently the Board adopted an "alternate pathway" for verifying a physician's identity when the educational program cannot or will not certify a photograph as required by the Board.

Board Action: Implement same pathway for physicians.

On-line application update
Catchline: L. King provided an update on the status of the on-line application.

Board Action: Accept as information.

Board's Role in EMS Committee
Catchline: Dr. Liz Kanof invited to attend to discuss role as the Medical Board's representative on the EMS Committee.

Board Action: Dr. Kanof will continue as NCMB's liaison and provide NCMB with EMT scopes of practice, medical protocols, disciplinary, quality of care issues. NCMB has no supervisory arrangement over who gets certified or recertified as an EMT. Currently EMT's do not have a program for impaired EMT's.

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

> Several Investigative cases and meetings were reported to the Committee. 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.

NC EMS Compliance Committee and Advisory Council Meetings
Catchline: EMS Compliance Committee and Advisory Council Meetings 02/14/07 Memo - Dr. Kanof.

Board Action: Accept as information.

Initial PA Applicants - Approved

Ambrose, Jessica
Armeau, Elin
Benjamin, Kristi
Cranick, Tarah
Doerksen, Dennis
Duncan, Megan
Faudree, Lindsey
Grullon, Rosemary
Hamilton-Powell, Billie

Kocian, Jason
Krall, Patricia
Lister, Steven
Marascalco, Ronald
McCormack, Vicki
McCreight, Trisha
McGroarty, Carrie
Norris, Jeana
Strickland, Jessica
Thompson, Hilary
Warden, Stephen
Weber, Colette
Wynn, Chileatha

Reactivations/Reinstatements/Re-Entries - Approved

CLANTON, Barry, PA - Reinstatement – 05/07
KROME, Sara D., PA - Reinstatement - 03/07
HAISLIP-RAMBO, Carole L., PA - - Re-Entry - 05/07

Additional Supervisor List - Approved

Name	Primary Supervisor	Practice City
Alexander, Robert	Thompson, Willard	Salisbury
Allen, Robert	Tarleton, Gregory	Winston-Salem
Alvarez, Osvaldo	Bate, David	Asheville
Avner, Belina	Mahan, Dennis	Fayetteville
Barringer, Kathi	Cockrell, Wiley	Rocky Mount
Berkey, Sandra	Tobin, H.	Fayetteville
Best, Jessica	Goubran, Michel	Burlington
Bethea, Angela	Burks, April	Mamers
Bost, Derek	Hirsch, Michael	Hickory
Brock, Lauren	Eglinton, Daniel	Asheville
Caffey, Karen	Fernandez, Jairo	Winston Salem
Castro, Claudelina	Le, Mark	Charlotte
Chan, Gerald	Pence, James	Leland
Chastain, Misty	Byrum, Graham	Greenville
Chauvin, Robert	Fisher, Donald	Burlington
Chazan, Jennifer	Fogartie, James	Tampa
Crawley, John	Flom, Jonathan	Fayetteville
Davis, William	Partridge, James	Durham
Despaigne, Policarpo	Cromer, John	Southport
Drinkwater, Don	MacPhee, Keelee	Raleigh
Edge, Kendra	Smull, David	Winston-Salem
Elmore, Melanie	Mong, James	Raleigh
Gatlin, Lois	Reddick, Bradley	Charlotte
Griffin, Lindsay	Brick, Wendy	Charlotte
Griffin, Lindsay	Higgs, Vetta	Charlotte
Griffin, Lindsay	Miller, David	Charlotte
Hammond, Jane	Whitaker, Gary	Hendersonville

Haser, Thomas	Springer, Bryan	Charlotte
Heins, Marilyn	Bunn, Barry	Tarboro
Hinkle, Shannon	Bloem, Josephus	Rocky Mount
Hinkle, Shannon	Marsigli, Eduardo	Rocky Mount
Johnson, Mary Ann	Harrell, Russell	Sanford
Jones, Stephen	Cabral, Gonzalo	Wilson
Kirk, John	Elgendy, Samar	Fayetteville
Knight, Valerie	Jordan, Joseph	Greenville
Krome, Sara	Foster, Mary	Durham
Kuhl, Lauren	Patel, Manesh	Raleigh
Labs, John	Ternes, John	Charlotte
Lamoureux, M.	Ng, Wing	Raleigh
Lamoureux, M.	O'Brien, Patrick	Raleigh
Lawyer, Christopher	Spear, Tammy	Summerfield
Levy, Antoinette	Vaden, Tracela	Charlotte
Lewis, Yvonne	Flom, Jonathan	Fayetteville
Martin, Jeffrey	Williams, Barton	Wilmington
Massenburg, O'Laf	Baugham, Leonard	Statesville
McKay, Bruce	Burks, April	Spring Lake
McMorrow, Carol	Amaldoss, Nirmala	Durham
Melgar, Tammy	O'Neil, Kevin	Wilmington
Moreno, Paula	Corvino, Timothy	Gastonia
Morimoto, Victoria	Carter, Coleman	Charlotte
Morris, Joseph	Harmaty, Myron	Gastonia
Murphy, Michael	Pence, James	Leland
Murray, Susan	Goubran, Michel	Durham
Nasrallah, Victor	Stinson, Charles	Winston-Salem
Newton, Meredith	Briggs, John	Lillington
Phillips, Erin	Kelling, Douglas	Concord
Ratcliffe, Heather	Landis, Darryl	Greensboro
Richards, Dick	Joiner, Jancinta	Lexington
Ritter, Karen	Pratt, Tanya	Greensboro
Schade, Jana	Reyes, Rodolfo	Lillington
Scime, Kseniya	Forlaw, James	Ashville
Scott, Mark	Bradley, Elizabeth	Jefferson
Shar, Gina	Rosen, Robert	Winston-Salem
Smith, Jeremy	Fisher, David	High Point
Srikantha, Venayagaratnam	Parker, David	Goldsboro
Staton, Forrest	Eskew, Lawrence	High Point
Sterling, David	Hines, Marcono	Smithfield
Sullivan, Colleen	Benedict, Frederick	Raleigh
Sullivan, Colleen	Charron, George	Raleigh
Sullivan, Colleen	Summers, Ronald	Raleigh
Swansiger, David	White, Diane	Elkin
White, Kevin	Lin, Shu	Durham
Williams, Todd	Vreeland, Matthew	Ft Bragg

Removal of NP section from the AH Committee Agenda
Catchline: Because NP issues are now taken to the NP Joint Sub-Committee meeting it is recommended that the Open and Closed Section for NPs on this agenda be removed.

BOARD ACTION: Remove Open and Closed Sessions for NPs from the AH agenda.

Perfusionist Report
Catchline: Minutes of the February meeting.

BOARD ACTION: Accept as information

Pharmacists reporting of influenza vaccines to physicians
Catchline: Concern has been expressed that some pharmacists were not reporting to physicians those patients that received an influenza vaccine, as the rule requires.

BOARD ACTION: Report to NC Board of Nursing.

Proposed changes to the vaccination rule
Catchline: The vaccine committee of the NCBOP has offered an amendment to the proposed vaccination rule.

BOARD ACTION: Amend rule to all Zostavax & pneumococcal vaccines but only to be administered by a pharmacist if there is a written prescription from the patient's primary physician.

A motion passed to close the session pursuant to NCGS 143-318.11(a) to investigate, examine, or determine the character and other qualifications of applicants for professional licenses or certificates while meeting with respect to individual applicants for such licenses or certificates.

> The Board reviewed six license applications. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

List of Initial Applicants - Approved

NAME	PRIMARY SUPERVISOR	PRACTICE CITY
Altermatt, Susan	Zacher, Allan	Clyde
Bewayo, Georgia	Sido, Obukohwo	Gastonia
Bland, Wendy	Pofahl, Walter	Greenville
Brown, Regan	Monteith, Charles	Chapel Hill
Bubb, Marcie	Fisher, David	Charlotte
Cupp, Brenda	Long, William	Charlotte
Doyle, Melissa	Murphy, Gregory	Rocky Mount
Ginn, Mary	Davis, John	Winston-Salem
Gross, Teresa	Wagner, Peter	Greenville
Hairfield, Keavie	Adams, Douglas	Eden
Hammonds, Linda	Russ, Donald	Hickory
Heavner, Angela	Watkins, William	Gastonia
Kruth, Lena	Harris, Charles	Durham
Lanius, Deborah	Melvin, Shirley	Ft. Bragg

Metzelaars, Barbara	Palermo, Nancy	Charlotte
Mollenkopf, Denise	Mims, Susan	Asheville
Morace, Joanne	Daniel, Myriam	Greenville
O'Neal, Mary-Jo	Busteed, Timothy	Morehead City
Phillips, Tracey	Szabo, Stephen	Pinehurst
Pool, Tracey	Hussein, Diaa	Morganton
Price, David	Gallaher, Keith	Fayetteville
Sadiq, Teresa	Calvo, Benjamin	Chapel Hill
Watson, Elizabeth	Cobos, Fernando	Pinehurst
Wilfong, Monica	Tuccero, Donna	Raleigh

NP ADDITIONAL SUPERVISOR LIST - Approved

Bach, Cynthia	Davis, Michael	New Bern
Bach, Cynthia	Oliver, David	New Bern
Beard Byrd, Karen	Reifler, Burton	Winston-Salem
Belden, Rosemary	Greenberg, Gary	Raleigh
Bertolette, Barry	Smith, Douglas	Durham
Boatwright, Melanie	Johnson, Michael	Charlotte
Bray, Wanda	Patterson, Robert	Sanford
Bringolf, Rebecca	Hager, Angela	Ft. Bragg
Brown, Penny	El-Khoury, Semaan	Aulander
Chauvigne, Brigitte	MacArthur, Robert	Greensboro
Ciecko, Shannon	Cummings, DeLora	Cary
Curran, Mary	Hall, Timothy	Charlotte
Desai, Shakti	Bruce-Mensah, Kofi	Wake Forest
Desamero, Jonathan	Watling, Bradley	Charlotte
Dorney, Jewel	Hall, John	Fayetteville
Dorroh, Martha	Jefferson, Henry	Cary
Ebert, Cynthia	Bell, Brian	Forest City
Emmons, Deborah	Shukla, Nilima	Gastonia
Everts, Shelley	Nordstrom, Carl	Locust
Fedziuk, Bernadette	Joiner, Jancinta	Lexington
Ferree, Bette	Holness, Kenworth	Winston-Salem
Gamewell, Marilyn	Fisher, William	N. Wilkesboro
Guarini, Eleanor	MacArthur, Robert	Greensboro
Gusler, Jennifer	Buchheit, Thomas	Raleigh
Haaga, Margaret	McKay, Martha	Burnsville
Harris, Crystal	Marion, Dominique	Charlotte
Honeycutt, Sheila	Beittel, Timothy	Wilmington
Johnson, Candace	Lankford, Clyde	Pilot Mountain
Jones, Shirley	Kraemer, Thomas	Greenville
Kirchner, Kathy	MacArthur, Robert	Greensboro
Koepp, Susan	Rosso-Salisbury, Bianca	Cedar Point
Laliberte, Sally	Taavoni, Shohreh	Chapel Hill
Lowe, Karen	MacArthur, Robert	Greensboro
Lundrigan, Carol	Joiner, Jancinta	Lexington
Madden, Reginald	Charles, Kirk	Raleigh
Marsh, Annette	MacArthur, Robert	Greensboro
Martin, Mary	Gaffney, Mary	Charlotte

McCallum, Stephanie	Block, Steven	Winston-Salem
Michael, Ralph	Joiner, Jancinta	Lexington
Miller, Cynthia	Hsieh, Stephen	Lexington
Mitchell, Mary	MacArthur, Robert	Greensboro
Moore, Mark	Watts, Larry	Charlotte
Nash, Bessie	Gallinger, Roy	Sylva
Nesbitt, Shirley	Bradshaw, William	Asheville
New, Paula	Pridgen, James	Sneads Ferry
Olson-Kennedy, Kristin	Keener, Stephen	Charlotte
Oursler, Theresa	Swearingen, George	Asheville
Packheiser, Marigold	MacArthur, Robert	Greensboro
Pearson, Tamera	Blair, Charles	Asheville
Penn, LaShanda	Scarff, John	Lexington
Pharr, Amy	Flom, Jonathan	Fayetteville
Pittman, Laura	Pohlman, Barbara	Emerald Isle
Plemmons, Nancy	Spencer, Donald	Charlotte
Ponniah, Shivanthi	Bruce-Mensah, Kofi	Cary
Poole, Brenda	Modi, Seema	Greenville
Rafson, Judy	Hudson, Richard	Bayboro
Redding, Susan	Modi, Seema	Greenville
Royal, Nicole	McMillan, Edward	Charlotte
Severns, Catherine	Purdy, William	Durham
Shannon, Michael	Jefferson, Henry	Cary
Stupka, Anne	Chewning, John	Winston-Salem
Tabb, Deborah	Sim, Peter	Randleman
Tolbert, April	Burdick, Richard	Wilson
Tolbert, April	Pita, James	Wilson
Wachowiak, Wilma	Anderson, Evelyn	Monroe
Walker, Lucy	Sherrill, John	Granite Falls
Wenning, Pamela	Kramer, Peter	Wilmington
Wicker, Dale	Morgante, Patrick	Hickory
Witkin, Debra	Vincent, Mark	Charlotte

PHYSICIAN ASSISTANT ADVISORY COUNCIL REPORT

Don Jablonski, DO ; Savesh Sathiraju, MD; Peggy Robinson, PA-C;

The Physician Advisory Council (PAAC) met on Wednesday, May 16, 2007 at the office of the Board.

Present: Peggy Robinson, Chairperson, Dr. Jablonski, Dr. Sathiraju, Marcus Jimison, Lori King, CPCS, Jeffrey Katz, PA-C, Mike Borden, CAE, Jim Hill, PA-C, Patricia Dieter, PA-C, Douglas Hammer, MD, Lisa Shock, PA-C, Marc Katz, PA-C and Robin Hunter-Buskey, PA-C via phone.

Ms. Peggy Robinson chaired the meeting.

Open Session

Old Business

New Business

Physician/PA Team

NCMS Legislative Doctor of the Day Program. Dr. Sathiraju and group discussed.

Primary supervising physician must attend with PA and the PA needs to inform NCMB of additional site information.

PA Certification

PA Recertification as a requirement for licensure. Ms. Hunter-Buskey and group discussed.

Adding recertification as a requirement for maintaining licensure was discussed along with specialty certifications.

Discuss again at next PAAC Mtg.

Next PAAC Mtg.

Date: Tentative date of November 14, 2007

For information.

NCMB Insurance Coverage for PAAC Members

Dr. Hammer discussed NCMB insurance coverage for PAAC members. M. Jimison stated that the PAAC is an advisory committee but will follow-up.

M. Jimison to follow-up.

LICENSING COMMITTEE REPORT

Ralph Loomis, MD, Chair; Robert Moffatt, MD; John Lewis, JD

Revision of Question 12 on the application form.

Catchline: Question 12 on the application form currently reads, “Do you have any medical conditions, other than substance abuse? It has been suggested that the question be reworded as follows: “Other than substance abuse, do you have any medical conditions? Please describe the conditions and whether or not you have been told within the past five ears that you have been impaired as a result of any conditions that you have described.”

BOARD ACTION: Change question 12 to read: Do you have any medical conditions and have you been told or are you impaired as a result of these conditions?

Revision of Question 1 on the application form.

Catchline: During the March License Interview report the Committee was asked to revisit Question 1 on the application form in view of the number of applicants who answer incorrectly. The question currently reads, “Are you aware of any complaint or investigation, past or present,

regarding you that has been received or conducted by any governmental agency or any professional licensing board or agency?"

BOARD ACTION: Insert the following verbiage in front of question 1: For the purpose of Questions 1-5, you should answer the question affirmatively if you know of any complaint or investigation that has been made, regardless of whether you consider the complaint or investigation frivolous or groundless, and regardless of the disposition.

Update on Best Practices Committee recommendations for License Department

Catchline: Dr. Loomis reported actions taken regarding recommendations from the Best Practices Committee as follows:

1. Licensing Committee to study the viability of using information, such as medical school completion, information already verified by another state where the applicant holds a license.

   It has been determined that this is not a viable option except in extreme circumstances. It is this Board's duty to primary source verify medical education of applicants.

2. Licensing Committee to study a breakdown of the licensing process: where the most time is spent? What delays are there in the process? How could it be streamlined?

   The process has been studied and it has been determined that no changes will be made in the process at this time.

3. Licensing Committee to study the concept of issuing a license after a Board Member reviews the application and okays the license without waiting till the next Board Meeting.

   Implemented March 2007 and working well.

BOARD ACTION: Accept as information

Finger prints/criminal background check

BOARD ACTION: In the event that an applicant for resident training license is unable to obtain finger prints to submit with an application because they are outside the United States, the Committee recommends the following policy be used when and if this type of situation should arise in the future:

New RT Fingerprint Policy for Out-of-Country Applicants: If an application for RT license is otherwise routine but the applicant cannot produce completed fingerprint cards, consider issuing a training license that will expire **60** days after the physician begins work at the NC teaching institution. This should allow sufficient time to obtain prints once the physician has arrived in the U.S. The Board will issue a regular RT license once the applicant submits completed fingerprint cards.

A motion passed to close the session pursuant to NCGS 143-318.11(a) to investigate, examine, or determine the character and other qualifications of applicants for professional licenses or certificates while meeting with respect to individual applicants for such licenses or certificates.

The Board reviewed 13 license applications. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

SPLIT BOARD LICENSURE INTERVIEWS

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

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

A motion passed to return to open session.

APPLICANTS PRESENTED TO THE BOARD

Abcarian, Peter Winslow
Abou-Elella, Ashraf Ahmed
Abraham, Vinod
Adeyina, Feyisayo Adenike
Ahluwalia, Hardeep Singh
Alliss, Samir Jose
Bahn, Bret Matthew
Baker, Donald James
Belle, John Stephen
Bennett, Jeremy Jon
Bennett, Stacy Kaija
Benoit-Fischer, Carol E
Bloomfield, Gerald Samuel
Boardman, Lynn Amy
Boehmke, Karen Louise
Boghossian, Van
Bomback, Andrew Stephen
Bouneva, Iliana Simeonova
Bowman, James Thomas
Branner, Christopher Malcolm
Brar, Navpreet Singh
Brockmeier, Stephen Frederick
Brown, Kevin Nathaniel
Brown, Rachel Rosenberg
Brydon, John Bruce
Bryskin, Robert Boris
Burbridge, Rebecca Ann
Burke, Les Georgia K Quenon
Carbone, Dominic John, Jr.
Cates, Casey Allen
Chappell, Jonathan Douglas
Chavala, Sai Hemanth
Chen, Jerome Gene
Chiu, Jenyung Andy
Chuang, Peale
Clark, Adam Nathaniel
Clarke, Michael Thomas
Coath, Gwennaye Cherie
Coleman, Kevin Maurice
Collins, Paul Dwayne
Combs, Glen A.
Connor-Riddick, Tracy Nickol
Crill, Richard Joseph
Dale-Shall, Amanda Watson
Dambro, Timothy
Danekas, Michael Gene
Darovsky, Boris Marat
Dasso, Edwin Joseph
Davidson, Arthur Jr.
de La Fe, Alfredo Pedro
DeOrio, Matthew James
Desai, Tanvi Naresh
Dibble, David Joseph
Duffy, Carol Ibach
Eaker, Kathyrn Grace
Englert, Danielle Elizabeth
Farash, Ann Elizabeth
Farmer, Laurance David
Farquhar, Joseph Alexander
Farrar, Robert Allen
Faulcon, Sheritia Tijuana
Fernandez, Martha Elizabeth
Ferrandino, Michael Nicolo
Frederick, Andre Dean

Freidinger, Brad Alan
Frisby, Xenia Yvette
Gascon, Cupid Capinpin
Gbadegesin, Rasheed Adebayo
Gerasimon, Gregg Gordon
Gianini, Angela McClellan
Girard, Christina Marie
Glover, William Bryan
Goodmon, Anna Brame
Gretter, Brock John
Hansen, Jason Paul
Harding, David Wayne
Hargrove, Roderick Neil
Harris, William Thomas
Hata, Jonathan Andrew
Heer, Kathleen Elaine
Hight, Nicole Bernice
Hoffmeister, Dean Louis
Holliday, Ruth
Horne, Kristopher Cornell
Hubbard, John Behrens
Humble, Scott David
Hynes, Michael Loren
Individual Tester, MR Magoo The
Isley, Ronald Elwyn
Jackson, Anthony Wayne
Jacobs, Kenneth Lee
Johnson, Jeremiah John
Johnson, Ramona Elizabeth
Jones, James Earl
Juan, Emerson Alfonso
Judy, David Warner
Kandula, Leena
Katopes, Charles Peter
Khandelwal, Gautam
Kelly, Margaret
Klisch, Gregory
Kobayshi, Daisuke
Koehler, John J.
Kramer, Kyle Vernon
Kumar, Balvinder
Kurup, Vinod V
Ladwig, Jason Ronald
Laudadio, Jennifer
Leder, Henry Alexander
Lederer, David Elliott
Lee, Mark Hyon-Min
Lee, Teng
Lesko, Paul David
Levi, Angelique Wolf
Levkulich-Kramer, Olga Maria
Lochow, Steven Charles
Long, John Jacob
Losinski, Tiana Noelle
Lugo-Somolinos, Aida
Lugue, Carmelita Jasmine
Luthin, William Nolan
MacNeill, Emily Champe
Marchand, Mark David
Matisoff, Andrew Jeffrey
May, Bryan Vincent
McKenna, Jay Harvey
McKinley, Steven Hang
Meltzer, Eric Barrie
Merck, Lisa H.
Messier, Matthew Roland
Mileti, Carmen Gabriela
Miller, Ansley Carnochan
Miller, Charles Brock
Morris, Tammy Lynn
Mounsey, John Paul
Mulroy, Constance Marie
Musulin, Matthew Michael
Myers, Christopher James
Nortey, Cynthia Korlei
Nurnberg, Ruth Diane
Patil, Neil Aneel
Peacock, Aurora Jean
Perrott, Ashley Miller
Peterson, Eleanor Blake
Pham, Hung Hoang
Phichith, Alounthith
Pickering, Nathan Roger
Pierce, Helen Elizabeth
Pinninti, Usha Rani
Pittman, Jessica Erin
Plummer, Janelle Renee
Prabhakaran, Sujatha
Privette, Crystal Goodwin
Pucilowska, Jolanta
Puri, Mala
Rader, Dale Kantrice
Ramsey, Carolyn Hubbard
Rea, Janice Lee
Reiners, Andrew Todd
Richards, Kristy Lee
Schlossberg, Peter
Schneider, Brian Joseph
Schuette, Patrick John
Schwartz, Matthew Charles
Scott, Aaron Titus
Sherman, Alan William
Simon, Stephanie Young
Singh, Paul Gulsharan
Smiley, Margaret Lynn
Smith, Douglas Kevin
Smith, Phillip Brian
Snetman, Lawrence
Stancil, Jennifer Marie
Standridge, Matthew Thomas
Starnes, Harrison Benjamin
Stephens, Caroline Dove

Stork, Richard James
Sturgill, Stephanie Bialas
Sun, Albert Yuan-Yen
Sunshire, Thomas John
Taber, Brooks William
Taylor, Jonathan Harris
Tillerson, Elbert Stinson
Torrent, Jose Rafael
Verma, Lalit Mohan
Vetrovec, George Wayne
Villanova, Lynnea
Wasudev, Nikunj Pramod
Weed, Barry Christopher
Weiss, Anna
Wellen, Marcus Gregory
Whitmore, Edna Clarissa
Winchester, John Brandon Burl
Woofter, Aaron Lee
Wright, Marion Edward
Wright, Tarra Marie
Wylie, Lindsay Anne
Yasunaga, Judith April
Yoder, Amy Beisswanger
Young, Jordon Terrell
Yount, Mitchell Lee
Zanone, Justin William
Zia, Shams
Zipkin, Daniella Ann

LICENSES APPROVED
(April 21 to May 14, 2007)

Abcarian, Peter Winslow
Abou-Elella, Ashraf Ahmed
Abraham, Vinod
Adeyina, Feyisayo Adenike
Ahluwalia, Hardeep Singh
Alliss, Samir Jose
Bahn, Bret Matthew
Baker, Donald James
Belle, John Stephen
Bennett, Jeremy Jon
Bennett, Stacy Kaija
Benoit-Fischer, Carol E
Bloomfield, Gerald Samuel
Boardman, Lynn Amy
Boghossian, Van
Bomback, Andrew Stephen
Bouneva, Iliana Simeonova
Branner, Christopher Malcolm
Brar, Navpreet Singh
Brockmeier, Stephen Frederick
Brown, Kevin Nathaniel
Brown, Rachel Rosenberg
Bryskin, Robert Boris
Burbridge, Rebecca Ann
Burke, Les Georgia K Quenon
Cates, Casey Allen
Chappell, Jonathan Douglas
Chavala, Sai Hemanth
Chen, Jerome Gene
Chuang, Peale
Clark, Adam Nathaniel
Clarke, Michael Thomas
Coath, Gwennaye Cherie
Coleman, Kevin Maurice
Crill, Richard Joseph
Dale-Shall, Amanda Watson
Danekas, Michael Gene
Darovsky, Boris Marat
de La Fe, Alfredo Pedro
DeOrio, Matthew James
Desai, Tanvi Naresh
Dibble, David Joseph
Duffy, Carol Ibach
Eaker, Kathyrn Grace
Englert, Danielle Elizabeth
Farash, Ann Elizabeth
Farmer, Laurance David
Farrar, Robert Allen
Faulcon, Sheritia Tijuana
Fernandez, Martha Elizabeth
Frederick, Andre Dean
Freidinger, Brad Alan
Frisby, Xenia Yvette
Gascon, Cupid Capinpin
Gbadegesin, Rasheed Adebayo
Gerasimon, Gregg Gordon
Gianini, Angela McClellan
Glover, William Bryan
Goodmon, Anna Brame
Gretter, Brock John
Hansen, Jason Paul
Harding, David Wayne
Hargrove, Roderick Neil
Harris, William Thomas
Hata, Jonathan Andrew
Heer, Kathleen Elaine
Hight, Nicole Bernice
Hoffmeister, Dean Louis
Holliday, Ruth
Horne, Kristopher Cornell
Hubbard, John Behrens
Hynes, Michael Loren

Individual Tester, MR Magoo The
Isley, Ronald Elwyn
Jackson, Anthony Wayne
Johnson, Jeremiah John
Johnson, Ramona Elizabeth
Jones, James Earl
Juan, Emerson Alfonso
Judy, David Warner
Kandula, Leena
Katopes, Charles Peter
Khandelwal, Gautam
Klisch, Gregory
Koehler, John J.
Kramer, Kyle Vernon
Kumar, Balvinder
Kurup, Vinod V
Ladwig, Jason Ronald
Laudadio, Jennifer
Leder, Henry Alexander
Lederer, David Elliott
Lee, Mark Hyon-Min
Levi, Angelique Wolf
Lochow, Steven Charles
Long, John Jacob
Losinski, Tiana Noelle
Lugo-Somolinos, Aida
Lugue, Carmelita Jasmine
Luthin, William Nolan
MacNeill, Emily Champe
Marchand, Mark David
Matisoff, Andrew Jeffrey
May, Bryan Vincent
McKenna, Jay Harvey
McKinley, Steven Hang
Meltzer, Eric Barrie
Merck, Lisa H.
Messier, Matthew Roland
Mileti, Carmen Gabriela
Miller, Ansley Carnochan
Miller, Charles Brock
Morris, Tammy Lynn
Mulroy, Constance Marie
Musulin, Matthew Michael
Myers, Christopher James
Nortey, Cynthia Korlei
Nurnberg, Ruth Diane
Patil, Neil Aneel
Peacock, Aurora Jean
Perrott, Ashley Miller
Peterson, Eleanor Blake
Pham, Hung Hoang
Phichith, Alounthith
Pickering, Nathan Roger
Pierce, Helen Elizabeth
Pinninti, Usha Rani
Pittman, Jessica Erin
Plummer, Janelle Renee
Prabhakaran, Sujatha
Privette, Crystal Goodwin
Puri, Mala
Rader, Dale Kantrice
Ramsey, Carolyn Hubbard
Rea, Janice Lee
Richards, Kristy Lee
Schlossberg, Peter
Schneider, Brian Joseph
Schuette, Patrick John
Schwartz, Matthew Charles
Scott, Aaron Titus
Sherman, Alan William
Simon, Stephanie Young
Singh, Paul Gulsharan
Smith, Phillip Brian
Stancil, Jennifer Marie
Starnes, Harrison Benjamin
Stephens, Caroline Dove
Stork, Richard James
Sturgill, Stephanie Bialas
Sun, Albert Yuan-Yen
Taber, Brooks William
Taylor, Jonathan Harris
Tillerson, Elbert Stinson
Verma, Lalit Mohan
Vetrovec, George Wayne
Villanova, Lynnea
Wasudev, Nikunj Pramod
Wellen, Marcus Gregory
Winchester, John Brandon Burl
Woofter, Aaron Lee
Wright, Marion Edward
Wright, Tarra Marie
Wylie, Lindsay Anne
Yasunaga, Judith April
Yoder, Amy Beisswanger
Yount, Mitchell Lee
Zanone, Justin William
Zia, Shams
Zipkin, Daniella Ann

Reinstatement

Chiu, Jenyung Andy
Smith, Douglas Kevin

CONTINUED COMPETENCE COMMITTEE

Michael Norins, MD, Chair; EK Fretwell, PhD; Peggy Robinson, PA-C

The Continued Competence Committee of the North Carolina Medical Board was called to order at 3:10 p.m., Thursday, May 17, 2007, at the office of the Board. Members present were: Michael Norins, MD, Chair; and Peggy Robinson, PA-C. Also attending were: Michael Sheppa, MD, Medical Director; Katherine Carpenter, JD, Legal Department; David Henderson, Executive Director; Hari Gupta, Operations Director; Thomas Ricketts, PhD, Deputy Director, Cecil G. Sheps Center, UNC Chapel Hill; Brad Wright, UNC Chapel Hill; and. Absent were: E. K. Fretwell, PhD; Jeffery Denton, Recorder (Staff); and Thomas Mansfield, JD, Director, Legal Department (Staff).

Cecil B. Sheps Center

Analysis of PLIPs

Dr. Sheppa previously presented a report of the analysis of PLIPs data. The goal was to determine if PLIPs data could serve to identify doctors of concern who have had malpractice actions and who may require further Board action. Dr. Ricketts, of Sheps, continues to analyze the available data base for other sentinel variables.

At this committee meeting Dr. Rickets presented additional statistical reports. He indicated there is not yet a predictive model as it currently relates to malpractice. He and Sheps staff continue to analyze information from the Board; the current focus of attention is directed toward the narrative content of the PLIP in an attempt to categorize the area of competency that contributed to the PLIP.

Action: Dr. Ricketts will continue his analysis.

Affiliated Monitors, Inc.

Motion: A motion passed to add Affiliated Monitors, Inc. to the Board's approved options. It was noted that there is no cost to the Board. The cost is passed on to the licensee.

Action: Mr. Denton will acquire additional written material to be provided to all Board Members.

Registration Questionnaire Review

Background: It has been noted that the questions on the annual registration form that relate to not being in the active practice of medicine, the whys and what have you really been doing are all optional responses. Thus, no reliable data along this line is available. A motion passed to reevaluate subject questions and make answering them "mandatory." This relates to those questions along the line of being out of the active practice of medicine, why and what are you doing. Reviewing the registration questionnaire is a priority for the Continued Competence Committee. Reviewers will be looking for more specific questions pertaining to practice activity and how to refine questions to be useful in identifying physicians that may be in need of reentry type education.

Action: This item was tabled till the July 2007 Committee Meeting

The next regular meeting of the Continued Competence Committee is tentatively set for Thursday, July 19, 2007.

DISCIPLINARY (COMPLAINT) COMMITTEE REPORT

Janelle Rhyne, MD; Michael Norins, MD; Donald Jablonski, DO; Ralph Loomis, MD; John Lewis, JD

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

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

A motion passed to return to open session.

PROFESSIONAL LIABILITY INSURANCE PAYMENTS

Janelle Rhyne, MD; Michael Norins, MD; Donald Jablonski, DO; Ralph Loomis, MD; John Lewis, JD

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

The Professional Liability Insurance Payments Committee reported on 71 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.

DISCIPLINARY (MEDICAL EXAMINER) COMMITTEE REPORT

Janelle Rhyne, MD; Michael Norins, MD; Donald Jablonski, DO; Ralph Loomis, MD; John Lewis, JD

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

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

A motion passed to return to open session.

NORTH CAROLINA PHYSICIANS HEALTH PROGRAM (NCPHP) COMMITTEE REPORT

Sarvesh Sathiraju, MD; George Saunders, MD; Andrea Bazan-Manson

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

The Board reviewed 41 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.

DISCIPLINARY (INVESTIGATIVE) COMMITTEE REPORT

Janelle Rhyne, MD; Michael Norins, MD; Donald Jablonski, DO; Ralph Loomis, MD; John Lewis, JD

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

The Disciplinary (Investigative) Committee reported on 28 investigative cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

INFORMAL INTERVIEW REPORT

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

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

A motion passed to return to open session.

DISCIPLINARY (INVESTIGATIVE) REVIEW COMMITTEE REPORT

Janelle Rhyne, MD; Michael Norins, MD; Donald Jablonski, DO; Ralph Loomis, MD; John Lewis, JD

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

The Disciplinary (Investigative) Review Committee reported on 38 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.

ADJOURNMENT

This meeting was adjourned on May 18, 2007.

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George L. Saunders III, MD
Secretary