



Professionalism: Why we do what we do

As my term as NCMB President approached last fall, I spent some time thinking about what my first words to you, my colleagues, should be. My thoughts quickly turned to a lesson learned over years of involvement with the Boy Scouts, which is the importance of having before me at all times the equivalent of a standard—the stick a scout holds before him to guide his way on a hiking trip, uphill or downhill, treacherous or easy. I decided that professionalism was to be the metaphorical “standard” I hold before me over the coming year, and that I should begin my dialogue with licensees with an article on that subject.

Commitment to professionalism is acknowledgment of the honor and responsibility we have as medical practitioners. It is unequivocal and enduring. Professionalism encompasses principles of unselfish concern for others, dedication to quality patient care and commitment to patient autonomy and confidentiality. I can think of few qualities that are more essential to the competent, compassionate practice of medicine.

I want to challenge every licensee of this Board to recommit to the values stated above. In this article, I also want to share three examples of professionalism from my own life and career. I happen to be a third generation physician, so I have been fortunate to have not just one, but two examples of professionalism in my own family. I was also extremely blessed to find, during my residency training in neurosurgery, a peer whose actions have been a beacon of professionalism. The lessons learned from these three men are as essential to my life today as the many standards I have carried with the scouts over the years.

Grandfather Loomis: Care with compassion and respect

As a five-year-old in the mid-1950's I accompanied my physician grandfather, Ralph Henry Loomis, MD, on house calls. At the time, of course, I did not know what “professionalism” meant, but I saw it in my grandfather's every interaction with his patients and their loved ones. As a physician, he interacted as easily with the president of the local bank as he did with the cook at the local diner. He was able to articulate the health challenges each faced and the choices each needed to make, always in the appropriate manner for that patient. He treated each patient as if he or she was his only patient. He sat at many bedsides carefully taking in the list of symptoms conveyed by the patients, always showing compassion and concern. I realize now that, during the early years of his practice, the best method of diagnosis was often a listening ear. Watching him was an ideal training ground for how to behave in patient interactions. I saw how he dropped his six foot frame to the floor to talk on



NCMB President, Dr. Ralph C. Loomis, says “The realities of today's health care marketplace may make it challenging to uphold the seemingly impractical value of professionalism.”

IN THIS ISSUE

- | | |
|----------------------------------------------|-------------------------------------------------------|
| 3 Urgent notice to professional corps, PLLCs | 22 Are ‘pill mills’ Florida's newest export? |
| 21 NCMB gets new members; reappointments | 24 Quarterly adverse report |
| | 28 Need an Intent to Practice acknowledgement letter? |



Dr. Loomis's father, Charles Henry Loomis, with his dad (Dr. Loomis's grandfather) Ralph Henry Loomis.

eye level with a child. I observed as he held the older patient's hand as he gave his advice. I noticed how he sympathized with caregivers as he gave instructions on the care to be given. He was paid for his services in farm animals, vegetables, canned goods and cash. His unselfish concern for patient care went beyond compensation.

Father: Striving for excellence through lifelong learning

My father, Charles Henry Loomis, MD, was a general surgeon who began his practice as the doctor for a manufacturing company in Benham, Kentucky. As a teenager, I stood wide-eyed beside him as an observer in his operating room, and it was there that the seeds of my own career as a surgeon were sown. My father's young life and education were in large cities, but he saw the need for doctors in rural areas and stepped up to the plate. As a small town doctor, he was privy to confidences of many. In fact, he likely knew more details about the people in a room than anyone else there; nevertheless, he held the confidences shared with him as tightly as the logs on a log truck are bound.

My father was never board certified (certification was not available until he was well into his career) but he sought out every opportunity to improve his clinical skills. He allied

himself with organizations that would require surgical data from him, to have the opportunity to objectively analyze his practice and compare it with others. Most of our family vacations were his continuing education jaunts. Through him, I saw the value of committing to lifelong learning in order to improve patients' lives.

Practice partner: Living professionalism every day

When I entered my neurosurgery residency in 1976, I worked day to day beside a fellow resident, Lary Schulhof, MD, whom I respected and whom I later followed to the city that would become my home. This man, my eventual partner in the neurosurgery group I joined, adhered to the highest standards of patient care. He discussed with his patients all available care options, but recommended only those that he believed had a high likelihood of improving the patient's condition. He never yielded to that frequent temptation among surgeons to think that he could produce a positive result in a patient, even when reliable data suggested otherwise. He made a conscious effort not to "ride in on a white horse." Instead, he went at his work from the vantage point of a wise and well-trained work horse. For him, this meant explaining all risks of complications in a manner understood by his listeners. It meant answering questions as many times and in as many ways as they were asked. He was wise enough to know that he did not know everything, and never lost an opportunity to learn from his colleagues. I received many a call from him – at night, while I was on vacation – seeking my opinion and my experience. He once told me that the only bad thing about not being on call every night is that you miss half the cases. He kept a relentless schedule, yet his patience in providing care and, as a result, the number of patients under his care, abounded. Moreover, he remained humble and gracious in all that he did. I have spent my career striving to model his fine example.

Conclusion

The realities of today's health care marketplace may make it challenging to uphold the seemingly impractical value of professionalism. But I would argue that doing so has infinite

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We welcome letters to the editor addressing topics covered in the *Forum*. They will be published in edited form depending on available space. A letter should include the writer's full name, address, and telephone number.

BOARD NEWS

rewards. Living these values on a daily basis reminds each of us what drew us to the practice of medicine. It feeds the soul and provides a counterbalance to the stresses of dealing with insurance company hassles or fretting over how to comply with the latest government mandates.

On a recent night dining out with my family, a middle-aged man came to the table and offered that, nearly 30 years ago, I had cared for his mother after she was diagnosed with a malignant brain tumor. At the time, his mother was an uninsured widow.

He and other family members, who at the time had little ability to help, had wondered whether his mother would get the care she needed. I listened quietly as this gentleman, who is now a retired and highly regarded law enforcement official, told my two teenage sons that his mother did indeed get the highest quality of care, and that her bill was summarily written off by my group when her financial situation was known. He described me as “just the doctor they would have ordered.” He said that I took the time to explain his mother’s diagnosis and treatment options, that I was supportive and compassionate as those options were chosen and acted upon, and that no one would have known that her care from me was given without remuneration.

I offer this anecdote not to highlight my own actions or those of my practice group (I know plenty of others that rou-

RALPH C. LOOMIS, MD

Interesting facts about your new Board president

City: Asheville, NC

Term ends: October 31, 2012

Specialty: Neurological Surgery

Certification: American Board of Neurological Surgery

Personal: Wife, Doris; Father of six sons, ages 13-30

tinely provide charity care). Rather, I mention this experience to show the real and lasting impact professionalism can have on the lives of patients and their loved ones. It was a potent reminder to me, and to my family, of why I do what I do.

As I mentioned at the beginning of this article, I’d like this column to facilitate a dialogue. So now, I’d like to hear your thoughts on professionalism. Who are your personal models of professionalism? How do you find ways to honor professionalism in your practice? Send replies to me at forum@ncmedboard.org or comment on the online version of this article. The next issue of the Forum will publish a selection of responses.

Urgent notice to professional corps, PLLCs

As of mid-January, more than 40 percent of all professional medical corporations and professional limited liability corporations (PLLCs) operating in the state had failed to complete their annual registration as required under North Carolina law. The registration renewal deadline for all medical corporations and PLLCs was December 31.

If you have not renewed, please do so as soon as possible to avoid adverse action against your business. Any professional medical corporation or PLLC that fails to renew by the end of February will be suspended by the Medical Board and the N.C. Secretary of State. When a professional corporation or PLLC is suspended, it is not

lawful for it to provide professional services in North Carolina.

Final notices were sent to registrants via regular mail at the end of January. Registrants who missed the December 31 deadline must pay a late fee.

The NC Medical Board is in the process of implementing an annual renewal for all professional medical corporations and PLLCs, which will replace the current biennial renewal system.

Please email questions to corporations@ncmedboard.org. Please include the full name of the business you are inquiring about and, if known, the registration ID number.

DID YOU KNOW ?

...if you have not provided your current practice address and telephone number to the Board, you may be out of compliance with state law. NC law requires all physicians and physician assistants with an active state medical or PA license to provide the Board with this information. If the practice

address/phone changes, it is the licensee’s responsibility to notify the Board of the change within 60 days.

Please check the NCMB website at www.ncmedboard.org to verify that your information is correct. From the Home Page, select “Look Up a Licensee” from the green Quick Links box at the right of the screen and look yourself up by name or license number. Click on the Practice Information tab to see the address currently on file with the Board.

TO CHANGE YOUR ADDRESS: Click on “Update Licensee Info Page” from the Quick Links box. Once you have logged in, select “Address” from the menu.

NC Medical Board Position Statements

A guide to the Board’s Position Statements as of 12/31/2011

Each year, the NC Medical Board publishes its complete position statements as a quick reference guide for all licensees. The position statements are a collection of interpretive statements developed and approved by the Board, with input from licensees and other interested parties, that attempt to explain laws and rules, or explain the Board’s expectations for licensee conduct under specific circumstances. The complete position statements are also available online at www.ncmedboard.org

The Board’s Policy Committee regularly reviews the content of the statements, making necessary revisions to address changes in medical practice or matters of policy, and to acknowledge new or evolving methods or procedures. This year, in an effort to make this guide more user-friendly, we have employed a color-coding system to identify position statements that were added, reviewed or revised in 2011. New statements are identified in green; statements that were revised are coded purple; statements that were reviewed with no changes are marked in blue.

The principles of professionalism and performance expressed in the position statements of the North Carolina Medical Board apply to all persons licensed and/or approved by the Board to render medical care at any level.

Disclaimer

The North Carolina Medical Board makes the information in this publication available as a public service. We attempt to update this printed material as often as possible and to ensure its accuracy. However, because the Board’s position statements may be revised at any time and because errors can occur, the information presented here should not be considered an official or complete record. Under no circumstances shall the Board, its members, officers, agents, or employees be liable for any actions taken or omissions made in reliance on information in this publication or for any consequences of such reliance. A more current version of the Board’s position statements will be found on the Board’s Web site: www.ncmedboard.org, which is usually updated shortly after revisions are made. In no case, however, should this publication or the material found on the Board’s Web site substitute for the official records of the Board.

WHAT ARE THE POSITION STATEMENTS OF THE BOARD AND TO WHOM DO THEY APPLY?

The North Carolina Medical Board’s Position Statements are interpretive statements that attempt to define or explain the meaning of laws or rules that govern the practice of physicians,* physician assistants, and nurse practitioners in North Carolina, usually those relating to discipline. They also set forth criteria or guidelines used by the Board’s staff in investigations and in the prosecution or settlement of cases.

When considering the Board’s Position Statements, the following four points should be kept in mind.

- 1) In its Position Statements, the Board attempts to articulate some of the standards it believes applicable to the medical profession and to the other health care professions it regulates. However, a Position Statement should not be seen as the promulgation of a new standard as of the date of issuance or amendment. Some Position Statements are reminders of traditional, even millennia old, professional standards, or show how the Board might apply such standards today.
- 2) The Position Statements are not intended to be comprehensive or to set out exhaustively every standard that might apply in every circumstance. Therefore, the absence of a Position Statement or a Position Statement’s silence on certain matters should not be construed as the lack of an enforceable standard.
- 3) The existence of a Position Statement should not necessarily be taken as an indication of the Board’s enforcement priorities.
- 4) A lack of disciplinary actions to enforce a particular standard mentioned in a Position Statement should not be taken as an abandonment of the principles set forth therein.

The Board will continue to decide each case before it on all the facts and circumstances presented in the hearing, whether or not the issues have been the subject of a Position Statement. The Board intends that the Position Statements will reflect its philosophy on certain subjects and give licensees some guidance for avoiding Board scrutiny. The principles of professionalism and performance expressed in the Position Statements apply to all persons licensed and/or approved by the Board to render medical care at any level.

*The words “physician” and “doctor” as used in the Position Statements refer to persons who are MDs or DOs licensed by the Board to practice medicine and surgery in North Carolina. (Adopted November 1999) (Reviewed May 2010)

TABLE OF CONTENTS

The Physician-Patient Relationship.....	5	Joint Statement on Pain Management in End-of-Life Care.....	11
Medical Record Documentation.....	5	Office-Based Procedures.....	11
Access to Medical Records.....	6	Laser Surgery.....	15
Retention of Medical Records.....	6	Care of the Patient Undergoing Surgery or Other Invasive Procedure	16
Departures From or Closings of Medical Practices.....	6	HIV/HBV Infected Health Care Workers.....	16
The Retired Physician.....	7	Professional Obligation to Report Incompetence, Impairment, and Unethical Conduct.....	17
Advance Directives and Patient Autonomy.....	7	Advertising and Publicity.....	17
Availability of Physicians to Their Patients.....	7	Sales of Goods from Physicians Offices.....	18
Guidelines for Avoiding Misunderstandings During Physical Examinations.....	7	Referral Fees and Fee Splitting.....	18
Sexual Exploitation of Patients.....	8	Unethical Agreements in Complaint Settlements.....	18
Contact with Patients Before Prescribing.....	8	Medical Supervisor-Trainee Relationship.....	18
Writing of Prescriptions.....	8	Competence and Reentry to the Active Practice of Medicine	18
Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist.....	8	Capital Punishment	18
The Treatment of Obesity.....	9	Physician Supervision of Other Licensed Health Care Practitioners.....	19
Prescribing Legend/Controlled Substances for Other Than Valid Medical or Therapeutic Purposes, with Particular Reference to Substances or Preparations with Anabolic Properties.....	9	Drug Overdose Prevention.....	19
Policy for the Use of Controlled Substances for the Treatment of Pain.....	9	Medical Testimony.....	19
End-of-Life Responsibilities and Palliative Care.....	10	Collaborative Care within the Health Care Team.....	20
		Telemedicine.....	20
		Physician Scope of Practice.....	20

POSITION STATEMENTS

THE PHYSICIAN-PATIENT RELATIONSHIP

The duty of the physician is to provide competent, compassionate, and economically prudent care to all his or her patients. Having assumed care of a patient, the physician may not neglect that patient nor fail for any reason to prescribe the full care that patient requires in accord with the standards of acceptable medical practice. Further, it is the Board's position that it is unethical for a physician to allow financial incentives or contractual ties of any kind to adversely affect his or her medical judgment or patient care.

Therefore, it is the position of the North Carolina Medical Board that any act by a physician that violates or may violate the trust a patient places in the physician places the relationship between physician and patient at risk. This is true whether such an act is entirely self-determined or the result of the physician's contractual relationship with a health care entity. The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship remains inviolate. The physician who puts the physician-patient relationship at risk also puts his or her relationship with the Board in jeopardy.

Elements of the Physician-Patient Relationship

The North Carolina Medical Board licenses physicians as a part of regulating the practice of medicine in this state. Receiving a license to practice medicine grants the physician privileges and imposes great responsibilities. The people of North Carolina expect a licensed physician to be competent and worthy of their trust. As patients, they come to the physician in a vulnerable condition, believing the physician has knowledge and skill that will be used for their benefit.

Patient trust is fundamental to the relationship thus established. It requires that:

- there be adequate communication between the physician and the patient;
- the physician report all significant findings to the patient or the patient's legally designated surrogate/guardian/personal representative;
- there be no conflict of interest between the patient and the physician or third parties;
- personal details of the patient's life shared with the physician be held in confidence;
- the physician maintain professional knowledge and skills;
- there be respect for the patient's autonomy;
- the physician be compassionate;
- the physician respect the patient's right to request further restrictions on medical information disclosure and to request alternative communications;
- the physician be an advocate for needed medical care, even at the expense of the physician's personal interests; and
- the physician provide neither more nor less than the medical problem requires.

The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship, founded on patient trust, is considered sacred, and when the elements crucial to that relationship and to that trust—communication, patient primacy, confidentiality, competence, patient autonomy, compassion, selflessness, appropriate care—are foremost in the hearts, minds, and actions of the physicians licensed by the Board.

This same fundamental physician-patient relationship also applies to mid-level health care providers such as physician assistants and nurse practitioners in all practice settings.

Termination of the Physician-Patient Relationship

The Board recognizes the physician's right to choose patients and to terminate the professional relationship with them when he or she believes it is best to do so. That being understood, the Board maintains that termination of the physician-patient relationship must be done in compliance with the physician's obligation to support continuity of care for the patient.

The decision to terminate the relationship must be made by the physician personally. Further, termination must be accompanied by appropriate written notice given by the physician to the patient or the patient's representative sufficiently far in advance (at least 30 days) to allow other medical care to be secured. A copy of such notification is to be included in the medical record. Should the physician be a member of a group, the notice of termination must state clearly whether the termination involves

only the individual physician or includes other members of the group. In the latter case, those members of the group joining in the termination must be designated. It is advisable that the notice of termination also include instructions for transfer of or access to the patient's medical records.

(Adopted July 1995) (Amended July 1998, January 2000, March 2002, August 2003, September 2006)

MEDICAL RECORD DOCUMENTATION

The North Carolina Medical Board takes the position that an accurate, current and complete medical record is an essential component of patient care. Licensees should maintain a medical record for each patient to whom they provide care. The medical record should contain an appropriate history and physical examination, results of ancillary studies, diagnoses, and any plan for treatment. The medical record should be legible. When the care giver does not handwrite legibly, notes should be dictated, transcribed, reviewed, and signed within a reasonable time. The Board recognizes and encourages the trend towards the use of electronic medical records ("EMR"). However, the Board cautions against relying upon software that pre-populates particular fields in the EMR without updating those fields in order to create a medical record that accurately reflects the elements delineated in this Position Statement.

The medical record is a chronological document that:

- 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.

The following required elements should be present in all medical records:

1. The record reflects the purpose of each patient encounter and appropriate information about the patient's history and examination, and the care and treatment provided are described.
2. The patient's past medical history is easily identified and includes serious accidents, operations, significant illnesses and other appropriate information.
3. Medication and other significant allergies, or a statement of their absence, are prominently noted in the record.
4. When appropriate, informed consent obtained from the patient is clearly documented.
5. All entries are dated.

The following additional elements reflect commonly accepted standards for medical record documentation.

1. Each page in the medical record contains the patient's name or ID number.
2. Personal biographical information such as home address, employer, marital status, and all telephone numbers, including home, work, and mobile phone numbers.
3. All entries in the medical record contain the author's identification. Author identification may be a handwritten signature, initials, or a unique electronic identifier.
4. All drug therapies are listed, including dosage instructions and, when appropriate, indication of refill limits. Prescriptions refilled by phone should be recorded.
5. Encounter notes should include appropriate arrangements and specified times for follow-up care.
6. All consultation, laboratory and imaging reports should be entered into the patient's record, reviewed, and the review documented by the practitioner who ordered them. Abnormal reports should be noted in the record, along with corresponding follow-up plans and actions taken.
7. An appropriate immunization record is evident and kept up to date.
8. Appropriate preventive screening and services are offered in accordance with the accepted practice guidelines.

(Adopted May 1994) (Amended May 1996, May 2009)

POSITION STATEMENTS

ACCESS TO MEDICAL RECORDS

A physician's policies and practices relating to medical 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 medical records and a qualified right to amend their records pursuant to the HIPAA privacy regulations.

Medical 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 medical 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 endanger the patient's life or cause harm to another person. This includes medical 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 medical and other records. To assist in avoiding misunderstandings, and for a reasonable fee, the physician should be willing to review the medical records with the patient at the patient's request. Medical 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' medical 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.¹

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

¹See also Position Statement on Departures from or Closings of Medical Practices.

(Adopted November 1993) (Amended May 1996, September 1997, March 2002, August 2003)

RETENTION OF MEDICAL RECORDS

Physicians have both a legal and ethical obligation to retain patient records. The Board, therefore, recognizes the necessity and importance of a licensee's proper maintenance, retention, and disposition of medical records. The following guidelines are offered to assist licensees in meeting their ethical and legal obligations:

- State and federal laws require that records be kept for a minimum length of time including but not limited to:
 1. Medicare and Medicaid Investigations (up to 7 years);
 2. HIPAA (up to 6 years);
 3. 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;
 4. Immunization records always must be kept.
- In addition to existing state and federal laws, medical considerations may also provide the basis for deciding how long to retain medical records. Patients should be notified regarding how long the physician will retain medical records.

- 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. The Board, therefore, recognizes that the retention policies of physicians giving one-time, brief episodic care may differ from those of physicians providing continuing care for patients.
- In order to preserve confidentiality when discarding old records, all records should be destroyed, including both paper and electronic medical records.
- Those licensees providing episodic care should attempt to provide a copy of the patient's record to the patient, the patient's primary care provider, or, if applicable, the referring physician.
- If it is feasible, patients should be given an opportunity to claim the records or have them sent to another physician before old records are discarded.
- The physician should respond in a timely manner to requests from patients for copies of their medical records or to access to their medical records.
- Physicians should notify patients of the amount, and under what circumstances, the physician will charge for copies of a patient's medical record, keeping in mind that N.C. Gen. Stat. 90-411 provides limits on the fee a physician can charge for copying of medical records.

Physicians should retain medical records as long as needed not only to serve and protect patients, but also to protect themselves against adverse actions. The times stated may fall below the community standard for retention in their communities and practice settings and for the specific needs. Physicians are encouraged (may want to) seek advice from private counsel and/or their malpractice insurance carrier.

(Adopted May 1998) (Amended May 2009)

DEPARTURES FROM OR CLOSINGS OF MEDICAL PRACTICES

Departures from or closings of medical practices are trying times. If mishandled, they can significantly disrupt continuity of care and endanger patients.

Provide Continuity of Care

Practitioners continue to have obligations toward their patients during and after the departure from or closing of a medical practice. Practitioners may not abandon a patient or abruptly withdraw from the care of a patient. Patients should therefore be given reasonable advance notice (at least 30 days) to allow other medical care to be secured. Good continuity of care includes preserving and providing appropriate access to medical records.* Also, good continuity of care may often include making appropriate referrals. The practitioner(s) and other parties that may be involved should ensure that the requirements for continuity of care are effectively addressed.

It is the position of the North Carolina Medical Board that during such times practitioners and other parties that may be involved in such processes must consider how their actions affect patients. In particular, practitioners and other parties that may be involved have the following obligations.

Permit Patient Choice

It is the patient's decision from whom to receive care. Therefore, it is the responsibility of all practitioners and other parties that may be involved to ensure that:

- Patients are notified in a timely fashion of changes in the practice and given the opportunity to seek other medical care, sufficiently far in advance (at least 30 days) to allow other medical care to be secured, which is often done by newspaper advertisement and by letters to patients currently under care;
- Patients clearly understand that they have a choice of health care providers;
- Patients are told how to reach any practitioner(s) remaining in practice, and when specifically requested, are told how to contact departing practitioners; and
- Patients are told how to obtain copies of or transfer their medical records.

No practitioner, group of practitioners, or other parties involved should interfere with the fulfillment of these obligations, nor should practitioners put themselves in a position where they cannot be assured these obligations can be met.

POSITION STATEMENTS

Written Policies

The Board recommends that practitioners and practices prepare written policies regarding the secure storage, transfer and retrieval of patient medical records. Practitioners and practices should notify patients of these policies. At a minimum, the Board recommends that such written policies specify:

- A procedure and timeline that describes how the practitioner or practice will notify each patient when appropriate about (1) a pending practice closure or practitioner departure, (2) how medical records are to be accessed, and (3) how future notices of the location of the practice's medical records will be provided;
- How long medical records will be retained;
- The procedure by which the practitioner or practice will dispose of unclaimed medical records after a specified period of time;
- How the practitioner or practice 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 practitioner's death or incapacity, how the deceased practitioner's executor, administrator, personal representative or survivor will notify patients of the location of their medical records and how patients can access those records; and
- The procedure by which the deceased or incapacitated practitioner's executor, administrator, personal representative or survivor will dispose of unclaimed medical records after a specified period of time.

The Board further expects that its licensees comply with any applicable state and/or federal law or regulation pertaining to a patient's protected healthcare information.

*NOTE: The Board's Position Statement on the Retention of Medical Records applies, even when practices close permanently due to the retirement or death of the practitioner.

(Adopted January 2000) (Amended August 2003, July 2009)

THE RETIRED PHYSICIAN

The retirement of a physician is defined by the North Carolina Medical Board as the total and complete cessation of the practice of medicine and/or surgery by the physician in any form or setting. According to the Board's definition, the retired physician is not required to maintain a currently registered license and SHALL NOT:

- provide patient services;
- order tests or therapies;
- prescribe, dispense, or administer drugs;
- perform any other medical and/or surgical acts; or
- receive income from the provision of medical and/or surgical services performed following retirement.

The North Carolina Medical Board is aware that a number of physicians consider themselves "retired," but still hold a currently registered medical license (full, volunteer, or limited) and provide professional medical and/or surgical services to patients on a regular or occasional basis. Such physicians customarily serve the needs of previous patients, friends, nursing home residents, free clinics, emergency rooms, community health programs, etc. The Board commends those physicians for their willingness to continue service following "retirement," but it recognizes such service is not the "complete cessation of the practice of medicine" and therefore must be joined with an undiminished awareness of professional responsibility. That responsibility means that such physicians SHOULD:

- practice within their areas of professional competence;
- prepare and keep medical records in accord with good professional practice; and
- meet the Board's continuing medical education requirement.

The Board also reminds "retired" physicians with currently registered licenses that all federal and state laws and rules relating to the practice of medicine and/or surgery apply to them, that the position statements of the Board are as relevant to them as to physicians in full and regular practice, and that they continue to be subject to the risks of liability for any medical and/or surgical acts they perform.

(Adopted January 1997) (Amended September 2006)

ADVANCE DIRECTIVES AND PATIENT AUTONOMY

Advances in medical technology have given physicians the ability to prolong the mechanics of life almost indefinitely. Because of this, physicians must be aware that North Carolina law specifically recognizes the individual's right to a peaceful and natural death. NC Gen Stat § 90-320 (a) (2007) reads:

The General Assembly recognizes as a matter of public policy that an individual's rights include the right to a peaceful and natural death and that a patient or his the patient's representative has the fundamental right to control the decisions relating to the rendering of his the patient's own medical care, including the decision to have extraordinary means life-prolonging measures withheld or withdrawn in instances of a terminal condition.

Physicians must also be aware that North Carolina law empowers any adult individual with capacity to make a Health Care Power of Attorney [NC Gen Stat § 32A-17 (2007)] and stipulates that, when a patient lacks understanding or capacity to make or communicate health care decisions, the instructions of a duly appointed health care agent are to be taken as those of the patient unless evidence to the contrary is available [NC Gen Stat § 32A- 24(b)(2007).

It is the position of the North Carolina Medical Board that it is in the best interest of the patient and of the physician/patient relationship to encourage patients to complete or authorize documents that express their wishes for the kind of care they desire at the end of their lives. Physicians should encourage their patients to appoint a health care agent to act through the execution of a Health Care Power of Attorney and to provide documentation of the appointment to the responsible physician(s). Further, physicians should provide full information to their patients in order to enable those patients to make informed and intelligent decisions preferably prior to a terminal illness. The Board also encourages the use of portable physician orders to improve the communication of the patient's wishes for treatment at the end of life from one care setting to another.

It is also the position of the Board that physicians are ethically obligated to follow the wishes of the terminally ill or incurable patient as expressed by and properly documented in a declaration of a desire for a natural death; however, when the wishes of a patient are contrary to what a physician believes in good conscience to be appropriate care, the physician may withdraw from the case once continuity of care is assured.

It is also the position of the Board that withholding or withdrawal of life-prolonging measures is in no manner to be construed as permitting diminution of nursing care, relief of pain, or any other care that may provide comfort for the patient.

(Adopted 7/1993) (Amended 5/1996; 3/2008)

AVAILABILITY OF PHYSICIANS TO THEIR PATIENTS

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

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

(Adopted July 1993) (Amended May 1996, January 2001, October 2003, July 2006)

GUIDELINES FOR AVOIDING MISUNDERSTANDINGS DURING PHYSICAL EXAMINATIONS

It is the position of the North Carolina Medical Board that proper care and sensitivity are needed during physical examinations to avoid misunderstandings that could lead to charges of sexual misconduct against licensees. In order to prevent such misunderstandings, the Board offers the following guidelines.

1. Sensitivity to patient dignity should be considered by the licensee when undertaking a physical examination. The patient should be assured of adequate auditory and visual privacy and should never be asked to disrobe in the presence of the licensee. Examining rooms should be safe, clean, and well maintained, and should be equipped with appropriate furniture for examination and treatment. Gowns, sheets and/or other appropriate apparel should be made available to protect patient dignity and decrease embarrassment to the patient while a thorough and professional examination is conducted.
2. Whatever the sex of the patient, a third party, a staff member, should be readily available at all times during a physical examination, and it is strongly advised that a third party be present when the licensee performs an examination of the breast(s), genitalia, or rectum. It is the licensee's responsibility to have a staff member available at any point

POSITION STATEMENTS

during the examination.

3. The licensee should individualize the approach to physical examinations so that each patient's apprehension, fear, and embarrassment are diminished as much as possible. An explanation of the necessity of a complete physical examination, the components of that examination, and the purpose of disrobing may be necessary in order to minimize the patient's possible misunderstanding.
4. The licensee and staff should exercise the same degree of professionalism and care when performing diagnostic procedures (eg, electro-cardiograms, electromyograms, endoscopic procedures, and radiological studies, etc), as well as during surgical procedures and postsurgical follow-up examinations when the patient is in varying stages of consciousness.
5. The licensee should be on the alert for suggestive or flirtatious behavior or mannerisms on the part of the patient and should not permit a compromising situation to develop.

(Adopted May 1991) (Amended May 1993, May 1996, January 2001, February 2001, October 2002, July 2010)

SEXUAL EXPLOITATION OF PATIENTS

It is the position of the North Carolina Medical Board that sexual exploitation of a patient is unprofessional conduct and undermines the public trust in the medical profession. Sexual exploitation encompasses a wide range of behaviors which have in common the intended sexual gratification of the physician. These behaviors include sexual intercourse with a patient (consensual or non-consensual), touching genitalia with ungloved hands, sexually suggestive comments, asking patients for a date, inappropriate exploration of the patients or physician's sexual phantasias, touching or exposing genitalia, breast, or other parts of the body in ways not dictated by an appropriate and indicated physical examination, exchanging sexual favors for services. Sexual exploitation is grounds for the suspension, revocation, or other action against a physician's license. This position statement is based upon the Federation of State Medical Board's guidelines regarding sexual boundaries.

Sexual misconduct by physicians and other health care practitioners is a form of behavior that adversely affects the public welfare and harms patients individually and collectively. Physician sexual misconduct exploits the physician-patient relationship, is a violation of the public trust, and is often known to cause harm, both mentally and physically, to the patient.

Regardless of whether sexual misconduct is viewed as emanating from an underlying form of impairment, it is unarguably a violation of the public's trust.

As with other disciplinary actions taken by the Board, Board action against a medical licensee for sexual exploitation of a patient is published by the Board, the nature of the offense being clearly specified. It is also released to the news media, to state and federal government, and to medical and professional organizations.

(Adopted May 1991) (Amended April 1996, January 2001, September 2006)

CONTACT WITH PATIENTS BEFORE PRESCRIBING

It is the position of the North Carolina Medical Board that prescribing drugs to an individual the prescriber has not personally examined is inappropriate except as noted in the paragraphs below. Before prescribing a drug, a licensee should make an informed medical judgment based on the circumstances of the situation and on his or her training and experience. Ordinarily, this will require that the licensee personally perform an appropriate history and physical examination, make a diagnosis, and formulate a therapeutic plan, a part of which might be a prescription. This process must be documented appropriately.

Prescribing for a patient whom the licensee has not personally examined may be suitable under certain circumstances. These may include admission orders for a newly hospitalized patient, prescribing for a patient of another licensee for whom the prescriber is taking call, or continuing medication on a short-term basis for a new patient prior to the patient's first appointment. Established patients may not require a new history and physical examination for each new prescription, depending on good medical practice.

Prescribing for an individual whom the licensee has not met or personally examined may also be suitable when that individual is the partner of a patient whom the licensee is treating for gonorrhea or chlamydia. Partner management of patients with gonorrhea or chlamydia should include the following items:

- a) Signed prescriptions of oral antibiotics of the appropriate quantity

and strength sufficient to provide curative treatment for each partner named by the infected patient. Notation on the prescription should include the statement: "Expedited partner therapy."

- b) Signed prescriptions to named partners should be accompanied by written material that states that clinical evaluation is desirable; that prescriptions for medication or related compounds to which the partner is allergic should not be accepted; and that lists common medication side effects and the appropriate response to them.
- c) Prescriptions and accompanying written material should be given to the licensee's patient for distribution to named partners.
- d) The licensee should keep appropriate documentation of partner management. Documentation should include the names of partners and a copy of the prescriptions issued or an equivalent statement.

It is the position of the Board that prescribing drugs to individuals the licensee has never met based solely on answers to a set of questions, as is common in Internet or toll-free telephone prescribing, is inappropriate and unprofessional.

(Adopted November 1999) (Amended February 2001, November 2009) (Reviewed July 2010)

WRITING OF PRESCRIPTIONS

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

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

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

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

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

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

((Adopted May 1991, September 1992) (Amended May 1996; March 2002; July 2002; March 2011)

SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS AND OTHERS WITH WHOM SIGNIFICANT EMOTIONAL RELATIONSHIPS EXIST*

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

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

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

*This position statement was formerly titled, "Treatment of and Prescribing for Family Members." (Adopted May 1991) (Amended May 1996; May 2000; March 2002; September 2005)

POSITION STATEMENTS

THE TREATMENT OF OBESITY

It is the position of the North Carolina Medical Board that the cornerstones of the treatment of obesity are diet (caloric control) and exercise. Medications and surgery should only be used to treat obesity when the benefits outweigh the risks of the chosen modality.

The treatment of obesity should be based on sound scientific evidence and principles. Adequate medical documentation must be kept so that progress as well as the success or failure of any modality is easily ascertained.

(Adopted [as The Use of Anorectics in Treatment of Obesity] October 1987) (Amended March 1996) (Amended and retitled January 2005) (Reviewed November 2010)

PRESCRIBING LEGEND OR CONTROLLED SUBSTANCES FOR OTHER THAN VALIDATED MEDICAL OR THERAPEUTIC PURPOSES, WITH PARTICULAR REFERENCE TO SUBSTANCE OR PREPARATIONS WITH ANABOLIC PROPERTIES

General

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

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

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

Substances/Preparations with Anabolic Properties

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

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

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

(Adopted May 1998) (Amended July 1998, January 2001; September 2011)

POLICY FOR THE USE OF CONTROLLED SUBSTANCES FOR THE TREATMENT OF PAIN

- Appropriate treatment of chronic pain may include both pharmacologic and non-pharmacologic modalities. The Board realizes that controlled substances, including opioid analgesics, may be an essential part of the treatment regimen.
- All prescribing of controlled substances must comply with applicable state and federal law.
- Guidelines for treatment include: (a) complete patient evaluation, (b) establishment of a treatment plan (contract), (c) informed consent, (d) periodic review, and (e) consultation with specialists in various treatment modalities as appropriate.
- Deviation from these guidelines will be considered on an individual basis for appropriateness.

Section I: Preamble

The North Carolina Medical Board recognizes that principles of quality medical practice dictate that the people of the State of North Carolina have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbidity and costs associated with untreated or inappropriately treated pain. For the purposes of this policy, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

The diagnosis and treatment of pain is integral to the practice of medicine. The Board encourages physicians to view pain management as a part of quality medical practice for all patients with pain, acute or chronic, and it is especially urgent for patients who experience pain as a result of terminal illness. All physicians should become knowledgeable about assessing patients' pain and effective methods of pain treatment, as well as statutory requirements for prescribing controlled substances. Accordingly, this policy has been developed to clarify the Board's position on pain control, particularly as related to the use of controlled substances, to alleviate physician uncertainty and to encourage better pain management.

Inappropriate pain treatment may result from physicians' lack of knowledge about pain management. Fears of investigation or sanction by federal, state and local agencies may also result in inappropriate treatment of pain. Appropriate pain management is the treating physician's responsibility. As such, the Board will consider the inappropriate treatment of pain to be a departure from standards of practice and will investigate such allegations, recognizing that some types of pain cannot be completely relieved, and taking into account whether the treatment is appropriate for the diagnosis.

The Board recognizes that controlled substances including opioid analgesics may be essential in the treatment of acute pain due to trauma or surgery and chronic pain, whether due to cancer or non-cancer origins. The Board will refer to current clinical practice guidelines and expert review in approaching cases involving management of pain. The medical management of pain should consider current clinical knowledge and scientific research and the use of pharmacologic and non-pharmacologic modalities according to the judgment of the physician. Pain should be assessed and treated promptly, and the quantity and frequency of doses should be adjusted according to the intensity, duration of the pain, and treatment outcomes. Physicians should recognize that tolerance and physical dependence are normal consequences of sustained use of opioid analgesics and are not the same as addiction.

The North Carolina Medical Board is obligated under the laws of the State of North Carolina to protect the public health and safety. The Board recognizes that the use of opioid analgesics for other than legitimate medical purposes pose a threat to the individual and society and that the inappropriate prescribing of controlled substances, including opioid analgesics, may lead to drug diversion and abuse by individuals who seek them for other than legitimate medical use. Accordingly, the Board expects that physicians incorporate safeguards into their practices to minimize the potential for the abuse and diversion of controlled substances.

Physicians should not fear disciplinary action from the Board for ordering, prescribing, dispensing or administering controlled substances, including opioid analgesics, for a legitimate medical purpose and in the course of professional practice. The Board will consider prescribing, ordering, dispensing or administering controlled substances for pain to be for a legitimate medical purpose if based on sound clinical judgment. All such prescribing must be based on clear documentation of unrelieved pain. To be within the usual course of professional practice, a physician-patient relationship must exist and the prescribing should be based on a diagnosis and documentation of unrelieved pain. Compliance with applicable state or federal law is required.

The Board will judge the validity of the physician's treatment of the patient based on available documentation, rather than solely on the quantity and duration of medication administration. The goal is to control the patient's pain while effectively addressing other aspects of the patient's functioning, including physical, psychological, social and work-related factors.

Allegations of inappropriate pain management will be evaluated on an individual basis. The Board will not take disciplinary action against a physician for deviating from this policy when contemporaneous medical records document reasonable cause for deviation. The physician's conduct will be evaluated to a great extent by the outcome of pain treatment, recognizing that some types of pain cannot be completely relieved, and by taking into account whether the drug used is appropriate for the diagnosis, as well as improvement in patient functioning and/or quality of life.

Section II: Guidelines

The Board has adopted the following criteria when evaluating the physician's treatment of pain, including the use of controlled substances:

Evaluation of the Patient —A medical history and physical examination must be obtained, evaluated, and documented in the medical record.

POSITION STATEMENTS

The medical record should document the nature and intensity of the pain, current and past treatments for pain, underlying or coexisting diseases or conditions, the effect of the pain on physical and psychological function, and history of substance abuse. The medical record also should document the presence of one or more recognized medical indications for the use of a controlled substance.

Treatment Plan —The written treatment plan should state objectives that will be used to determine treatment success, such as pain relief and improved physical and psychosocial function, and should indicate if any further diagnostic evaluations or other treatments are planned. After treatment begins, the physician should adjust drug therapy to the individual medical needs of each patient. Other treatment modalities or a rehabilitation program may be necessary depending on the etiology of the pain and the extent to which the pain is associated with physical and psychosocial impairment.

Informed Consent and Agreement for Treatment —The physician should discuss the risks and benefits of the use of controlled substances with the patient, persons designated by the patient or with the patient's surrogate or guardian if the patient is without medical decision-making capacity. The patient should receive prescriptions from one physician and one pharmacy whenever possible. If the patient is at high risk for medication abuse or has a history of substance abuse, the physician should consider the use of a written agreement between physician and

- patient outlining patient responsibilities, including
- urine/serum medication levels screening when requested;
- number and frequency of all prescription refills; and
- reasons for which drug therapy may be discontinued (e.g., violation of agreement); and
- the North Carolina Controlled Substance Reporting Service can be accessed and its results used to make treatment decisions.

Periodic Review —The physician should periodically review the course of pain treatment and any new information about the etiology of the pain or the patient's state of health. Continuation or modification of controlled substances for pain management therapy depends on the physician's evaluation of progress toward treatment objectives. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Objective evidence of improved or diminished function should be monitored and information from family members or other caregivers should be considered in determining the patient's response to treatment. If the patient's progress is unsatisfactory, the physician should assess the appropriateness of continued use of the current treatment plan and consider the use of other therapeutic modalities. Reviewing the North Carolina Controlled Substance Reporting Service should be considered if inappropriate medication usage is suspected and intermittently on all patients.

Consultation —The physician should be willing to refer the patient as necessary for additional evaluation and treatment in order to achieve treatment objectives. Special attention should be given to those patients with pain who are at risk for medication misuse, abuse or diversion. The management of pain in patients with a history of substance abuse or with a comorbid psychiatric disorder may require extra care, monitoring, documentation and consultation with or referral to an expert in the management of such patients.

Medical Records —The physician should keep accurate and complete records to include

- the medical history and physical examination,
- diagnostic, therapeutic and laboratory results,
- evaluations and consultations,
- treatment objectives,
- discussion of risks and benefits,
- informed consent,
- treatments,
- medications (including date, type, dosage and quantity prescribed),
- instructions and agreements and
- periodic reviews including potential review of the North Carolina Controlled Substance Reporting Service.

Records should remain current and be maintained in an accessible manner and readily available for review.

Compliance With Controlled Substances Laws and Regulations

To prescribe, dispense or administer controlled substances, the physician must be licensed in the state and comply with applicable federal and state regulations. Physicians are referred to the Physicians Manual of the U.S.

Drug Enforcement Administration and any relevant documents issued by the state of North Carolina for specific rules governing controlled substances as well as applicable state regulations.

Section III: Definitions

For the purposes of these guidelines, the following terms are defined as follows:

Acute Pain —Acute pain is the normal, predicted physiological response to a noxious chemical, thermal or mechanical stimulus and typically is associated with invasive procedures, trauma and disease. It is generally time-limited.

Addiction —Addiction is a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired control over drug use, craving, compulsive use, and continued use despite harm. Physical dependence and tolerance are normal physiological consequences of extended opioid therapy for pain and are not the same as addiction.

Chronic Pain —Chronic pain is a state in which pain persists beyond the usual course of an acute disease or healing of an injury, or that may or may not be associated with an acute or chronic pathologic process that causes continuous or intermittent pain over months or years.

Pain —An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage. **Physical Dependence** —Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

Pseudoaddiction —The iatrogenic syndrome resulting from the misinterpretation of relief seeking behaviors as though they are drug-seeking behaviors that are commonly seen with addiction. The relief seeking behaviors resolve upon institution of effective analgesic therapy.

Substance Abuse —Substance abuse is the use of any substance(s) for non-therapeutic purposes or use of medication for purposes other than those for which it is prescribed.

Tolerance —Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction.

(Adopted September 1996 as "Management of Chronic Non-Malignant Pain.") (Redone July 2005 based on the Federation of State Medical Board's "Model Policy for the Use of Controlled Substances for the Treatment of Pain," as amended by the FSMB in 2004.) (Amended 9/2008)

END-OF-LIFE RESPONSIBILITIES AND PALLIATIVE CARE

Assuring Patients

Death is part of life. When appropriate processes have determined that the use of life prolonging measures 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

POSITION STATEMENTS

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.**

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 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.

(Adopted 10/1999) (Amended 5/2007; 3/2008)

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

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

JOINT STATEMENT ON PAIN MANAGEMENT IN END-OF-LIFE CARE

(Adopted by the North Carolina Medical, Nursing, and Pharmacy Boards)

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

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

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

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

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

specific cases. However, these occasions would be exceptions to general practice and would need to be properly documented to establish informed consent of the patient and family.

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

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

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

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

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

(October 1999) (Amended January 2011)

OFFICE-BASED PROCEDURES

Preface

This Position Statement on Office-Based Procedures is an interpretive statement that attempts to identify and explain the standards of practice for Office-Based Procedures in North Carolina. The Board's intention is to articulate existing professional standards and not to promulgate a new standard.

This Position Statement is in the form of guidelines designed to assure patient safety and identify the criteria by which the Board will assess the conduct of its licensees in considering disciplinary action arising out of the performance of office-based procedures. Thus, it is expected that the licensee who follows the guidelines set forth below will avoid disciplinary action by the Board. However, this Position Statement is not intended to be comprehensive or to set out exhaustively every standard that might apply in every circumstance. The silence of the Position Statement on any particular matter should not be construed as the lack of an enforceable standard.

General Guidelines

The Physician's Professional and Legal Obligation

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

POSITION STATEMENTS

takes responsibility for the supervision of all aspects of the perioperative surgical, procedural and anesthesia care delivered in the office setting, including compliance with all aspects of these guidelines.

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

Exemptions

These guidelines do not apply to Level I procedures.

Written Policies and Procedures

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

Emergency Procedure and Transfer Protocol

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

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

Infection Control

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

Performance Improvement

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

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

Medical Records and Informed Consent

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

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

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

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

Credentialing of Physicians

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

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

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

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

Accreditation

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

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

Patient Selection

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

ASA Physical Status Classifications

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

Candidates for Level II Procedures

Patients with an ASA physical status classification I, II, or III may be acceptable candidates for office-based surgical or special procedures

POSITION STATEMENTS

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

Candidates for Level III Procedures

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

Surgical or Special Procedure Guidelines

Patient Preparation

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

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

The physician performing the surgical or special procedure also should:

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

Discharge Criteria

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

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

Information to the Patient

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

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

Reportable Complications

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

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

Equipment Maintenance

All anesthesia-related equipment and monitors should be maintained to

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

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

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

Compliance with Relevant Health Laws

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

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

Patient Rights

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

Enforcement

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

Level II Guidelines

Personnel

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

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

Surgical or Special Procedure Guidelines

Intraoperative Care and Monitoring

The physician who performs Level II procedures that require conscious sedation in an office should ensure that monitoring is provided by a separate health care professional not otherwise involved in the surgical or special procedure. Monitoring should include, when clinically indicated for the patient:

- direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
 - pulse oximetry should be performed continuously (an alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness);
 - an electrocardiogram monitor should be used continuously on the patient;
 - the patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes; and
 - the body temperature of a pediatric patient should be measured continuously.
- Clinically relevant findings during intraoperative monitoring should be documented in the patient's medical record.

Postoperative Care and Monitoring

The physician who performs the surgical or special procedure should

POSITION STATEMENTS

evaluate the patient immediately upon completion of the surgery or special procedure and the anesthesia.

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

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

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

Equipment and Supplies

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

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

Level III Guidelines

Personnel

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

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

Surgical or Special Procedure Guidelines

Intraoperative Monitoring

The physician who performs procedures in an office that require major conduction blockade, deep sedation/analgesia, or general anesthesia should ensure that monitoring is provided as follows when clinically indicated for the patient:

- direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
- pulse oximetry should be performed continuously. Any alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness;
- an electrocardiogram monitor should be used continuously on the patient;
- the patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes;
- monitoring should be provided by a separate health care professional not

- otherwise involved in the surgical or special procedure;
- end-tidal carbon dioxide monitoring should be performed on the patient continuously during endotracheal anesthesia;
- an in-circuit oxygen analyzer should be used to monitor the oxygen concentration within the breathing circuit, displaying the oxygen percent of the total inspiratory mixture;
- a respirometer (volumeter) should be used to measure exhaled tidal volume whenever the breathing circuit of a patient allows;
- the body temperature of each patient should be measured continuously; and
- an esophageal or precordial stethoscope should be utilized on the patient. Clinically relevant findings during intraoperative monitoring should be documented in the patient's medical record.

Postoperative Care and Monitoring

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

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

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

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

Equipment and Supplies

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

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

Definitions

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

AAAHCC – the Accreditation Association for Ambulatory Health Care

ABMS – the American Board of Medical Specialties

ACGME – the Accreditation Council for Graduate Medical Education

ACLS certified – a person who holds a current "ACLS Provider" credential certifying that

POSITION STATEMENTS

they have successfully completed the national cognitive and skills evaluations in accordance with the curriculum of the American Heart Association for the Advanced Cardiovascular Life Support Program.

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

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

Anesthesia provider – an anesthesiologist or CRNA.

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

AOA – the American Osteopathic Association

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

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

ASA – the American Society of Anesthesiologists

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

Board – the North Carolina Medical Board.

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

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

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

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

FDA – the Food and Drug Administration.

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

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

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

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

Immediately available – within the office.

JCAHO – the Joint Commission for the Accreditation of Health Organizations

Level I procedures – any surgical or special procedures:

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

Level II procedures – any surgical or special procedures:

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

Level III procedures – any surgical or special procedures:

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

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

Major conduction blockade – the injection of local anesthesia to stop or prevent a

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

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

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

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

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

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

OSHA – the Occupational Safety and Health Administration.

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

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

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

Reasonable Proximity–The Board recognizes that reasonable proximity is a somewhat ambiguous standard. The Board believes that the standard often used by hospitals of thirty (30) minutes travel time is a useful benchmark.

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

Reportable complications – untoward events occurring at any time within forty-eight (48) hours of any surgical or special procedure or the administration of anesthesia in an office setting including, but not limited to, any of the following: paralysis, nerve injury, malignant hyperthermia, seizures, myocardial infarction, pulmonary embolism, renal failure, significant cardiac events, respiratory arrest, aspiration of gastric contents, cerebral vascular accident, transfusion reaction, pneumothorax, allergic reaction to anesthesia, unintended hospitalization for more than twenty-four (24) hours, or death.

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

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

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

[A Position Statement on Office-Based Surgery was adopted by the Board on September 2000. The statement above (Adopted January 2003) replaces that statement.] (Anended May 2011)

LASER SURGERY

It is the position of the North Carolina Medical Board that the revision, destruction, incision, or other structural alteration of human tissue using laser technology is surgery.* Laser surgery should be performed only by a physician or by a licensed health care practitioner working within his or her professional scope of practice and with appropriate medical training functioning under the supervision, preferably on-site, of a physician or by those categories of practitioners currently licensed by this state to perform surgical services.

Licensees should use only devices approved by the U.S. Food and Drug Administration unless functioning under protocols approved by institutional review boards. As with all new procedures, it is the licensee's responsibility to obtain adequate training and to make documentation of this training available to the North Carolina Medical Board on request.

Laser Hair Removal

Lasers are employed in certain hair-removal procedures, as are various devices that (1) manipulate and/or pulse light causing it to penetrate

POSITION STATEMENTS

human tissue and (2) are classified as “prescription” by the U.S. Food and Drug Administration. Hair-removal procedures using such technologies should be performed only by a physician or by an individual designated as having adequate training and experience by a physician who bears full responsibility for the procedure. The physician who provides medical supervision is expected to provide adequate oversight of licensed and non-licensed personnel both before and after the procedure is performed. The Board believes that the guidelines set forth in this Position Statement are applicable to every licensee of the Board involved in laser hair removal, whether as an owner, medical director, consultant or otherwise.

It is the position of the Board that good medical practice requires that each patient be examined by a physician, physician assistant or nurse practitioner licensed or approved by this Board prior to receiving the first laser hair removal treatment and at other times as medically indicated. The examination should include a history and a focused physical examination. Where prescription medication such as topical anesthetics are used, the Board expects physicians to follow the guidelines set forth in the Board’s Position Statement titled “Contact with Patients Before Prescribing.” When medication is prescribed or dispensed in connection with laser hair removal, the supervising physician shall assure the patient receives thorough instructions on the safe use or application of said medication. The responsible supervising physician should be on site or readily available to the person actually performing the procedure. What constitutes “readily available” will depend on a variety of factors. Those factors include the specific types of procedures and equipment used; the level of training of the persons performing the procedure; the level and type of licensure, if any, of the persons performing the procedure; the use of topical anesthetics; the quality of written protocols for the performance of the procedure; the frequency, quality and type of ongoing education of those performing the procedures; and any other quality assurance measures in place. In all cases, the Board expects the physician to be able to respond quickly to patient emergencies and questions by those performing the procedures.

*Definition of surgery as adopted by the NCMB, November 1998: Surgery, which involves the revision, destruction, incision, or structural alteration of human tissue performed using a variety of methods and instruments, is a discipline that includes the operative and non-operative care of individuals in need of such intervention, and demands pre-operative assessment, judgment, technical skills, post-operative management, and follow up. (Adopted July 1999) (Amended January 2000; March 2002; August 2002; July 2005)

CARE OF PATIENT UNDERGOING SURGERY OR OTHER INVASIVE PROCEDURE*

The evaluation, diagnosis, and care of the surgical patient is primarily the responsibility of the surgeon. He or she alone bears responsibility for ensuring the patient undergoes a preoperative assessment appropriate to the procedure. The assessment shall include a review of the patient’s data and an independent diagnosis by the operating surgeon of the condition requiring surgery. The operating surgeon shall have a detailed discussion with each patient regarding the diagnosis and the nature of the surgery, advising the patient fully of the risks involved. It is also the responsibility of the operating surgeon to reevaluate the patient immediately prior to the procedure.

It is the responsibility of the operating surgeon to assure safe and readily available postoperative care for each patient on whom he or she performs surgery. It is not improper to involve other licensed health care practitioners in postoperative care so long as the operating surgeon maintains responsibility for such care. The postoperative note must reflect the findings encountered in the individual patient and the procedure performed.

When identical procedures are done on a number of patients, individual notes should be done for each patient that reflect the specific findings and procedures of that operation. (Invasive procedures includes, but is not limited to, endoscopies, cardiac catheterizations, interventional radiology procedures, etc. Surgeon refers to the provider performing the procedure)

*This position statement was formerly titled, “Care of the Surgical Patients.” (Adopted September 1991) (Amended March 2001, September 2006)

HIV/HVB INFECTED HEALTH CARE WORKERS

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

health care workers.

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

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

- (1) “Health care organization” means hospital; clinic; physician, dentist, podiatrist, optometrist, or chiropractic office; home health agency; nursing home; local health department; community health center; mental health agency; hospice; ambulatory surgical center; urgent care center; emergency room; or any other health care provider that provides clinical care.
- (2) “Invasive procedure” means entry into tissues, cavities, or organs or repair of traumatic injuries. The term includes the use of needles to puncture skin, vaginal and cesarean deliveries, surgery, and dental procedures during which bleeding occurs or the potential for bleeding exists.
- (b) Health care workers, emergency responders, and funeral service personnel shall follow blood and body fluid precautions with all patients.
- (c) Health care workers who have exudative lesions or weeping dermatitis shall refrain from handling patient care equipment and devices used in performing invasive procedures and from all direct patient care that involves the potential for contact of the patient, equipment, or devices with the lesion or dermatitis until the condition resolves.
- (d) All equipment used to puncture skin, mucous membranes, or other tissues in medical, dental, or other settings must be disposed of in accordance with 10A NCAC 36B after use or sterilized prior to reuse.
- (e) In order to prevent transmission of HIV and hepatitis B from health care workers to patients, each health care organization that performs invasive procedures shall implement a written infection control policy. The health care organization shall ensure that health care workers in its employ or who have staff privileges are trained in the principles of infection control and the practices required by the policy; require and monitor compliance with the policy; and update the policy as needed to prevent transmission of HIV and hepatitis B from health care workers to patients. The health care organization shall designate a staff member to direct these activities. The designated staff member in each health care organization shall complete a course in infection control approved by the Department. The course shall address:

- (1) Epidemiologic principles of infectious disease;
 - (2) Principles and practice of asepsis;
 - (3) Sterilization, disinfection, and sanitation;
 - (4) Universal blood and body fluid precautions;
 - (5) Engineering controls to reduce the risk of sharp injuries;
 - (6) Disposal of sharps; and
 - (7) Techniques that reduce the risk of sharp injuries to health care workers.
- (f) The infection control policy required by this Rule shall address the following components that are necessary to prevent transmission of HIV and hepatitis B from infected health care workers to patients:
- (1) Sterilization and disinfection, including a schedule for maintenance and microbiologic monitoring of equipment; the policy shall require documentation of maintenance and monitoring;
 - (2) Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules;
 - (3) Accessibility of infection control devices and supplies;
 - (4) Procedures to be followed in implementing 10A NCAC 41A .0202(4) and .0203(b)(4) when a health care provider or a patient has an exposure to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV or hepatitis B.

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

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

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

- (1) “Surgical or obstetrical procedures” means vaginal deliveries or surgical entry into tissues, cavities, or organs. The term does not include phlebotomy; administration of intramuscular, intradermal, or subcutaneous injections; needle biopsies; needle aspirations; lumbar punctures; angiographic procedures; endoscopic and bronchoscopic procedures; or placing or maintaining peripheral or central intravascular lines.
- (2) “Dental procedure” means any dental procedure involving manipulation, cutting, or removal of oral or perioral tissues, including tooth structure during which bleeding occurs or the potential for bleeding exists. The term does not include the brushing of teeth.
- (b) All health care workers who perform surgical or obstetrical procedures or dental procedures and who know themselves to be infected with HIV or hepatitis B shall notify the State Health Director. Health care workers who assist in these procedures in a manner that may result in exposure of patients to their blood and who know themselves to be infected with HIV or hepatitis B shall also notify the State Health Director. The notification shall be made in writing to the Chief, Communicable Disease Control Branch, 1902 Mail Service Center, Raleigh, NC 27699-1902.

POSITION STATEMENTS

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

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

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

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

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

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

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

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

(j) If practice restrictions are imposed on a licensed health care worker, a copy of the isolation order shall be provided to the appropriate licensure board. The

State Health Director shall report violations of the isolation order to the appropriate licensure board. The licensure board shall report to the State Health Director any information about the infected health care worker that may be relevant to the risk of transmission of HIV or hepatitis B to patients.

History Note: Authority G.S. 130A 144; 130A 145; Eff. October 1, 1992; Amended Eff. April 1, 2003. (Adopted November 1992) (Amended May 1996; January 2005, January 2011)

PROFESSIONAL OBLIGATIONS PERTAINING TO INCOMPETENCE, IMPAIRMENT OR UNETHICAL CONDUCT OF LICENSEES

It is the position of the North Carolina Medical Board that its licensees have a professional obligation to act when confronted with an impaired or incompetent colleague or one who has engaged in unethical conduct.

When appropriate, an offer of personal assistance to the colleague may be the most compassionate and effective intervention. When this would not be appropriate or sufficient to address the problem, licensees have a duty to report the matter to the institution best positioned to deal with the problem. For example, impaired licensees should be reported to the North Carolina Physicians Health program. Incompetent licensees should be reported to the clinical authority empowered to take appropriate action. Licensees also may report to the North Carolina Medical Board, and when there is no other institution reasonably likely to be able to deal with the problem, this will be the only way of discharging the duty to report.

This duty is subordinate to the duty to maintain patient confidences. In other words, when the colleague is a patient or when matters concerning a colleague are brought to the licensee's attention by a patient, the licensee must give appropriate consideration to preserving the patient's confidences in deciding whether to report the colleague.

(Adopted November 1998) (Amended May 2010)

ADVERTISING AND PUBLICITY*

It is the position of the North Carolina Medical Board that advertising or publicity that is deceptive, false, or misleading constitutes unprofessional conduct under the Medical Practice Act.*

The term "advertising" includes oral, written and other types of communication disseminated by or at the direction of a licensee for the purpose of encouraging or soliciting the use of the licensee's services. At issue is whether a member of the general public would be confused or deceived by the advertising in question. The following general principles are intended to assist licensees in meeting the Board's expectations: (1) advertisements should not contain false claims or misrepresentations of fact, either expressly or by implication; (2) advertisements should not omit material facts; and (3) licensees should be prepared to substantiate claims made in advertisements.

Licensees should avoid advertising and publicity that create unjustified medical expectations, that are accompanied by deceptive claims, or that imply exclusive or unique skills or remedies. Similarly, a statement that a licensee has cured or successfully treated a large number of patients suffering a particular ailment is deceptive if it implies a certainty of results and/or creates unjustified or misleading expectations. When using patient photographs, they should be of the licensee's own patients and demonstrate realistic outcomes. Likewise, when a change of circumstances renders advertising inaccurate or misleading, the licensee is expected to make reasonable efforts to correct the advertising within a reasonable time frame.

The advent of the Internet and the proliferation of websites purporting to "rate" healthcare providers mean that licensees cannot always control information about themselves in the public domain. However, a licensee is expected to exercise reasonable efforts to bring about the correction or elimination of false or misleading information when he or she becomes aware of it.

Physicians Advertising Board Certification

The term "board certified" is publicly regarded as evidence of the skill and training of a physician carrying this designation. Accordingly, in order to avoid misleading or deceptive advertising concerning board certification, physicians are expected to meet the following guidelines.

No physician should advertise or otherwise hold himself or herself out to the public as being "board certified" without proof of current certification by a specialty board approved by the (1) American Board of Medical Specialties (ABMS); (2) the Bureau of Osteopathic Specialists of the American Osteopathic Association (AOA-BOS); (3) the Royal College of Physicians and Surgeons of Canada (RCPSC); or (4) a board that meets the following requirements:

POSITION STATEMENTS

1. the organization requires satisfactory completion of a training program with training, documentation and clinical requirements similar in scope and complexity to ACGME- or AOA-approved programs, in the specialty or subspecialty field of medicine in which the physician seeks certification. Solely experiential or on-the-job training is not sufficient;
2. the organization requires all physicians seeking certification to successfully pass a written or oral examination or both, which tests the applicant's knowledge and skill in the specialty or subspecialty area of medicine. All examinations require a psychometric evaluation for validation;
3. the organization requires diplomates to recertify every ten years or less, and the recertification requires, at a minimum, passage of a written examination;
4. the organization prohibits all certification and recertification candidates from attempting more than three times in three years to pass the examination;
5. the organization has written by-laws and a code of ethics to guide the practice of its members and an internal review and control process including budgetary practices to ensure effective utilization of resources;
6. the organization has written proof of a determination by the Internal Revenue Service that the certifying organization is tax-exempt under Section 501(c) of the Internal Revenue Code; and
7. the organization has a permanent headquarters and staff sufficient to respond to consumer and regulatory inquiries.

Any physician advertising or otherwise holding himself or herself out to the public as "board certified" should disclose in the advertisement the specialty board by which the physician was certified. A physician is expected to maintain and provide to the Board upon request evidence of current board certification. In the case of physicians who have been certified by non-ABMS, non-AOA and non-RCPSC boards, the physician is expected to maintain and provide to the Board upon request evidence that the certifying board meets the criteria listed above.

The above limitations are only intended to apply to physicians who advertise or otherwise hold themselves out to the public as being "board certified." The above criteria are not applicable in other instances, such as employment determinations, privileging or credentialing decisions, membership on insurance panels, or setting reimbursement rates.

*Business letterheads, envelopes, cards, and similar materials are understood to be forms of advertising and publicity for the purpose of this Position Statement.

(Adopted November 1999) (Amended March 2001) (Reviewed September 2005) (Amended November 2010)

SALE OF GOODS FROM PHYSICIAN OFFICES

Inherent in the in-office sale of products is a perceived conflict of interest. On this issue, it is the position of the North Carolina Medical Board that the following instructions should guide the conduct of physicians or licensees.

Sale of practice-related items such as ointments, creams and lotions by Dermatologists, splints and appliances by Orthopedists, spectacles by Ophthalmologists, etc., may be acceptable only after the patient has been told those or similar items can be obtained locally from other sources. Any charge made should be reasonable.

Due to the potential for patient exploitation, the Medical Board opposes licensees participating in exclusive distributorships and/or personal branding, or persuading patients to become dealers or distributors of profit making goods or services.

Licensees should not sell any non health-related goods from their offices or other treatment settings. (This does not preclude selling of such low cost items on an occasional basis for the benefit of charitable or community organizations, provided the licensee receives no share of the proceeds, and patients are not pressured to purchase.)

All decisions regarding sales of items by the physician or his/her staff from the physician's office or other place where health care services are provided, must always be guided by what is in the patient's best interest. (Adopted March 2001) (Amended March 2006)

REFERRAL FEES AND FEE SPLITTING

Payment by or to a physician solely for the referral of a patient is unethical. A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company, or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source. In each case, the payment violates the requirement to deal honestly with patients and colleagues. The

patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

It is unethical for physicians to offer financial incentives or other valuable considerations to patients in exchange for recruitment of other patients. Such incentives can distort the information that patients provide to potential patients, thus distorting the expectations of potential patients and compromising the trust that is the foundation of the patient-physician relationship.

Furthermore, referral fees are prohibited by state law pursuant to N.C. Gen. Stat. Section 90-401. Violation of this law may result in disciplinary action by the Board.

Except in instances permitted by law (NC Gen Stat §55B-14(c)), it is the position of the Board that a physician cannot share revenue on a percentage basis with a non-physician. To do so is fee splitting and is grounds for disciplinary action.

(Adopted November 1993) (Amended May 1996, July 2006)

UNETHICAL AGREEMENTS IN COMPLAINT SETTLEMENTS

It is the position of the North Carolina Medical Board that it is unethical for a licensee to settle any complaint if the settlement contains an agreement by a patient not to complain or provide information to the Board.

(Adopted November 1993) (Amended May 1996, March 2010)

THE MEDICAL SUPERVISOR-TRAINEE RELATIONSHIP

It is the position of the North Carolina Medical Board that the relationship between medical supervisors and their trainees in medical schools and other medical training programs is one of the most valuable aspects of medical education. We note, however, that this relationship involves inherent inequalities in status and power that, if abused, may adversely affect the educational experience and, ultimately, patient care. Abusive behavior in the medical supervisor-trainee relationship, whether physical or verbal, is a form of unprofessional conduct. However, criticism and/or negative feedback that is offered with the aim of improving the educational experience and patient care should not be construed as abusive behavior.

(Adopted April 2004) (Reviewed November 2010)

COMPETENCE AND RE-ENTRY TO THE ACTIVE AND RE-ENTRY TO THE ACTIVE PRACTICE OF MEDICINE

The ability to practice medicine results from a complex interaction of knowledge, physical skills, judgment, and character tempered by experience leading to competence. Maintenance of competence requires a commitment to lifelong learning and the continuous practice of medicine, in whatever field one has chosen. Absence from the active practice of medicine leads to the attenuation of the ability to practice competently.

It is the position of the North Carolina Medical Board, in accord with GS 90-6(a), that practitioners seeking licensure, or reactivation of a North Carolina medical license, who have had an interruption, for whatever reason, in the continuous practice of medicine greater than two (2) years must reestablish, to the Board's satisfaction, their competence to practice medicine safely.

Any such applicant must meet all the requirements for and completion of a regular license application. In addition, full-scale assessments, engagement in formal training programs, supervised practice arrangements, formal testing, or other proofs of competence may be required.

The Board will cooperate with appropriate entities in the development of programs and resources that can be used to fulfill the above requirements, including the issuance, when necessary and appropriate, of a time or location limited and/or restricted license (e.g., residency training license).

It shall be the responsibility of the applicant to develop a reentry program subject to the approval of the Board.

(Adopted July 2006) (Reviewed July 2011)

CAPITAL PUNISHMENT

In *North Carolina Dept. Correction v. North Carolina Medical Board*, the North Carolina Supreme Court ruled that while the North Carolina Medical Board does "retain disciplinary power over a licensed medical doctor who participates in an execution," the Board "may not discipline or threaten discipline against its licensees solely for participating in the execution alone." Consistent with the Supreme Court's ruling, the Board will not take any disciplinary action against a physician for participation in an execution.

The North Carolina Medical Board does, however, continue to take the

POSITION STATEMENTS

position that physician participation in capital punishment is a departure from the ethics of the medical profession. The North Carolina Medical Board cites the provisions of AMA Code of Medical Ethics Opinion 2.06 (printed below) as an accurate statement of the professional ethics of physician participation in executions.

Relevant Provisions of AMA Code of Medical Ethics Opinion 2.06

An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

Physician participation in an execution includes, but is not limited to, the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution.

In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their doses or types; inspecting, testing, or maintaining lethal injection devices; and consulting with or supervising lethal injection personnel.

The following actions do not constitute physician participation in execution: (1) testifying as to medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution; (2) certifying death, provided that the condemned has been declared dead by another person; (3) witnessing an execution in a totally nonprofessional capacity; (4) witnessing an execution at the specific voluntary request of the condemned person, provided that the physician observes the execution in a nonprofessional capacity; and (5) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution. (Created Jan 2007) (Amended July 2009)

PHYSICIAN SUPERVISION OF OTHER LICENSED HEALTH CARE PRACTITIONERS

The physician who provides medical supervision of other licensed health-care 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 (Adopted July 2007)

DRUG OVERDOSE PREVENTION

The Board is concerned about the three-fold rise in overdose deaths over the past decade in the State of North Carolina as a result of both prescription and non-prescription drugs. The Board has reviewed, and is encouraged by, the efforts of Project Lazarus, a pilot program in Wilkes County that is attempting to reduce the number of drug overdoses by making the drug naloxone* and an educational program on its use available to those persons at risk of suffering a drug overdose.

The prevention of drug overdoses is consistent with the Board's statutory mission to protect the people of North Carolina. The Board therefore encourages its licensees to cooperate with programs like Project Lazarus in their efforts to make naloxone available to persons at risk of suffering opioid drug overdose.

* Naloxone is the antidote used in emergency medical settings to reverse respiratory depression due to opioid toxicity. (Adopted September 2008)

MEDICAL TESTIMONY

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 evidence presented in 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 constitutes unprofessional conduct and may expose the physician expert witness to disciplinary action by the Board pursuant to N.C. Gen Stat. § 90-14(a)(6).

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

POSITION STATEMENTS

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. (March 2008)

COLLABORATIVE CARE WITHIN THE HEALTHCARE TEAM

The North Carolina Medical Board ("the Board") recognizes that the manner in which its licensees interact with others can significantly impact patient care.

The Board strongly urges its licensees to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. The Accreditation Council for Graduate Medical Education highlights the importance of interpersonal/communication skills and professionalism as two of the six core competencies required for graduation from residency. Licensees should consider it their ethical duty to foster respect among all health care professionals as a means of ensuring good patient care.

Disruptive behavior is a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that disruptive behavior is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. As a result, disruptive behavior may reach a threshold such that it constitutes grounds for further inquiry by the Board into the potential underlying causes of such behavior. Behavior by a licensee that is disruptive could be grounds for Board discipline.

The Board distinguishes disruptive behavior from constructive criticism that is offered in a professional manner with the aim of improving patient care. The Board also reminds its licensees of their responsibility not only to patients, but also to themselves. Symptoms of stress, such as exhaustion and depression, can negatively affect a licensee's health and performance. Licensees suffering such symptoms are encouraged to seek the support needed to help them regain their equilibrium.

Finally, licensees, in their role as patient and peer advocates, are obligated to take appropriate action when observing disruptive behavior on the part of other licensees. The Board urges its licensees to support their hospital, practice, or other healthcare organization in their efforts to identify and manage disruptive behavior, by taking a role in this process when appropriate. (January 2010)

TELEMEDICINE

"Telemedicine" is the practice of medicine using electronic communication, information technology or other means between a licensee in one location and a patient in another location with or without an intervening health care provider.

The Board recognizes that technological advances have made it possible for licensees to provide medical care to patients who are separated by some geographical distance. As a result, telemedicine is a potentially useful tool that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the reduced cost of patient care.

The Board cautions, however, that licensees practicing via telemedicine will be held to the same standard of care as licensees employing more traditional in-person medical care. A failure to conform to the appropriate standard of care, whether that care is rendered in-person or via telemedicine, may subject the licensee to potential discipline by this Board.

The Board provides the following considerations to its licensees as guidance in providing medical services via telemedicine:

Training of Staff -- Staff involved in the telemedicine visit should be trained in the use of the telemedicine equipment and competent in its operation.

Examinations -- Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate examination prior to diagnosing and/or treating the patient. However, this examination need not be in-person if the technology is sufficient to provide the same information to the licensee as if the exam had been performed face-to-face. Other examinations may also be considered appropriate if the licensee is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the licensee needs to complete an adequate assessment. On the other hand, a simple questionnaire without an appropriate examination may be a violation of law and/or subject the licensee to discipline by the Board.

Licensee-Patient Relationship -- The licensee using telemedicine should have some means of verifying that the person seeking treatment is in fact who he or she claims to be. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status examination, physical examination and appropriate diagnostic and laboratory testing. Licensees using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.

Medical Records -- The licensee treating a patient via telemedicine must maintain a complete record of the telemedicine patient's care according to prevailing medical record standards. The medical record serves to document the analysis and plan of an episode of care for future reference. It must reflect an appropriate evaluation of the patient's presenting symptoms, and relevant components of the electronic professional interaction must be documented as with any other encounter.

The licensee must maintain the record's confidentiality and disclose the records to the patient consistent with state and federal law. If the patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider's medical record and the telemedicine provider's record constitute one complete patient record.

Licensure -- The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina. Licensees need not reside in North Carolina, as long as they have a valid, current North Carolina license.

North Carolina licensees intending to practice medicine via telemedicine technology to treat or diagnose patients outside of North Carolina should check with other state licensing boards. Most states require physicians to be licensed, and some have enacted limitations to telemedicine practice or require or offer a special registration. A directory of all U.S. medical boards may be accessed at the Federation of State Medical Boards Web site: http://www.fsmb.org/directory_smb.html.

(Adopted July 2010)

¹See also the Board's Position Statement entitled "Contact with Patients before Prescribing." ²N.C. Gen. Stat. § 90-18(c)(11) exempts from the requirement for licensure: "The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State."

The Board also notes that the North Carolina General Statutes define the practice of medicine as including, "The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone." N.C. Gen. Stat. § 90-1.1(5)f.

PHYSICIAN SCOPE OF PRACTICE

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

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

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

^{*}In some instances, the Board may have provided relevant guidance to particular practice areas. See for example the Board's position statements on Laser Surgery, Office-Based Procedures, Care of the Patient Undergoing Surgery or Other Invasive Procedure, and Advertising and Publicity. (Adopted March 2011)

NCMB gets two new physician members; Governor reappoints Camnitz, Lennon

The NC Medical Board is pleased to welcome two new physician members, Dr. Shiva K. Rao of Roanoke Rapids, and Dr. Cheryl Walker-McGill of Charlotte. The Governor has also reappointed Dr. Paul S. Camnitz, of Greenville, and Ms. Thelma C. Lennon, of Raleigh, a public member of the Board. Their three years terms run November 1, 2011, to October 31, 2014.

SHIVA K. RAO, MD

Shiva K. Rao, MD, of Roanoke Rapids, graduated from Karnataka Medical College in Hubli, India, and completed a master's degree in surgery from the University of Bombay. Dr. Rao completed residency training in general surgery at Bronx Lebanon Medical Center in New York City and a fellowship in general surgery at Mt. Sinai Hospital in Hartford, Conn. Dr. Rao is certified by the American Board of Surgery and is a fellow of the American College of Surgeons. He currently practices general surgery in Roanoke Rapids



Dr. Rao

and is a past chief of medical staff at Halifax Regional Medical Center in Roanoke Rapids.

Dr. Rao is former chair of the North Carolina Medical Society (NCMS) International Medical Graduates Section. He was an NCMS Leadership Scholar in 2003 and received the American Medical Association's Foundation Leadership Award in 2005.

CHERYL WALKER-MCGILL, MD

Cheryl Walker-McGill, MD, earned her undergraduate and medical degrees from Duke University. She completed a residency in internal medicine and a fellowship in allergy-immunology at Northwestern University. Dr. Walker-McGill is certified by the American Board of Internal Medicine and by the American Board of Allergy and Immunology and is a fellow of the American Academy of Allergy, Asthma and Immunology.



Dr. Walker-McGill

Dr. Walker-McGill is president of American Health Strategy Institute for Quality Improvement, an organization dedicated to developing strategies for improving health and healthcare outcomes in high-risk, high-cost patient populations. In addition, she is medical director for Concentra, Daimler Trucks, NC, and she is the allergist for the Carolinas Medical Centers -Myers Park asthma clinic in Charlotte.

Dr. Walker-McGill is currently an assistant professor of clinical medicine at the University of North Carolina, Chapel Hill.

PAUL S. CAMNITZ, MD

Paul S. Camnitz, MD, attended the University of North Carolina, Chapel Hill, where he earned bachelor's degrees in both English and Chemistry. He earned his medical degree at the UNC School of Medicine in Chapel Hill and completed an internship in internal medicine at Stratford on Avon Hospital in Stratford, England, before returning to North Carolina Memorial Hospital in Chapel Hill, where he completed a residency in general surgery and served as Head and Neck Surgery Resident.

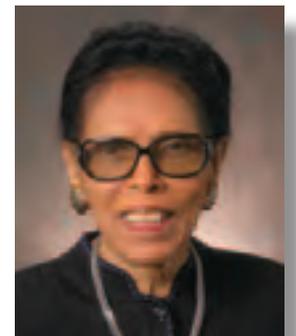


Dr. Camnitz

He currently practices at Eastern Carolina Ear, Nose & Throat/Head and Neck Surgery in Greenville. He is also a Clinical Professor of Surgery and Head of the Division of Otolaryngology at the Brody School of Medicine at East Carolina University, where he has been selected by the graduating medical school class as "Outstanding Teacher" 12 times and in 2003 was named a "Master Educator" by the faculty of the Brody School of Medicine.

THELMA C. LENNON

Thelma C. Lennon earned her undergraduate degree from North Carolina Central University and her master's degree from Boston University in guidance and counseling. She completed graduate study in adult education at North Carolina State University. Ms. Lennon served in education as an instructor and dean of students at a number of academic institutions. Before retiring, she worked as director of guidance and counseling for the NC Department of Education.



Ms. Lennon

Since her retirement, Ms. Lennon has devoted much of her time to volunteer activities focusing on health and education. She has served as a counselor at the NC Department of Insurance's Senior Health Insurance Information Program (SHIIP), a member of the Board of Directors of the Carolinas Center for Medical Excellence, and as chairman for the Alliance for Medical Excellence. From 1996 to 2000, Ms. Lennon was the first NC state president for AARP and was selected as an alternate delegate to the White House Conference on Aging.

Are “pill mills” Florida’s newest export?

North Carolina won’t tolerate excessive prescribing

Scott G. Kirby, MD, and Curt Ellis, Director, Investigations

In July 2011, Florida enacted sweeping new restrictions that aim to stop or at least dramatically reduce the flow of narcotics from the state’s many “pill mills.” The crackdown has many regulatory and law enforcement agencies concerned that operators of these clinics will attempt to shift



From the Office of
the Medical Director

**SCOTT G.
KIRBY, MD**

their illegal and medically unacceptable practices to other states.

The North Carolina Medical Board considers excessive and inappropriate prescribing of controlled substances among its most pressing patient safety and public health concerns. It will not tolerate the patterns of practice typically associated with illegal pill mills and will act swiftly upon any information that such activity is taking place in North Carolina.

This article will provide a brief overview of the prob-

lems associated with prescription drug misuse, review the characteristics of pain management clinics often referred to as pill mills and, finally, provide treating practitioners with guidance on spotting “red flags” that may signal drug seeking behavior and/or possible drug abuse/addiction in patients. Prescribers can protect themselves by becoming educated about appropriate standards of care and best practices in pain management.

OVERVIEW OF THE PROBLEM

Each day throughout the US about 75 people die and 2,000 people are treated in an emergency department due to unintentional poisoning. Between 85 and 95 percent of poisoning deaths result from prescription drug misuse. According to the latest data from the NC Center for Health Statistics, unintentional overdoses of prescription medi-

cations account for almost three deaths a day in North Carolina. The U.S. Centers for Disease Control and Prevention (CDC) reports that the increase in deaths from drug overdose is a direct result of increasing abuse and misuse of prescription opioids and other controlled substances.

This increase in some states is directly related to the abundant supply of narcotic medications available due to malicious, illegal and excessive prescribing by individual physicians operating out of what have been termed pill mill pain management clinics. For example, recently a Florida physician was arrested and his medical license summarily suspended. From January through August 2011, this physician reportedly prescribed 250,000 oxycodone pills to his patients. By comparison, in all of California just 300,000 pills were prescribed in the last six months of 2010. The federal government has stepped up law enforcement actions against physicians and others who prescribe excessively and inappropriately. Public policy changes, such as the new law enacted in Florida, are another way of addressing the issue.

REGULATORS’ CONCERNS

Medical regulators in other states know that operators of Florida’s many pill mills won’t simply close their doors. Rather, some are concerned that dangerous and illegal prescribing practices may migrate to other states. A recent article in the Georgia Composite Medical Board’s newsletter, prepared by Adrienne Baker and Jeffrey Lane, outlined certain characteristics associated with these pill mill operations that are not typically found within a legitimate pain management practice. We have shared their list here in order to educate prescribers in North Carolina. Licensees should avoid associating themselves with any practice or clinic with some or all of the following characteristics:

- The physician has minimal to no training in pain management.
- A cursory or no patient exam performed.
- Large volume of patients seen daily (100+).
- Patients drive long distances, often from other states. In

ARE YOU PRESCRIBING BLIND?

The NC Controlled Substance Reporting System (CSRS) is a database of all controlled substance prescriptions dispensed in outpatient pharmacies in North Carolina. This resource can help a practitioner avoid prescribing to a patient who may be receiving controlled substances from multiple sources.

For more information on the CSRS, or to download an application for access, visit:
www.ncdhhs.gov/mhddsas/controlledsubstance/

DEATHS FROM DRUG OVERDOSE



The above chart illustrates drug overdose deaths in the United States from 2000-2008. Numbers shown are per 100,000 population. *Source: National Vital Statistics System*

- many cases patients carpool.
- Clinics place advertisements for pain management physicians in small papers or *craigslist.com*
- Employer is a non-physician owned staffing company and work is part time. Clinic owners are not health care providers, have no medical training, may be from out of state, and attempt to convince the physician the clinic is operating legally.
- Clinic is run on a cash only basis.
- Similar prescription “cocktail” for each patient.
- Drugs are dispensed onsite (patient pays for office visit then pays for the drugs).
- Security guards are employed by the clinic.
- All patients receive an identical diagnostic work-up or are referred to the same MRI imaging facility.

SPOTTING “DRUG SEEKERS” AND MISUSE

The NCMB often hears that licensees are hesitant or unwilling to prescribe controlled substances because they fear they will be subject to public action by the Board. It’s important to understand what practices are likely to bring a prescriber to the NCMB’s attention. Often prescribers who come under Board scrutiny have overlooked red flags that should have indicated the possibility of diversion, abuse or misuse. While the presence of “red flags” does not necessarily mean that the patient is “drug seeking” the presence of some or all of the following circumstances should raise the prescribers index of suspicion:

- The patient is from out of state.
- The patient requests a specific drug and states that alternative medications do not work.
- The patient says his or her previous physician closed their practice.
- Prior treatment records cannot be obtained.
- The patient claims he or she cannot afford indicated or appropriate diagnostic testing.
- The patient presents to the appoint-

ment with an MRI.

- The patient presents to the appointment with his or her pharmacy profile showing specific drugs they want prescribed.
- Several patients arrive by carpool.
- The patient tests positive for illegal drugs.
- Drug screen reveals no prescribed medication in the patient’s system.
- The patient recites textbook symptoms.
- The patient pays in cash only and has no insurance.
- The patient calls for early refills and prescriptions or regularly reports that medications are lost or stolen.
- The patient’s pain level remains the same over several subsequent visits.
- The patient is noncompliant with the physician’s treatment plan.

CONCLUSION

The Board recognizes that quality medical care includes the appropriate, effective treatment of chronic pain and supports patients’ rights to such care. The Board further recognizes that prescribing controlled substances over the long term may be an essential part of an appropriate treatment program. However licensees who inappropriately or excessively prescribe opioids and

other controlled substances remain an enduring problem. Once again, North Carolina will not tolerate illegitimate pain management practice as described in this article.

ARTICLE SUMMARY

- The state of Florida recently enacted new restrictions targeting the state’s many “pill mills.”
- A “pill mill” is a clinic that operates outside of accepted standards for prescribing controlled substances for the treatment of pain, providing easy access to prescription narcotics.
- Regulators are concerned that unscrupulous clinics will seek to move illegal practices from Florida to other states.
- The NC Medical Board will act swiftly upon information that pill mill-like activity is happening in North Carolina.
- All physicians, even those who do not regularly prescribe controlled substances, should remain alert to signs of prescription abuse/misuse.
- Prescribers should use the NC Controlled Substances Reporting System to avoid prescribing to drug seekers.

North Carolina Medical Board

Quarterly Adverse Report | August - October 2011

Board actions are now published in an abbreviated format. The report no longer includes non-prejudicial actions such as reentry agreements and non-disciplinary consent orders. If you prefer the previous method of reporting Board actions, you may access an expanded disciplinary report by visiting the Board's website at www.ncmedboard.org. Readers who prefer the more comprehensive version may sign up on the website to be notified when a new report is posted. Go to "Professional Resources" and select "Subscriptions" to sign up for an RSS Feed to be notified. Be sure to select the feed for "Bimonthly Disciplinary Report."

Name/license#/location	Date of action	Cause of action	Board action
<u>ANNULMENTS</u>			
[NONE]			
<u>SUMMARY SUSPENSIONS</u>			
GILLIS, Jacinta Irene, MD (200701587) Fort Myers, FL	10/26/2011	While practicing in Florida, MD engaged in inappropriate prescribing of controlled substances to patients/undercover police officers. The Fla. Board adopted an Order of Emergency Suspension on 5/18/2011.	Summary suspension of NC medical license; Notice of Charges & Allegations issued.
<u>REVOICATIONS</u>			
HUGHES, William Henry, MD (000027807) Brentwood, TN	10/28/2011	MD was convicted of felony bank fraud.	NC medical license revoked
<u>SUSPENSIONS</u>			
ANDREW, Raymond Hall, MD (000027015) Winston-Salem, NC	09/08/2011	A review of five patient records revealed deficiencies in MD's prescribing of controlled substances.	MD is suspended for six mos. immediately stayed on probationary terms/conditions.
ARCEO-FREDERICK, Liza A., MD (200201038) Charleston, WV	09/27/2011	WV license suspended by the West Virginia Board of Medicine due to history of substance abuse, failure to disclose.	MD is suspended for three yrs.; stayed provided MD abides by the terms of the WV order.
BILLINSKY, John Milton, Jr., MD (000027893) Shelby, NC	08/15/2011	MD inappropriately prescribed controlled substances for the treatment of chronic pain.	MD is suspended for six months, stayed on probationary terms/conditions.
BUTLER, Cynthia Poff, DO (000036668) Stoneville, NC	08/24/2011	DO made inappropriate comments about a patient's weight and use of medications. DO threw her pen on the floor and struck the patient in the chest with a closed fist during an office visit.	DO is suspended for six months, stayed all but 30 days. Shall attend a difficult communications course.
DOVER, Cathy Nichelson, MD (009701323) Concord, NC	09/23/2011	MD self-prescribed, prescribed to a person with whom she has an emotional relationship and acknowledged taking Phentermine from out-of-date office supplies. Patient care/medical record keeping below standard.	Indefinite suspension of NC medical license
DUGLISS, Malcolm Andrew John, PA-C, (000103305) Asheville, NC	08/15/2011	History of substance abuse, diversion of prescription drugs for personal use.	PA is indefinitely suspended.
FITZGERALD, Dwight Melvin, MD (000020792) Conover, NC	08/19/2011	History of repeated incidents of disruptive behavior.	MD is suspended for two yrs., immediately stayed. Fined \$2,000. NCPHP contract.
BILLINSKY, John Milton, Jr., MD (000027893) Shelby, NC	08/15/2011	MD inappropriately prescribed controlled substances for the treatment of chronic pain.	MD is suspended for six mos., stayed on probationary terms/conditions. Restrictions placed on prescribing. MD shall obtain a professional assessment by a center approved by the Board.
GOLDBERGER, Neal Michael, MD (200100039) Monroe, NC	10/20/2011	MD and his partners performed unnecessary plasma disc compression procedures and solicited patients by sending letters to area personal injury lawyers.	Consent order, MD's license is suspended for 18 months, stayed; fined \$85,000.
HAYES, Chason Spencer, MD (009400181) Charlotte, NC	10/20/2011	MD and his partners performed unnecessary plasma disc compression procedures and solicited patients by sending letters to area personal injury lawyers.	Consent order, MD's license is suspended for 18 months, stayed; fined \$85,000.
HUFFMAN, Robert Allen, NP (000200993) Bladenboro, NC	10/20/2011	Prescribing of controlled substances was below accepted standards.	NP's approval to practice is suspended for one year, stayed all but 30 days. Conditions on approval to practice.

PUBLIC ACTIONS

Name/license#/location	Date of action	Cause of action	Board action
JAFFE, Seth Lewis, DO (200001495) Monroe, NC	10/20/2011	DO and his partners performed unnecessary plasma disc compression procedures and solicited patients by sending letters to area personal injury lawyers.	Consent order, DO's license is suspended for 18 months, stayed; fined \$85,000.
JAMES, James Franklin, MD (000015359) Greenville, NC	09/21/2011	History of PTSD, substance abuse; violation of NCPHP contract. Wrote prescriptions for controlled substances without valid DEA registration number.	Indefinite suspension of NC medical license
PARIKH, Himanshu Pravinchandra, MD (009600671) Cary, NC	09/13/2011	History of substance abuse; MD has completed residential treatment	MD's medical license is reinstated and suspended. Dated license issued with conditions.
RODGERS, Carolyn Vance, PA (000102371) Cary, NC	08/04/2011	PA prescribed controlled substances to close family members. PA admitted she had taken some of the Vynase she prescribed to her family members.	NC PA license is suspended for one year, stayed all but 30 days. Probation and conditions.
SALERNO, James George, MD (000025948) Columbus, NC	09/08/2011	A review of six patient records revealed deficiencies in record keeping, prescribing and other aspects of care	Indefinite suspension of NC medical license
SMITH, Bryan Dorsey, MD (200201531) Apex, NC	09/07/2011	History of alcohol/substance dependence/abuse	Indefinite suspension of NC medical license
<u>PROBATION</u>			
<i>[NONE]</i>			
<u>REPRIMAND</u>			
GRAY, Derwin Pearson, MD (009300708) Nags Head, NC	10/11/2011	MD failed to diagnose and aggressively treat a post-operative bleeding complication in a patient. Patient experienced post-operative cardiac arrest with anoxic brain injury and subsequently died.	MD is reprimanded. MD must complete CME in the areas of postpartum hemorrhaging and OB emergencies.
GUHA, Subrata, MD (000038071) Smithfield, NC	10/20/2011	Inadequate supervision of mid-level practitioners.	MD is reprimanded. May not supervise mid-level practitioners unless in an ER setting.
HAKIM, John Pierre, MD (200100044) Clinton, MD	08/05/2011	MD entered into consent order with the Maryland Board: reprimanded, placed on probation for a minimum of two yrs. until the order's conditions are met.	MD is reprimanded
JONES, Robert Glen, MD (009400536) Raleigh, NC	08/05/2011	MD consumed alcohol in violation of his previous consent order with the Board; history of alcohol abuse.	MD is suspended indefinitely, stayed. 90-day active suspension and NCPHP contract.
KIM, Edward Han, MD (200801503) Rocky Mount, NC	10/13/2011	MD prescribed controlled substances to a patient with whom he had a significant emotional relationship and failed to maintain a medical record of prescribing.	MD is reprimanded
LEWIS, Marvin, MD (000033542) Spring Lake, NC	08/04/2011	MD's care of a patient was below accepted standards of care.	MD is reprimanded
OUDEH, Ibrahim Naim, MD (000034428) Dunn, NC	10/20/2011	MD failed to comply with the Board's order to be assessed by the Center for Personalized Education for Physicians related to the Board's concerns about MD's quality of care.	MD is reprimanded; must obtain a practice monitor approved by the Board within 30 days of the date of this order.
SINTHUSEK, Chirapa, MD (000018717) Winston-Salem, NC	08/04/2011	MD permitted a physician relative to practice medicine without a license in her Winston-Salem medical office between 8/2006-9/2009.	MD is reprimanded and fined \$1,000
STAHLER, Scott Douglas, MD (009701158) Williamston, NC	10/20/2011	MD's treatment of a pregnant woman complaining of nausea, loose stools, abdominal tightness and decreased fetal movement was below standard. Patient underwent emergency c-section eight hrs. after MD was first called.	MD is reprimanded. Within six mos. of the date of the order, MD must complete five hrs. CME preapproved by the Board's medical director.
<u>DENIALS OF LICENSE/APPROVAL</u>			
DE RIDDER, Gustaaf Gregoire, MD, Durham, NC	08/29/2011	MD reported a DWI arrest on his RTL application. MD was referred to NCPHP for an assessment. A urine sample tested positive for cocaine metabolite.	Denial of application for NC resident training license.
GERLACH, David Campbell, MD (009500591) Burlington, NC	10/11/2011	History of substance abuse, including the admitted use of cocaine; January 2010 charge of felony possession of cocaine.	Denial of application for reinstatement of medical license.
HOLDER, William Berkeley, MD Parsippany, NJ	10/11/2011	Multiple non-disclosures on NC license application.	Denial of application for medical license; Hearing requested

PUBLIC ACTIONS

Name/license#/location	Date of action	Cause of action	Board action
MANNAL, Richard Knoll, MD Hyannis, MA	10/11/2011	Multiple non-disclosures on NC license application.	Denial of application for medical license; Hearing requested
<u>SURRENDERS</u>			
DESAI, Chetan Hasmukhbhai, MD (200700479) Winston-Salem, NC	10/07/2011		Voluntary surrender of NC medical license.
PUCKETT, Frankie Allen, MD Charlotte, NC	10/20/2011	MD inappropriately prescribed controlled substances to a woman with whom he was having an emotional relationship; Prior history of inappropriate prescribing.	Via consent order, MD's RTL is surrendered. MD agrees not to seek reinstatement or apply for a full license in NC for five years.
<u>PUBLIC LETTER OF CONCERN</u>			
CAMPONOVO, Ernest J., MD (200801761) Mechanicsburg, PA	07/28/2011	While residing in PA and employed by a MN-based teleradiology provider, MD incorrectly read a Fla. patient's testicular ultrasound as normal.	Public letter of concern
CAULFIELD, John Justin, MD (009600482) Irving, TX	08/24/2011	MD omitted information from his NC license application, including a 1977 misdemeanor charge and a SC regulatory board action in 1997.	Public letter of concern
CUDDAPAH, Deepak, MD (201101349) Potomac, MD	08/08/2011	MD failed to disclose a 2009 misdemeanor charge of possession of marijuana. The charge was dismissed after MD entered a guilty plea and completed six-month probation.	Public letter of concern
ERVINE, Harry Filmore, Jr., MD (200101334) Charleston, SC	10/03/2011	MD failed to consider/rule out diagnosis of ectopic pregnancy in a patient and failed to diagnose and treat a patient's chronic hypertension with superimposed preeclampsia. MD's performance of a tubal sterilization was substandard.	Public letter of concern. Via consent order, MD is limited to the practice of office-based gynecology. Conditions on license
GORECKI, John Paul, MD (009400064) Gainesville, GA	10/18/2011	Application for reinstatement was denied because MD failed to disclose information on his application, failed to respond timely to Board inquiries, was disciplined by the KS Board and owned/operated a medical spa with an inactive license. MD has explained the omissions and other circumstances.	NC medical license reinstated, with a public letter of concern
JONES, Kathryn Brown, NP (960002) Charlotte, NC	08/17/2011	NP was untruthful when asked by a Board investigator if she was engaged in an inappropriate relationship with a former supervising physician who had prescribed hydrocodone to her.	Public letter of concern
JONES, Kimberly Dawn, PA (001003200) Lexington, KY	10/27/2011	Action taken by Kentucky medical board.	Public letter of concern
HUDSPETH, Dudley Allen, MD (000032737) Winston-Salem, NC	07/28/2011	While practicing in AZ, MD performed a major vascular procedure for claudication on a patient in conflict with applicable standards of care. The patient lost some use of her right leg following the surgery. The AZ board issued a letter of reprimand in connection with this case.	Public letter of concern
MCCLANAHAN, Darbye Suzanne, MD (201101550) Virginia Beach, VA	09/12/2011	MD used a commercial service to prepare her NC license application, which resulted in inaccurate/incomplete information on the application.	Public letter of concern; \$500 administrative fine.
MONE, Andrew Paul, MD (201101684) Marion, VA	10/10/2011	MD failed to appropriately disclose an administrative suspension on his NC license application.	Public letter of concern
NGUYEN, Hoa Thai, MD (009900109) West Monroe, LA	09/12/2011	MD entered into a corrective order with the TX Board based on failure to identify an injury as a open fracture, resulting in failure to start prophylactic antibiotics and to call in an orthopedist.	Public letter of concern
RAMPELL, Nancy, MD (201101712) Clayton, GA	10/17/2011	Provided inaccurate answers to two questions on NC medical license application.	Public letter of concern
SAMUELS, Todd Louis, MD (200901365) West Lake Village, CA	10/11/2011	MD treated a patient for stroke as the on-call teleneurologist. MD ordered TPA therapy. The patient's weight was mistakenly recorded in kilograms, not pounds, resulting in an overdose of medication that likely led to her death.	Public letter of concern

PUBLIC ACTIONS

Name/license#/location	Date of action	Cause of action	Board action
SEYMORE, Karen Patricia, DO (200600612) Jacksonville, NC	10/06/2011	DO failed to timely recommend delivery by cesarean section. The Board is concerned that the subsequent death of the newborn infant may have been avoided if DO had reacted to fetal heart rate abnormalities and recommended cesarean section more quickly.	Public letter of concern
TURTON, Robert Lawrence, DO (201101367) Wilmington, NC	08/10/2011	MD falsely reported to the OH Board on his '07 renewal that he had completed all required CME; MD had not taken a CME course since 2004.	Public letter of concern
WIEST, Samuel Habecker, MD (000029447) Asheville, NC	9/12/2011	The Board is concerned that it appears MD accessed private and protected health information without a legitimate medical purpose.	Public letter of concern
MISCELLANEOUS ACTIONS			
DUNN, Lawrence Anthony, MD (000030018) Durham, NC	10/10/2011	Concerns about quality of care, prescribing.	
SMALL, Fairleigh David, MD (000024710) Abingdon, VA	09/15/2011	NCMB indefinitely suspended MD's license based on his felony conviction in the state of VA for malicious wounding, and the subsequent suspension of MD's VA medical license. The conviction was reversed and annulled and the VA Board has vacated its order of suspension.	
CONSENT ORDERS AMENDED			
SESSOMS, Rodney Kevin, MD (000033927) Clinton, NC	08/23/2011		Amended consent order from January 25, 2011. MD shall take a minimum of five CME hours per month. No carryover hours or averaging of hours may be counted towards the monthly requirement. To practice hospital medicine, MD shall first obtain a practice monitor approved by the Board's Office of the Medical Director.
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
ADKINS, Paula Clark, MD (009900745) Pinehurst, NC	09/23/2011	History of substance abuse	Temporary license extended; Expires January 31, 2012
CALDWELL, Chad Cameron, PA-C (00103163) Winston-Salem, NC	09/07/2011	History of alcohol dependence. MD has completed inpatient treatment.	Temporary medical license issued; Expires March 7, 2012
MCALLEN, Terry Joseph, DO (200301013) Henderson, NV	10/12/2011	History of alcohol dependence	Temporary medical license issued; Expires May 31, 2012
WILKINSON, Heather Lee, DO (200400777) Charlotte, NC	09/22/2011	History of substance abuse; DO has completed inpatient treatment.	Temporary medical license made full and unrestricted.
WRENN, Cynthia Helen, PA-C (000102752) Fayetteville, NC	09/22/2011	History of substance abuse; PA is in recovery	Temporary PA license made full and unrestricted.
ZELLER, Kathleen Elizabeth, MD (200700068) Greensboro, NC	09/22/2011	Quality of care issues; MD has completed an educational program to address knowledge gaps.	Temporary medical license issued; Expires May 31, 2012

FINES

The NCMB issues non-disciplinary administrative fines in certain cases where incorrect and/or incomplete information on a medical licensing application causes Board staff to spend an inordinate amount of time resolving the issue(s).

Date	Reason	Amount
June 2011	Failure to report a misdemeanor charge for possession of marijuana, to which licensee entered a guilty plea.	\$500
July 2011	Failure to report academic probation	\$500
July 2011	Failure to disclose an investigation by NBME, that resulted in notation of a "procedural violation" on transcript.	\$500
July 2011	Failure to disclose a malpractice payment and related investigation by another state medical board.	\$500
Sept. 2011	Failure to report misdemeanor DUI charge	\$1,000
Sept. 2011	A licensing application service provided incorrect answers on NC licensing application; applicants are responsible for accuracy.	\$500

North Carolina Medical Board

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EXAMINATIONS

Residents Please Note USMLE Information

United States Medical Licensing Examination

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the Federation of State Medical Board's Web site at www.fsmb.org.

Special Purpose Examination (SPEX)

The Special Purpose Examination (or SPEX) of the Federation of State Medical Boards of the United States is available year-round. For additional information, contact the Federation of State Medical Boards at PO Box 619850, Dallas, TX 75261-9850, or telephone (817) 868-4000.

BOARD MEETING DATES

February 16-17, 2012 (Hearings)
March 21-23, 2012 (Full Board)
April 19-20, 2012 (Hearings)
May 16-18, 2012 (Full Board)

Meeting agendas, minutes and a full list of meeting dates can be found on the Board's Web site

ncmedboard.org

Visit the Board's website at www.ncmedboard.org to change your address online. The Board requests all licensees maintain a current address on file with the Board office. Changes of address should be submitted to the Board within 30 days of a move.

Need an Intent to Practice acknowledgement letter?

Over the past few months, the Board has received a large number of requests for copies of physician assistant Intent to Practice acknowledgement letters. These requests are the result of the need to provide evidence of the physician assistant/supervising physician relationship for various credentialing purposes, including participation in federal programs such as Medicaid and Medicare.

When a physician assistant completes the Board's online Intent to Practice ("ITP") form, which establishes a physician assistant/supervising physician relationship, an acknowledgement letter confirming that relationship is sent to the primary supervising physician; a copy of the letter is also mailed to the physician assistant. It is the physician assistant's responsibility to keep a copy of the acknowledgement letter at all places where the physician assistant practices. Since instituting the online ITP process, the Board has not maintained copies of the acknowledgement letters and, thus, is unable to provide additional copies. Requests for copies of ITP letters will not be processed.

WHAT IF I AM UNABLE TO FIND MY ITP LETTER?

The information provided on the Board's website may serve as an official confirmation of the physician assistant/supervising physician relationship. For example, if the Board's website indicates that a physician assistant is currently being supervised by a particular physician, that indication is an official acknowledgement from the Board of that particular physician assistant/supervising physician relationship. The Board advises anyone not in possession of a written acknowledgement letter to use the information from the website in its place.

To find information about a particular physician assistant's supervisory relationship, enter the physician assistant's name using the "Look Up a Licensee" tool available on this website. To enter a name, click on "Look Up a Licensee" in the green Quick Links box on the right side of the Home Page.