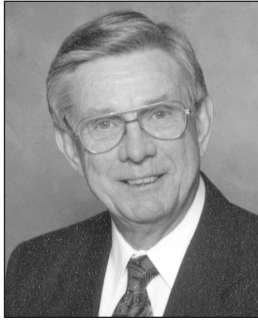


forum

N C M E D I C A L B O A R D

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Young Physician, Part IV - page 11



John T. Dees, MD

President's Message

Beginning a New Year

As we begin a new year at the North Carolina Medical Board, I want to thank my colleagues on the Board for their confidence in me by electing me president. We have a good, active, and energetic group of officers to round out the Executive Committee of the Board. These members are Charles (Buddy) Garrett, MD, a pathologist from Jacksonville; Stephen M. Herring, MD, a plastic surgeon from Fayetteville; and Mr Hari Gupta, a public member from Cary. Of course, Dr Walter J. Pories, of Greenville, is immediate past president of the Board and also a member of the Executive Committee.

Dr Elizabeth P. Kanof and Dr George C. Barrett have completed their terms on the Board and are being replaced by Dr Edwin R. Swann, an ophthalmologist from Raleigh, and Dr H. Arthur McCulloch, an anesthesiologist from Charlotte. As one member of the Board has said, we have a "new Board" and a lot to do.

Our first major undertaking is the securing of a new executive director. As many of you know, Mr Andrew Watry resigned in November to "seek new challenges," and we have instituted a nationwide search for a replacement. I hope we will have success in finding someone in the near future to continue the work that has been put in place by previous Boards and staff.

The good news is that the Board invited R. David Henderson, JD, of our staff to fill in as interim executive director and he accepted the task. David is a cum laude graduate of the University of North Carolina, Charlotte, and took his JD degree at the Wake Forest University School of Law. Prior to coming to work for the Medical Board in 1996, David was deputy counsel at the North Carolina State Bar, investigating grievances against attorneys, representing the Bar in disciplinary and reinstatement hearings before the Disciplinary Hearing Commission, and arguing cases before the North Carolina Court of Appeals.

Mr Henderson's warm, friendly, and inclusive personality has already endeared him to our staff and Board members. We are fortunate to have him lead our staff and our activities over the next few months.

In future issues of the *Forum*, I hope to introduce our licensees to other senior members of our staff, particularly our directors, who do such a great job of keeping the process moving. We have an absolutely wonderful staff at the Medical Board who are always eager to serve you. We are proud of them and hope you are, too.

The Team of a Lifetime!

Robin N. Hunter-Buskey, PA-C
Member, NCMB



Dr Moritsugu and Ms Hunter-Buskey

Just imagine the PA-MD team of a lifetime. I had a unique opportunity to utilize the skills and knowledge obtained from many years of experience as a clinician, and, by chance, I was paired with U.S. Deputy Surgeon General Kenneth Moritsugu, MD.

At a dinner gathering with friends and colleagues in Alexandria, Virginia, an urgent situation turned into an emergency. Our dinner was just being served and, as you can imagine, there was a great deal of chatter among the 18 people seated at a long, banquet-style table. For a moment, I turned to look behind me and saw two women coming in from the restaurant's patio. They paused at the top of the three steps just inside the doorway and I caught a glance from the older of the women. Her eyes appeared glossy and she seemed unsteady on her feet. I got up and went to her side to assist her down the steps. I thought she had a gait problem and just needed a support or helping hand. To my surprise, she said, "I am going to fall," and I told her to go ahead and fall. We both sat down on the top of the steps.

She and her companion were leaving the restaurant after having eaten on the patio in the humid, 90-plus degree evening. Her skin was cool and clammy. She began to pant. Her eyes became even glossier. The

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N C M E D I C A L B O A R D

Raleigh, NC

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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.

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Bryant D. Paris, Jr
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Editor
Dale G. Braden

Assistant Editor
Shannon L. Kingston

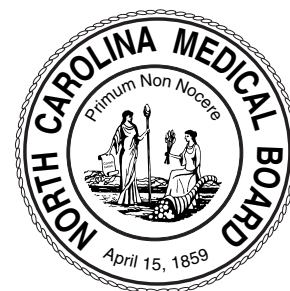
Address
1201 Front Street, Suite 100
Raleigh, NC 27609

Telephone
(919) 326-1100
(800) 253-9653

Fax
(919) 326-1130

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org



NCMB Revises Position Statement

At its meeting in October 2002, the North Carolina Medical Board completed work on and approved revision of its Position Statement on Guidelines for Avoiding Misunderstandings During Physical Examinations. This revision is presented below in a marked version to clearly indicate the changes made. Added language has been underlined. Deleted language has been lined through.

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 physicians. In order to prevent such misunderstandings, the Board offers the following guidelines.

1. Sensitivity to patient dignity should be considered by the physician 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

Team of a Lifetime

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restaurant manager offered to assist and I asked for some cool towels. Suddenly, she began to vomit all over me and the steps. Next, her eyes rolled back and she became limp. As I lowered her to the floor, I asked the manager to call 911.

Seconds later, she vomited again. I was able to get her head down and her feet up. Her pulse was thready and she was barely breathing. I looked up at my table and everyone was eating. In fact, everyone around me had continued with his or her meal. I got Dr Moritsugu's attention and he came to my side. Another PA, Mary Etter, also came over to help. Mary checked the woman's pulse again. It was very weak, then stopped. I asked Dr Moritsugu to check her airway. We began CPR.

In just about one minute, we noted her attempts to cough and we felt a pulse. As we got her feet up higher, the color began to return to her face. By then, we had her covered in cool towels. She began to speak.

She told us her name and took a few deep breaths. Her companion now began to appear relieved. They were just two friends

having dinner. Our patient told us that she had a history of hypertension and was taking a diuretic and an ACE inhibitor. She had felt dizzy when she left her table after sitting outside for about two hours.

She began to move her extremities. At that point, I began to look around. For the most part, the activities in the restaurant continued as if all were business as usual. I used some napkins to drape our patient and cover the floor. The patrons right next to us looked helpless and I assured them the woman was all right.

Then the paramedics and EMTs arrived with all their equipment. Our patient's pulse was strong and her voice much clearer. They applied oxygen and quickly went through their checklist. As we exchanged information, the patient was placed on a stretcher. She gave us each a strong grip and a very sincere thank you. Her companion, who had been very composed during this event, became tearful and offered her thanks.

In recalling the details of this event, each of us responded as we had been trained, well orchestrated and in sync with each other. We did not have gloves or any sophisticated equipment, just a strong desire to help this woman, our patient. At one point, Dr

presence of the physician. 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 acceptable to the patient~~, should be readily available at all times during a physical examination, and it is strongly advised that a third party ~~acceptable to the patient~~ be present when the physician performs an examination of the breast(s), genitalia, or rectum. ~~When appropriate or when requested by the patient, the physician should have a third party acceptable to the patient present throughout the examination or at any given point during the examination. It is the physician's responsibility to have a staff member available at any point during the examination.~~
3. The physician 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 physician 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 physician 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, October 2002)

Gov Easley Appoints Drs H. Arthur McCulloch and Edwin R. Swann to the North Carolina Medical Board

R. David Henderson, interim executive director of the North Carolina Medical Board, has announced that Governor Easley has appointed H. Arthur McCulloch, MD, of Charlotte, and Edwin R. Swann, MD, of Raleigh, to the North Carolina Medical Board. Mr Henderson said, "The members and staff of the Board are pleased and honored to welcome these two outstanding physicians to the Board." Drs McCulloch and Swann replace Dr George C. Barrett, of Charlotte, and Dr Elizabeth P. Kanof, of Raleigh, whose terms on the Board have ended. "Drs Barrett and Kanof have given invaluable service to the Board and deserve the thanks of us all for their work on behalf of the people of North Carolina," Mr Henderson said.

Dr McCulloch, of Charlotte



Dr McCulloch

A native of Ohio, Dr McCulloch received a BA from Ohio State University and took his MD from the Medical College of Ohio. He did his internship at St Thomas Hospital Medical Center in Akron, Ohio, and his residency in anesthesiology at North Carolina Memorial Hospital.

Following his residency, he was a staff anesthesiologist at Wilford Hall USAF Medical Center. He is a diplomate of the American Board of Anesthesiology and is a clinical assistant professor of anesthesiology at the University of North Carolina. He practices with Southeast Anesthesiology Consultants, in Charlotte, and is vice chief of the Department of Anesthesiology at Carolinas Medical Center.

Dr McCulloch is an active member of the North Carolina Medical Society and, among other things, has served on its MedPAC Board and its Task Force on Office-Based Surgery. He is also a member of the North Carolina Society of Anesthesiologists, serving on that organization's Executive Committee and as its president elect. He is a member of the House of Delegates of the American Society of Anesthesiologists.

Dr McCulloch is co-author of three journal articles.

Dr Swann, of Raleigh



Dr Swann

Born in North Carolina, Dr Swann received his BS from the University of North Carolina, Chapel Hill, and his MD from the University of North Carolina School of Medicine, where he was awarded the Duke Endowment—King Edward VI Foreign Medical Study Scholarship. He did his internship at the Youngstown Hospital Association, Youngstown, Ohio, and his residency in ophthalmology at the Medical College of Ohio, in Toledo. This was followed by a fellowship in neuro-ophthalmology at the Wills Eye Hospital, in Philadelphia. Dr Swann is a diplomate of the American Board of Ophthalmology and is in private practice in Raleigh.

Dr Swann is a member of the Wake County Medical Society and served on its Executive Committee. He is also active in the North Carolina Medical Society, being a member of its House of Delegates and its MedPAC Board of Directors.

He holds staff appointments at Wake Med and Raleigh Community Hospital, is a fellow of the American Academy of Ophthalmology, and is a member of the Board of Directors of the North Carolina Society for the Prevention of Blindness. He is the author of 4 articles.

North Carolina Medical Board

Web Site:
www.ncmedboard.org

E-Mail:
info@ncmedboard.org

Managing the Implementation of HIPAA and the Privacy Rule

Marjorie A. Satinsky, MA, MBA
President, Satinsky Consulting, LLC



Ms Satinsky

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has been called the most important piece of healthcare legislation since Medicare and Medicaid. Between now and April 14, 2003, medical practices that are covered entities must prepare themselves for compliance with one of four parts of HIPAA, the Privacy

Rule, and with related parts of the Security Rule.

This article provides help for those of you who have not yet begun your work on Privacy and for those who have begun to address the challenges of Privacy compliance and need help along the way. It covers the following topics.

- HIPAA Basics: Purpose, History, and How HIPAA Can Benefit Your Practice
- HIPAA: Timetable and Penalties
- Preemption of State Law
- Important HIPAA Definitions and Privacy Rule Standards
- Compliance with the Privacy Rule: One Step at a Time
- Challenges and Suggestions for Overcoming Them
- Helpful Resources

HIPAA Basics: Purpose, History, How HIPAA Can Benefit Your Practice

The Health Insurance Portability and Accountability Act of 1996 addressed two major problems in healthcare. One of those problems was the portability of health insurance. Historically, employees who changed jobs could not take their health insurance with them. As job changes have become more prevalent in our society, the portability dilemma has affected more members of the workforce. The portability section of HIPAA permits employees to continue their health insurance without waiting periods or pre-existing condition restrictions under certain circumstances. HIPAA also addressed the need to standardize the transmission of certain administrative and financial information and to simultaneously protect the privacy and security of personal health information.

HIPAA has four sections: Transaction and Code Set Standards, Privacy, Security, and National Identifiers.

The Privacy and Security sections fall into HIPAA's Administrative Simplification category. April 14, 2003, is the deadline for compliance with Privacy and related Security requirements.

The HIPAA legislation and subsequent regulations can bring important benefits to medical practices. These benefits include:

- improved accuracy and efficiency in posting accounts receivable;
- automatic posting of payments to your bank account;
- automated insurance eligibility check that tells you who has insurance coverage and the amount of the co-payments and deductibles;
- streamlined claims filing process that can accelerate your reimbursement;
- reduced time that clinical staff spend on administrative processes so they can devote more time to patient care.

HIPAA Timetable and Penalties

Make sure you understand the HIPAA timetable and penalties before initiating the tasks that need to be accomplished by April 2003.

HIPAA Timetable

During the six-year interval since the passage of HIPAA in 1996, the federal government has begun rolling out regulations for each of the four sections. The rollout process is standard, but the timetable for implementation is staggered. For each section, the Department of Health and Human Services (DHHS) issues a proposed rule that specifies a time period for public comment. Based on comments received, the DHHS publishes a final rule that includes effective and compliance dates.

For example, the Transaction and Code Set Standards were issued on October 16, 2000. The original date for compliance was October 16, 2002. In response to the many questions that arose during the period for public review and comment, the government has allowed covered entities, such as your practice, to request a year's extension. Many of you filed for an extension. Your compliance date will be October 16, 2003, although you must begin testing your transactions before then. Also, by mid-2003, the DHHS will publish a proposed claims attachment rule, a supplement to the standard claims transaction rule that has already been issued. The supplement will provide additional information related to claims adjudication.

"The HIPAA legislation and subsequent regulations can bring important benefits to medical practices"

The proposed Privacy Rule was issued on December 28, 2000. In response to comments made during the public review and comment period, the DHHS made many changes and issued the final rule on August 8, 2002, with an effective date of October 14, 2002. The deadline for Privacy compliance is April 14, 2003, just a few months away.

For Security, the DHHS issued the proposed rule in May 1998. A final rule has not yet been issued. When it is, compliance must occur within 24 months. Although compliance with Security Standards isn't imminent, parts of Security do impact Privacy and should be completed by the April 2003 deadline.

With respect to National Identifier standards, the DHHS expects to publish the final provider identifier rule and the proposed payer identifier rule by early spring 2003.

HIPAA Enforcement and Penalties

Although the DHHS has not yet issued a proposed HIPAA enforcement rule, remember that HIPAA contains standards, and standards are requirements. If you have postponed starting on HIPAA Privacy Rule activities because the burden of compliance feels overwhelming, rethink your position. If your practice is a covered entity under HIPAA, you don't have a choice. If you are still filing paper claims and hoping you can remain HIPAA exempt, remember that beginning in October 2003 Medicare plans to refuse to pay claims that are not filed electronically in practices with more than 10 employees.

The DHHS has designated the Office of Civil Rights (OCR) to be responsible for implementing HIPAA. The OCR has the right to:

- investigate complaints received from individuals and organizations that believe that a covered entity, such as your medical practice, is not complying with HIPAA's Privacy Rule standards;
- assist covered entities in achieving compliance with the Privacy Rule;
- make determinations regarding exemptions to state law preemption.

At this point, we believe the government will not audit your practice for HIPAA compliance or schedule a site visit to your office. Rather, if individuals or organizations file complaints within 180 days of the alleged occurrence, the OCR will respond to the complaint and may investigate your practice. If there is an investigation, you must comply with the OCR's request to provide documentation of HIPAA compliance activities. Improper use or disclosure of protected health information (PHI) can result in both civil and criminal penalties, including fines and imprisonment.

Preemption of State Law

HIPAA and the Privacy Rule contain general guidelines for the relationship between federal and state laws. For example, the regulation says that the state

law will prevail if the state law is more stringent than the federal law. The North Carolina Medical Society is currently assessing the impact of those guidelines and expects to support legislation to bring North Carolina law into conformance with HIPAA, with certain exceptions that will be outlined in the law. HIPAA specifically provides that state law prevails in the instances of reporting diseases, child abuse, birth or death, public health surveillance and investigation. It is believed that North Carolina statutes related to parental access to minor records would prevail over any HIPAA requirements.

Important Goals, Definitions, and Privacy Rule Standards

One of the most challenging aspects of HIPAA and the Privacy Rule is the introduction of new concepts. I recommend that you learn the concepts before taking specific action steps.

Start with the big picture of Administrative Simplification and focus on its three goals:

- improve the efficiency of healthcare delivery by standardizing electronic data interchange of administrative transactions between providers and payers;
- protect the privacy and security of individually identifiable healthcare information;
- empower patients by giving them new rights related to their individually identifiable health information.

The last goal is truly a reverse in the idea reflected in North Carolina practice guidelines that physicians are the owners of medical information about their patients. The Privacy Rule gives patients rights regarding their medical records and calls on physicians to help ensure those rights. In effect, physicians become the custodians of the records on behalf of their patients.

When you are clear about the goals of Administrative Simplification, move on to the 12 important HIPAA definitions and Privacy Rule standards. If you understand these clearly, you will make the compliance job easier for yourself. I've listed these items below and provided short explanations in Appendix 1.

- Covered Entity
- Protected Health Information (PHI)
- Individually Identifiable Health Information (IIHI)
- De-Identified Data
- Limited Data Set
- Patient Control over Health Information
- Limitations on Use and Disclosure of PHI
- Notice of Privacy Practices
- Authorization to Use or Disclose PHI
- Business Associates
- Marketing
- Personal Representatives

"If you have postponed starting on HIPAA Privacy Rule activities because the burden of compliance feels overwhelming, rethink your position"

HIPAA and Privacy Rule

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Compliance with the Privacy Rule: One Step at a Time

Compliance with the Privacy Rule includes five types of activities: learning the basics, developing and implementing policies and procedures, training your staff, documenting your activities, and ongoing monitoring. I suggest you organize your specific tasks within these major categories.

Although you will need to take many steps to achieve compliance, the steps aren't hard. They can be puzzling if you don't understand the important concepts. They can be confusing if you don't develop a logical work plan. They can be time consuming if you don't know what resources are available to you and how to use them to help your practice.

To help you understand the scope of your work, I've listed the important steps in Appendix 2. The order in which you perform these tasks is optional and should be related to the ways in which you use internal and external assistance. Two of the earliest steps are the most important because they set the stage and tone for the remaining steps. These critical early steps are designation of a Privacy Official for your practice and walking around your practice to determine the gaps between the Privacy standards and your current operations and physical set-up.

HIPAA and the Privacy Rule require you to designate a Privacy Official for your practice. Use the sample job description in Appendix 3 to help you tailor specifications for your practice and designate the most appropriate person for the position.

Most practices that have a practice administrator designate that individual as the Privacy Official. Small practices that do not have a formal practice administrator may take a different approach. The physician(s) in the practice may become the Privacy Official(s) and direct the compliance process. In one primary care practice for which I am presently consulting, two physicians share responsibility for HIPAA. They lead the small HIPAA team and interact with the external consultant.

After you designate a Privacy Official, take a walk around your practice so you can compare your current operations and physical facility with HIPAA and Privacy Rule standards. Make sure to use a comprehensive checklist to do this "gap analysis." My own checklist divides practice functions into six categories: check-in, check-out, front office general; business office; human resources and training; clinical areas; medical records; and business associates. It references relevant sections of HIPAA and the Privacy Rule and distinguishes between requirements and suggestions. It also supplements what you note about your practice with specific action steps and gives you a place to check off progress and completion.

Challenges and Suggestions for Overcoming Them

Two obstacles to moving forward with Privacy Rule compliance are time and money. Let's talk about both issues and ways in which you can address them.

Time

Learning about HIPAA and the Privacy Rule takes time, and hours devoted to compliance are hours subtracted from patient care. Here are practical suggestions.

- Learn about HIPAA in the evening or on weekends, not in the middle of busy office hours when you and your staff are concentrating on patient care. You can give your patients and HIPAA your full attention, but not at the same time.
- Take the initiative to educate yourself. The North Carolina Medical Society sponsored a series of informational sessions in 2002 and these are also available on videotape. Some of the larger physician organizations in the state sponsor group training for multiple practices and may make that training available to non-members. Group training has two advantages: price and the opportunity to share suggestions with other practices.
- Engage outside help that suits your needs. As with any new federal healthcare requirements, HIPAA and the Privacy Rule have created a consulting frenzy. Don't be put off by the barrage of offers. HIPAA is complex but manageable, and you may indeed benefit from external help. If you engage a consultant to work directly with your practice, you have choices. You can ask the consultant to do most of the work, or you can ask for guidance and feedback so you can do most of the work. Both approaches can be effective, provided they meet your needs and budget. Appendix 4 lists training and consultation services that have been reviewed by the North Carolina Medical Society.

Financial

HIPAA has the potential to bring financial gain to your office, to reduce staff time spent on administrative work, and to improve patient satisfaction. Depending on the size of your practice, for \$3,000-\$4,000 (less for group programs) plus the cost of minor physical changes, if any, you can address Privacy Rule compliance in an organized, timely way. Make the financial commitment; it's a long-term investment.

Helpful Resources

There are many HIPAA-related products on the market right now. The biggest challenge is determining what will help you the most. Appendix 5 lists books, on-line tools, and useful Web sites. The following general observations can guide you in your

"Two obstacles to moving forward with Privacy Rule compliance are time and money"

selection of resources.

- Books on HIPAA and the Privacy Rule: make sure you have in your office at least one comprehensive book on HIPAA that you can use as a desk reference. Once you master the basics, you need a good resource to help you answer less obvious questions.
- On-line material: some HIPAA and Privacy Rule material has been developed so you can download it from the Web site. This kind of information is particularly helpful when you need sample policies, procedures, and forms. Keep in mind, however, that it may be less comprehensive than the written desk references.
- Bookmark Web sites that provide information

and ongoing updates about HIPAA and check these sites regularly. The Frequently Asked Questions (FAQ) sections are particularly helpful and offer good practical advice.

Conclusion

The April 14, 2003, deadline for compliance with the Privacy Rule and relevant portions of the Security Rule is quickly approaching. Begin by understanding HIPAA basics, timetable and penalties, the relationship between federal and state law, and important definitions and standards. Then move on to specific steps. Take advantage of training and consultation that is available in your area. Start now and finish on time.

The author gratefully acknowledges the assistance of Carol Ann Scheele, JD, Associate General Counsel, Health Delivery Systems, North Carolina Medical Society, and Jerome Stracke, President & CEO of Visantis Healthcare Solutions.

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Ms Satinsky is President of Satinsky Consulting, LLC. She earned her BA in history from Brown University, her MA in political science from the University of Pennsylvania, and her MBA in healthcare administration from the Wharton School of the University of Pennsylvania. She is the author of two books: *The Foundation of Integrated Care: Facing the Challenges of Change* (American Hospital Publishing, 1997)

and *An Executive Guide to Case Management Strategies* (American Hospital Publishing, 1995). She is also author of a chapter titled Advanced Practice Nurse in a Managed Care Environment that appears in the book *Advanced Practice Nursing: Changing Roles and Clinical Applications*, edited by J.V. Hickey, et al (Lippincott, 1996, and Lippincott, 2000). An adjunct faculty member at the University of North Carolina School of Public Health and the Duke University School of Nursing, Ms Satinsky is also a Fellow of the American College of Healthcare Executives and a member of the Medical Group Management Association. She may be reached at (919) 383-5998 or margie@satinskyconsulting.com.

HIPAA and the Privacy Rule: Appendices

APPENDIX I

Important HIPAA Definitions and Privacy Rule Standards

Covered Entity: HIPAA defines covered entities as health plans, healthcare clearinghouses such as billing services, and any healthcare providers (physicians, hospitals, nursing homes, etc.) that transmit health information in electronic form in connection with a HIPAA transaction.

Protected Health Information (PHI): With few exceptions, PHI includes individually identifiable health information (IIHI) that is held or disclosed by a covered entity regardless of how it is communicated (e.g. electronically, verbally, or in writing). HIPAA and the Privacy Rule spell out specific requirements for obtaining authorization to use or disclose PHI.

Individually Identifiable Health Information (IIHI): Any health information that is collected from a patient: and (1) is created or received by a healthcare provider or other covered entity or employer and (2) that is related to the past, present, or future physical or mental health or condition of an individual; OR the provision of healthcare to an individual, or the past, present, or future payment for the provision of healthcare at your practice; AND that could potentially identify an individual.

De-Identified Data: Covered entities can determine that IIHI has been de-identified and no longer contains PHI that is subject to Privacy Rule restrictions and requirements. The two ways to de-identify IIHI are the safe harbour method and the expert opinion method.

Limited Data Set: PHI that excludes specific, readily identifiable information about patients and their relatives, employers, and household members.

Patient Control over Health Information: HIPAA and the Privacy Rule give patients control of PHI. Covered entities can use PHI without authorization for treatment, payment, and operations (TPO), with specific exceptions. Patients can request restrictions on the use or disclosure of PHI, and they can request that covered entities use alternative ways (e.g. work phone number) to contact them with confidential information.

Limitations on Use and Disclosure of PHI: HIPAA and the Privacy Rule require covered entities to use and disclose the "minimum necessary" PHI to accomplish the intended purpose. There are exceptions to this standard and specific rules for limiting the use of PHI to only those members of the workforce who need it to do their jobs.

Notice of Privacy Practices: Covered entities must develop, post, and distribute this document in order to inform patients about their rights surrounding the protec-

HIPAA and Privacy Rule

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tion of their PHI. Covered entities must also use their best efforts to obtain written Patient Acknowledgement of Receipt of the notice.

Authorization to Use or Disclose PHI: The Privacy Rule gives individuals and their personal representatives the right to authorize the use or disclosure of PHI except for treatment, payment, and operations (TPO). Psychotherapy notes are an exception to the rule. Their release always requires patient authorization.

Business Associates: A person or entity outside of your practice's workforce that is not a covered entity and that must use or disclose PHI to carry out certain functions or activities on behalf of your practice. Your practice must put in place Business Associate Agreements.

Marketing: HIPAA defines marketing as "making a communication about a product or service that encourages the recipients of the communication to purchase or use the product or service." Prior to disclosing PHI for marketing purposes, your practice must obtain written patient authorization.

Personal Representative: A person who, under applicable law, has the authority to act on behalf of an individual in making decisions related to healthcare. Examples are guardians and persons with power of attorney.

APPENDIX 2

Privacy Rule Compliance: One Step at a Time

HIPAA and the Privacy Rule are complex, not unmanageable. Take these steps before April 14, 2003.

- Educate yourself in HIPAA and Privacy Rule basics: overview, history, timetable, enforcement and penalties, and relationship between HIPAA and state laws.
- Dig deeper and review one of the many available HIPAA Glossaries so you are familiar with commonly used terms.
- Familiarize yourself with important HIPAA and Privacy Rule Definitions and Standards.
- Use a comprehensive HIPAA Privacy Checklist to walk around your practice and assess your current situation.
- Create a HIPAA Privacy Rule log so you can document in writing the activities that you perform and your accomplishments.
- Develop a HIPAA Privacy Official job description that is tailored to your practice's needs and designate someone within your practice to assume that responsibility.
- Develop and implement policies and procedures for the following:
 - general policies and procedures on PHI;
 - required disclosures: patients, public health purposes;
 - use and disclosure of PHI for treatment, payment, and operations within your practice and with respect to other practices;
 - disclosure of PHI for treatment, payment, and any operations of organized healthcare arrangements;
 - disclosure of PHI to family, friends, and disaster relief organizations;
 - incidental disclosures of PHI;

- patient authorization to use and disclose PHI;
- de-identification of PHI using safe harbor or expert statistician methods;
- use of limited data sets for research, public health, or healthcare operations;
- verification of identity of person requesting PHI;
- minimum necessary requirement for using and disclosing PHI;
- business associates and other vendors;
- personal representatives who request PHI;
- marketing;
- psychotherapy notes;
- commitment to consistency with notice of privacy;
- consent forms;
- general patient rights;
- patient access to PHI;
- patient requests for amendments to PHI;
- patient requests for accounting of uses and disclosures of PHI;
- patient requests for alternative communications;
- patient complaints;
- general management of privacy rule;
- privacy official/contact;
- notice of privacy practices;
- documentation relating to privacy policy;
- workforce training;
- internal sanctions of workforce who violate privacy policy;
- mitigation;
- no retaliation;
- no waiver;
- safeguards.

- Train all physicians and staff on Privacy Policies.
- Document all training.
- Obtain signed Workforce Confidentiality Agreements from all physicians and staff.
- Develop and implement a methodology for monitoring compliance with the Privacy Rule.
- If your practice uses and discloses PHI for research purposes, develop and implement a Data Use Agreement.
- If your practice participates in an Organized Healthcare Arrangement, develop and implement a policy and procedures regarding disclosure of PHI to another participating entity.
- Read the Security Rule and make sure that relevant requirements are a part of your Privacy activities.
- CELEBRATE!

APPENDIX 3

Sample Job Description: Privacy Official

Practice Name:

Revision Date:

REPORTING RELATIONSHIP: Designate the individual(s) to whom the Privacy Official will be accountable in setting up your Privacy system and in maintaining it. You may want to designate several people.

GENERAL DESCRIPTION: Oversee the development, implementation, and maintenance of and adherence to the practice's policies and procedures related to the privacy and access of patients' protected health information (PHI) in

compliance with federal and state laws and the practice's Privacy Policy.

ESSENTIAL DUTIES:

- Maintain current knowledge of applicable federal and state privacy laws, including but not limited to HIPAA and the Privacy Rule.
- Develop, oversee, and monitor implementation of the practice's Privacy Policy and ensure maintenance of the integrity of the Policy at all times.
- Regularly report to the practice governing body and officers (insert applicable term here) regarding the status of the Privacy Policy.
- Collaborate with legal counsel, other HIPAA consultants, management, and committees to ensure that the practice maintains appropriate privacy consent and authorization forms, notices, and other administrative materials in accordance with practice management and legal requirements.
- Patient Complaints: Establish and manage a process for receiving, documenting, tracking, investigating, and taking action on all complaints concerning the practice's Privacy Policies and Procedures in coordination and collaboration with other similar functions, and when necessary, with legal counsel.
- Patient Requests: Establish and oversee practice policies to address patient requests to obtain or amend patient records, restrict the means of communication, or obtain accountings of disclosures; ensure compliance with practice policies and legal requirements regarding such requests and establish and oversee grievance and appeals processes for denials of requests related to patient access or amendments to PHI.
- Privacy Training:
 1. Organize, deliver, and direct the delivery of privacy training and orientation to all members of the workforce (e.g. administrative staff, all clinical staff, including physicians, volunteers, and temporary employees) and other appropriate personnel.
 2. Set up and maintain a system for documenting privacy training.
 3. Monitor attendance at Privacy Policy training sessions and evaluate participants' understanding of the information presented.
- Practice Compliance: Monitor compliance with Privacy Policy by performing periodic privacy risk assessments at each practice location and by reporting results to practice board or governing body.
- Evaluation: Monitor and evaluate, at least annually, the success of the practice's Privacy Policy in meeting the practice's goal for protection of PHI. As appropriate, make recommendations for changes and improvements.
- Coordinate and participate in disciplinary actions related to the failure of practice members to comply with the practice's Privacy Policy and/or applicable law.
- Monitor technological advancements related to PHI protection and privacy for consideration of adaptation by the practice.
- Coordinate and facilitate the allocation of appropriate resources for the support of and the effective implementation of the Privacy Policy.
- Initiate, facilitate, and promote activities to foster pri-

vacuity information awareness within the practice.

- Cooperate with the Office of Civil Rights, other legal entities, and practice officers in any compliance reviews or investigations.
- Act as point of contact for practice legal counsel and HIPAA consultant in an ongoing manner and in the event of a reported violation.
- Maintain all Business Associate contracts and Confidentiality Agreements with non-Business Associate vendors and respond appropriately if problems arise.
- Act as the practice-based point of contact for receiving, documenting and tracking all complaints concerning privacy policies and procedures of the practice.

REQUIRED EDUCATION/KNOWLEDGE/

SKILLS: Organization and management skills; training.

REQUIRED EXPERIENCE: Familiarity with administrative and clinical functions of the practice.

PHYSICAL AND MENTAL EFFORT: Willing and able to devote significant effort to learning about new legal and regulatory requirements; ability to translate general requirements into practice-specific policies and procedures.

TIME COMMITMENT: Varies by practice.

SPAN OF CONTROL: Privacy resource for all administrative staff, clinical personnel, and patients, and link with legal counsel and other external consultants.

REQUIRED LEADERSHIP: Able to assume strong leadership role.

DECISION-MAKING/INDEPENDENT ACTION: Must be self-starter comfortable in taking the initiative and requesting guidance as needed.

APPENDIX 4

HIPAA Training and Consultation Programs Listed by North Carolina Medical Society: December 2002

For additional details and pricing, visit the North Carolina Medical Society Web site or contact specific vendors.

- **HIPAA Consulting and Training Programs for Physicians and Office Managers.** Vendor: Smith, Anderson, Dorsett, Mitchell and Jernigan, LLP. (Raleigh)
- **HIPAA Consulting and Training Programs for Physicians and Office Managers.** Vendor: HIPAA Regulatory Compliance, PC. (Richmond, VA)
- **HIPAA Privacy: A How-to Guide for Your Medical Practice.** Vendor: Gates, Moore, and Company, Atlanta, GA (in collaboration with Epstein, Becker, and Green).
- **HIPAA Gap Assessment and HIPAA Education and Training to Physicians and Office Managers.** Vendor: Smith Moore, LLP, in alliance with Health Resources Management.
- **HIPAA Legal Consulting & Assessment.** Vendor: Harrison Kaplan, Attorney at Law, and Samuel M. Taylor, Attorney at Law. (Raleigh)
- **On-Site Education & Coordination, HIPAA University.** Vendor: Health Resources Management. (Various locations in North Carolina)
- **HIPAA Privacy Workshops for Physician Groups.** Vendor: Visantis (Cary) in collaboration with Smith, Anderson, Blount, Dorsett, Mitchell, and Jernigan, LLP, and Satinsky Consulting, LLC.

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HIPAA and Privacy Rule

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APPENDIX 5

Helpful Resources on HIPAA and the Privacy Rule

There are many helpful HIPAA and Privacy Rule resources in the market place. This list contains books/manuals, Web-based self-assessment tools, and organizations with useful Web sites. Check with your professional or specialty organization to see what they offer. The free HIPAA catalogue available from Medical Arts Press (800.328-2179 or www.medicalartspress.com) is a comprehensive resource not only for books and Web-based material, but also for equipment and furniture that can help with HIPAA and Privacy Rule compliance.

Books/Manuals

Field Guide to HIPAA Implementation (2002). Chicago, American Medical Association Press. Authors: J. Root, DC. Kibbe, M. Hubbard, C. Hartley. Comprehensive desk reference covering all sections of HIPAA. Available directly from AMA and from Amazon.com.

HIPAA Policies and Procedures Desk Reference (available January 2002). Chicago, American Medical Association Press. Authors: M. Hubbard, K. Glover, C. Hartley. Specific policies and procedures for the Privacy Rule. Available directly from AMA and from Amazon.com.

HIPAA Answer Book (2002 Edition). Rockville, MD, HIPAA Compliance Alert. Easy-to-read alphabetized reference book. Available from publisher (877 397-1496) and through North Carolina Medical Society.

HIPAA Privacy Manual: A How to Guide for Your Medical Practice (October, 2002). Vendor: Gates, Moore, and Company, Atlanta, GA, in collaboration with Epstein, Becker, and Green. Practical "how to do it" manual with sample policies and forms. Web or CD-Rom version also available. Available through North Carolina Medical Society or directly from Gates, Moore and Company.

HIPAA: A Short- and Long-Term Perspective for Healthcare (2002). M. Doscher. Chicago, American Medical Association Press. Comprehensive background information and analysis of potential benefits to medical practices.

Privacy Rule Self-Assessment Tools

HIPAA Privacy Manual. Gates, Moore and Company, referenced under Books/Manuals above.

HIPAA EarlyView TM Privacy. Vendor: North Carolina Healthcare Information and Communication Alliance (NCHICA), RTP, North Carolina. Available from NCHICA or through North Carolina Medical Society.

Organizations with Web Sites That Have Useful HIPAA/Privacy Rule Information

American Hospital Association

HIPAA Web site

American National Standards Institute (ANSI)

ANSI standards information and HIPAA-related articles

American Society for Testing and Materials (ASTM)

Standard guides for health information access, individual

rights, data security, CPR, and more

Association for Electronic Healthcare Transactions (AFECHT)

HIPAA background, analysis, and information on work-groups

California HealthCare Foundation

Free HIPAA Administrative Simplification: Tool Kit for Small Group and Safety-Net Providers

Centers for Medicare and Medicaid Services (CMM)

Electronic Healthcare Network Accreditation Commission (EHNAC)

HIPAA security accreditation information

Department of Health and Human Services (DHHS)

HIPAA rules and proposed rules, comments, listservs

Healthcare Data Exchange (HDX)

The Integrated Healthcare EDI Network. Comprehensive electronic transaction services for the health industry

Health Care Financing Administration (HCFA)

HIPAA overview and links

Health Level 7

Standards for exchanging, managing, and integrating data to support clinical patient care

Health Privacy Project

Current information, fact sheets, and testimony

HHS Data Council

HIPAA's Administrative Simplification provisions

Joint Healthcare Information Technology Alliance

HIPAA privacy information

Massachusetts Health Data Consortium

Summaries of National Proposed Rule Modifications, compliance checklist, legislative background, HIPAA acronyms

Medicare

Medicare EDI information

National Council for Prescription Drug Programs (NCPDP)

NCPDP identified standards for HIPAA

North Carolina Healthcare Information and Communications Alliance, Inc. (NCHICA)

Multiple HIPAA resources including pre-emption analysis and tool for assessing current status of your medical practice

North Carolina Medical Society

Recommended HIPAA reference materials and consultants

U.S. General Printing Office

Numerous databases including the Federal Register, Congressional Record, and Code of Federal Regulations

Phoenix Health Systems

HIPAAAdvisory contains information, tools, updates, glossary of terms, and links

Washington Publishing Company (WPC)

HIPAA-EDI implementation guides, code lists, and Standard Transaction Format Compliance System (STFCS) information

Workgroup for Electronic Data Interchange (WEDI)

Industry technical reports, HIPAA security matrix, and more

Letters to a Young Physician: Part IV



Carolyn E. Hart, MD

Dr Carolyn E. Hart, who practices neurology in Charlotte, is president of the Mecklenburg County Medical Society. In place of the usual president's comments in the Society's publication, Mecklenburg Medicine, she has prepared a series of letters to a medical student, "W," whose parents are physicians and friends of hers. Her thoughts, so clearly and simply expressed, unfold as a primer of sorts, laced with insight and wisdom, a gentle and

conversational guide and reminder for health care professionals at any point in their careers. We thank Dr Hart and Mecklenburg Medicine for allowing us to present the letters here. Eight were published in the first three numbers of the Forum for 2002. With the two letters appearing below, we complete publication of the full series of ten letters. (Titles of all ten letters to W appear in the box following this article.)

Take Time to Advocate

Dear W:

I am so glad to hear that you and B did so well on your exams! That reflects not only your intelligence, but also your commitment to learning, organization, and support of each other. Congratulations! I am also really happy that your relationship is going so well, especially despite the pressures of your schooling and this profession! B is a special person and you two seem to have something that could last. I have enjoyed talking with you both by phone and e-mail but continue to hope you will come visit soon!

W, my little patient C died this month, and losing one doesn't ever seem to get easier. I wanted to tell you her story to encourage you to "Take Time to Advocate." This tiny 16-month-old girl had a mitochondrial disorder, which not only blocked her development but also caused her to have horrible seizures. Her seizures persisted despite all the best medications, and I finally recommended a vagal nerve stimulator (VNS). Although VNS has been helpful to many patients of various ages, C's insurance company considered it "experimental" since C was so young. Despite the data I provided to support its safety, efficacy, and appropriateness for this child, the insurance company denied coverage. We put it in anyway. Cyberonics donated the device, and pediatric neurosurgeon MH donated his expertise. So did the hospital, pediatrician, and I. And guess what? Her seizures improved dramatically, allowing her and her parents some meaningful time together. Still, the insurance company would not acknowledge this as a valid treat-

ment! Of course, she ultimately succumbed anyway, but she died quietly in her parents' arms and not in a seizure. Even though we failed to get her insurance company to pay for the treatment, all of our advocating for this child was a success because we helped her get relief from terrifying symptoms and to die peacefully.

To "advocate" is "to speak for" (*ad* + *vocare*), to support, to plead the cause of another. Physicians have often been advocates for safety, public health, and social justice around the world. In this country, collective and individual physician efforts in the political arena and in public education have helped effect the passage of laws pertaining to speed limits, car seats, water quality, housing safety, child abuse, and many other important issues. Physicians have also long advocated for patients simply by taking care of them kindly and competently.

More recently, we have had to learn to advocate for patients for financial coverage of their visits, medications, and procedures. We have each had to make many phone calls and write many letters to insurance companies on behalf of our patients. Be sure to take time to do this, but do it as quickly and efficiently as possible. The insurance companies may hope you won't take the time, and there are time and financial pressures not to, but you know you should. You still know what is best for your patient, and if you take a firm stand the insurance companies will often yield. Once during residency, your mother and I had a patient who needed a hemispherectomy for seizure control, and the insurance company felt that it was "experimental." After contesting this vigorously, our team finally got an authorization from the insurance company with the qualification that they would not pay if he ever needed another hemispherectomy!

Physician advocacy also must involve some participation in government. Get involved in your regional medical societies and the AMA, and you will find that it is quite enjoyable to interact with other physicians and advocate together. Also, write or call your government representatives and tell them about your own and your patients' battles for coverage, timely payment, and good health in general. Federal and state senators and representatives are all on line: see www.senate.gov; www.house.gov; and www.northcarolina.gov.

The president elect of our county medical society recently called my attention to a publication that is very relevant to this concept of physician advocacy. The Charter on Medical Professionalism is the product of a large collaborative effort and articulates the shared

"Your voice as a physician is trusted and respected in the community, and you should make it heard"

Fondly, Carolyn

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principles of healers around the world. This encouraging credo affirms our beliefs in the primacy of patient welfare, respect for patient autonomy, and the importance of social justice. Like Thomas Jefferson said of the American Declaration of Independence, the document did not aim at creating but rather expressing principles held by a people. In these changing times, we must hold fast to these timeless values. (If you would like to read the Charter, go to www.annals.org, then select Past Issues, 2002, Number 3, February 5, 2002.)

Because of our managed care, political, and other difficulties, physicians may be tempted to forsake our role in promoting public health and safety. Nevertheless, your voice as a physician is trusted and respected in the community, and you should make it heard. The first time you speak at your local school board or county commissioners meeting, you will be surprised at the respect you are afforded. The board members will certainly listen and consider your points carefully, even if they may not vote as you recommended!

Your mother just called me and told me of B's accident this morning. Oh, W! I am so sorry to hear of this. I hope they will be able to save her foot. I hope you know how much she needs you now, as an advocate certainly, but mostly as her partner. Oh, my young friend, do you have enough support? Should I come?

Fondly,
Carolyn

Take Time to Notice Beauty

Dear W:

I cannot tell you how relieved I am that B is recovering well. I am really sorry about her foot and hope the prosthesis and physical therapy will be helpful. Perhaps you and she will be able to see them as tools to recovery rather than as a burden, although I suppose they are both. I guess I was a little silly to think that you might need me to come out there when you have so many caring supporters close to home. It sounds like C especially was a tremendous help. That "little" brother of yours has sure turned out to be a good friend, hasn't he? Sometimes, a sad experience like this can actually serve to show you how many people care about you and how fortunate you really are. W, do I sound like some "glass half full or half empty" parrot? I don't mean to, but I do hope you and B will not let this ordeal embitter you and instead focus on the positives and "Take Time to Notice Beauty."

Once during residency, I had my car broken into and all my best possessions stolen. I had my suitcase (full

of my best clothes), my good clarinet, and my hand-made dulcimer in the car overnight while I was on call. It was a high-crime area, so this wasn't ideal (or even very smart), but this way I could go directly to the airport to travel to play in a friend's wedding. When I found the window smashed and all my things gone, I was stunned. Your mother "called in the troops," and while she sped to my house and packed another suitcase for me, another friend rented a clarinet for me at a music store, and another brought me her dulcimer. Another friend stayed with my car to file the police report, and another took me to the airport. I found myself sitting on the plane smiling because the lasting impression of that experience was not that of being victimized but that of being surrounded by loving friends. I don't mean to imply this problem compared to the challenges you and B are facing now, but it was a very instructive experience for me and helped me learn to pay attention to the good parts of life.

The friend who brought me her dulcimer that day went with me to volunteer one month on the Navajo/Hopi reservation in Arizona. While there, we learned a little about their interesting tribal customs, herbal remedies, and beliefs, not to mention their tasty mutton sandwiches! In the *Book of the Navajo*, Raymond Locke describes the Navajo belief that the universe is an orderly system of interrelating elements, including both good and evil. Except for occasional long ceremonies involving hymn-like chants and dry-paintings (sand paintings), traditional Navajo culture includes no specific place, calendar, or even word for religion. In fact, visitors and sociologists long thought they had no form of worship, only later to slowly realize that religious philosophy pervaded the daily lives of the Navajo. Many have a profound awareness of the sacred and a consciousness of beauty, poetically expressed in the Navajo Night Chant.

With beauty before me I walk;
With beauty behind me I walk;
With beauty above me I walk;
With beauty below me I walk;
With beauty all around me I walk;
With beauty within me I walk;
It is finished in beauty.

(www.artsmia.org/surrounded-by-beauty)

W, you have always seemed to have an inherently cheerful personality, and what a blessing that is! Even so, it is easy to forget to notice the beauty around you, especially during trying times in your life. You know how much I like "Desiderata" (by Max Ehrmann); it includes this line: "With all its sham, drudgery and broken dreams, it is still a beautiful world." Christianity, Islam, Buddhism, and Judaism all teach that, too. In his comforting book, *Living Buddha, Living Christ*, Thich Nhat Hanh describes the peace

"The core messages of each religion seem to focus on living justly and being aware of beauty and goodness"

and insight that come from being “mindful,” noticing all senses, and entering deeply into the present moment. He urges his students to walk mindfully, even to eat mindfully, in order to achieve love and understanding—values that transcend dogma. Although religions have often been used to justify violence, the core messages of each religion seem to focus on living justly and being aware of beauty and goodness.

The challenges of physicians’ daily lives could easily distract us from noticing the beauty around us: in nature, in people, and in ourselves. W, I know you and B are dealing with some particularly tough times right now and it would be understandable if you got discouraged. I hope you both will remember, though, how many people need you and how many people care about you. As it says in the recent remake of the old Bob Dylan lyrics “Forever Young,” I hope you both will always be able to “see the light surrounding you.”

W, I have enjoyed writing you this year. I want you to know how honored I felt that you asked for my

advice and how touched I was that you might listen. I am certain you will be a great physician. You know I am pulling for you!

Hugs to your family and to B.

Fondly,
Carolyn

W’s List

The following is a list of the ten letters appearing in the Fondly, Carolyn series.

- Take Time to Comfort
- Take Time to Volunteer
- Take Time to Keep Learning
- Take Time to Relax with Your Family
- Take Time to Run Your Business
- Take Time to Use Your Manners
- Take Time to Be Culturally Competent
- Take Time to Live Healthily
- Take Time to Advocate
- Take Time to Notice Beauty

From NCDHHS Division of Medical Assistance

Anticoagulation in Patients with Atrial Fibrillation: A Missed Opportunity?

*David H. Gremillion, MD, FACP
N.C. Medicaid DUR Board Member
President, Wake County Medical Society*



Dr Gremillion

The Medicaid Drug Utilization Review Board recently evaluated warfarin-prescribing patterns of North Carolina physicians in their patients with atrial fibrillation (AF). Results of these studies document a disappointing adherence to the emerging standard of care. Over 2 million patients nationwide experience sustained AF. In our review of North Carolina patients on Medicaid during the fourth quarter of 2001, only 50.8% of patients with an ICD-9 code for atrial fibrillation (427.3) was receiving warfarin. This may represent a missed opportunity to reduce morbidity, mortality, and unnecessary expense. Of the 3,021 physicians caring for such patients, 353 physicians accounted for a majority of patients.

A growing body of evidence documents that patients with sustained atrial fibrillation are at high

risk of CNS embolic events. Patients randomized to control groups in primary stroke prevention trials sustain stroke at a surprisingly high 5% per year, with a dramatic age variation from 1.5% in the fifth decade of life to 23.5% in the eighth. Carefully conducted trials and subsequent meta-analyses further document the safety and efficacy of using oral anticoagulant therapy (OAC) to reduce this risk.^{1,2} Anticoagulants are particularly effective in patients with AF who have additional risk factors (Table 1). Since the risk of a hemorrhagic complication is increased, OAC should be avoided in patients with a high risk of this complication (Table 2) and good anticoagulation monitoring techniques should be employed (Table 3).

Other anticoagulation strategies such as aspirin or other antiplatelet agents are less effective but may be useful in selected patients with contraindications to warfarin.

In the DUR Board’s review of 2,702 patients, we were unable to comprehensively review all medical records and thus may have missed key contraindications or alternative therapies not covered by Medicaid,

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Anticoagulation

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such as aspirin. Nevertheless, even with these study limitations we conclude that improved attention to warfarin use in AF is justified. Several hospitals have instituted tasteful "reminder" stickers on EKG's with a diagnosis of AF. These have been anecdotally successful in stimulating proper use of OAC in AF. There is no single area of routine clinical practice where practicing clinicians can have a greater impact on quality of life, reduced morbidity, and cost than with proper attention to the anticoagulation needs of their patients with atrial fibrillation.

Table 1. Risk Factors For Stroke In Patients With Atrial Fibrillation³

>75 years old
 prosthetic heart valve
 prior stroke/HA/embolus
 Hypertension
 Poor LV function
 Diabetes
 Coronary artery disease

Table 2. Potential Contraindications For Warfarin Therapy In AF

Pregnancy
 Protein C deficiency
 Recent GI bleed

Table 3. Anticoagulation Monitoring Techniques

Stabilize INR at 2-3 with 3-7 day monitoring then monitor at least every 2 months.
 Check INR in patients within 7 days of beginning or ending medications known to affect warfarin response
 Utilize an anticoagulation service if available locally

1. Albers GW, Dalen JE. Antithrombotic Therapy in Atrial Fibrillation. *Chest*, 2001; 119:194-206s.
2. Segal JB, McNamara RL, et al. Prevention of Thromboembolism in Atrial Fibrillation: A Meta Analysis of Trials of Anticoagulants and Antiplatelet Drugs. *Journal of General Internal Medicine*, 15 (1) pp 56-67.
3. See <http://www.abrq.org/clinic/strokecln.htm> for additional information.

NOTICE TO LICENSE APPLICANTS

Additional License Application Requirements Effective February 1, 2003

Beginning February 1, 2003, applicants for licensure by the North Carolina Medical Board will be required to provide certain additional information in order for the Board to conduct state and federal criminal history checks. This is in addition to all other information required by the license application and instructions.

Specifically, the applicant will be required to complete and submit an acceptable fingerprint card and a form entitled "Authority for Release of Information." Further, the license application fee must include an added fee to cover costs associated with the background check. Details regarding these requirements will be found at the end of the application materials sent the applicant and are available in the "MD/DO Medical License Application" section of the Board's Web site (www.ncmedboard.org).

All applications received on or after February 1, 2003, must include the required information.

MEDLINEplus Goes Spanish

MEDLINEplus, the National Library of Medicine's consumer-friendly health Web site, now speaks Spanish! The new site is at medlineplus.gov/esp.

Recent surveys show more than 50 percent of adult Hispanics in the U.S. use the Internet. More than half of those, in fact, look to the Web for medical and health information. In response to this, the National Library of Medicine is introducing its popular consumer health information Web site, MEDLINEplus, in Spanish. Now users will find many of the authoritative, full-text resources that are available on MEDLINEplus "en Español," too.

MEDLINEplus, available free of charge 24 hours a day, debuted in October 1998. Today, the site has over 560 health topics and receives over 1 million visitors a month. The Web address for MEDLINEplus is medlineplus.gov. Hundreds of topics in Spanish point users to appropriate, credible information from the NIH and other federal government agencies, professional medical associations, and health-related organizations. On the medical encyclopedia pages, full-color illustrations and photographs accompany over 4,000 articles on diseases, injuries, tests, and surgeries. The interactive health tutorials, narrated guides to various health topics, use animated illustrations and plain-language to describe medical procedures, surgeries, and the symptoms and effects of disease.

Non-Spanish-speaking physicians, nurses, librarians, and others looking for Spanish-language materials for their clients will find the new service to be especially useful. A single click of the "Español" link will take users from the English MEDLINEplus page to its corresponding Spanish page.

Position Statements of the North Carolina Medical Board

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[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.

The words "physician" and "doctor" as used in the position statements of the North Carolina Medical Board refer to persons who are MDs or DOs licensed by the Board to practice medicine and surgery in North Carolina.]

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]

THE PHYSICIAN-PATIENT RELATIONSHIP

The North Carolina Medical Board recognizes the movement toward restructuring the delivery of health care and the significant needs that motivate that movement. The resulting changes are providing a wider range and variety of health care delivery options to the public. Notwithstanding these developments in health care delivery, the duty of the physician remains the same: to provide competent, compassionate, and economically prudent care to all his or her patients. Whatever the health care setting, the Board holds that the physician's fundamental relationship is always with the patient, just as the Board's relationship is always with the individual physician. 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 association 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;
- there be no conflict of interest between the patient and the physician or third parties;
- intimate 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 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, the relatives, or the legally responsible parties sufficiently far in advance (at least 30 days) to allow other medical care to be secured. 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.

(Adopted July 1995)

(Amended July 1998, January 2000; March 2002)

MEDICAL RECORD DOCUMENTATION

- The North Carolina Medical Board takes the position that physicians and physician extenders should maintain accurate patient care records of history, physical findings, assessments of findings, and the plan for treatment. The Board recommends the Problem Oriented Medical Record method known as SOAP (developed by Lawrence Weed).
- SOAP charting is a schematic recording of facts and information. The S refers to "subjective information" (patient history and testimony about feelings). The O refers to objective material and measurable data (height, weight, respiration rate, temperature, and all examination findings). The A is the assessment of the subjective and objective material that can be the diagnosis but is always the total impression formed by the care provided after review of all materials gathered. And finally, the P is the treatment plan presented in sufficient detail to allow another care provider to follow the plan to completion. The plan should include a follow-up schedule.
- Such a chronological document
 - records pertinent facts about an individual's health and well-being;
 - 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.
- Certain items should appear in the medical record as a matter of course:
 - the purpose of the patient encounter;
 - the assessment of patient condition;
 - the services delivered—in full detail;
 - the rationale for the requirement of any support services;
 - the results of therapies or treatments;
 - the plan for continued care;
 - whether or not informed consent was obtained; and, finally,
 - that the delivered services were appropriate for the condition of the patient.
- The record should be legible. When the care giver will not write legibly, notes should be dictated, transcribed, reviewed, and signed within reasonable time. Signature, date, and time should also be legible. All therapies should be documented as to indications, method of delivery, and response of the patient. Special instructions given to other care givers or the patient should be documented: Who received the instructions and did they appear to understand them?
- All drug therapies should be named, with dosage instructions and indication of refill limits. All medications a patient receives from all sources should be inventoried and listed to include the method by which the patient understands they are to be taken. Any refill prescription by phone should be recorded in full detail.
- The physician needs and the patient deserves clear and complete documentation.

(Adopted May 1994)

(Amended May 1996)

ACCESS TO PHYSICIAN 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 when such a transfer is requested by the patient or anyone authorized by law to act on the patient's behalf. 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 are therefore the property of that physician. Moreover, the resulting record is a confidential document and should only be released with proper written consent or authorization of the patient. Each physician has a duty on the request of a patient to release a copy or a summary of the record in a timely manner to the patient or anyone the patient designates. If a summary is provided, it should include all the information and data necessary to allow continuity of care by another physician.

The physician may charge a reasonable fee for the preparation and/or the photocopying of the materials.¹ To assist in avoiding misunderstandings, and for a reasonable fee, the physician should be willing to review the materials with the patient at the patient's request. Materials should not be held because an account is overdue or a bill is owed.

■ 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 patients' access to their records.² This provision does not apply if the primary custodian of the records is a hospital or other health care facility.

■ 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 patient records and about completing forms should be made available in writing to patients when the physician-patient relationship begins.

■ When responding to subpoenas for medical records, unless there is a court or administrative order, physicians should follow the recommendations set out in the *North Carolina Medico-Legal Guidelines*.³

(Adopted November 1993)

(Amended May 1996, September 1997; March 2002)

¹This is subject to some exceptions, including, but not limited to: (1) records sought with respect to claims for personal injury and Social Security disability, which are governed by the maximum fees set forth in NC Gen. Stat. 90-411; (2) records sought in worker's compensation cases, which are subject to fees established by the North Carolina Industrial Commission; and (3) NC Gen. Stat. 44-49, governing medical liens for physicians in personal injury cases.

²See also Position Statement on Departures from or Closings of Medical Practices.

³Link: *The North Carolina Medico-Legal Guidelines*.

RETENTION OF MEDICAL RECORDS

The North Carolina Medical Board supports and adopts the following language of Section 7.05 of the American Medical Association's current Code of Medical Ethics regarding the retention of medical records by physicians.

7.05: Retention of Medical Records

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

(1) Medical considerations are the primary basis for deciding how long to retain medical records. For example, operative notes and

chemotherapy records should always be part of the patient's chart. In deciding whether to keep certain parts of the record, an appropriate criterion is whether a physician would want the information if he or she were seeing the patient for the first time.

(2) If a particular record no longer needs to be kept for medical reasons, the physician should check state laws to see if there is a requirement that records be kept for a minimum length of time. Most states will not have such a provision. If they do, it will be part of the statutory code or state licensing board.

(3) In all cases, medical records should be kept for at least as long as the length of time of the statute of limitations for medical malpractice claims. The statute of limitations may be three or more years, depending on the state law. State medical associations and insurance carriers are the best resources for this information.

(4) Whatever the statute of limitations, a physician should measure time from the last professional contact with the patient.

(5) If a patient is a minor, the statute of limitations for medical malpractice claims may not apply until the patient reaches the age of majority.

(6) Immunization records always must be kept.

(7) The records of any patient covered by Medicare or Medicaid must be kept at least five years.

(8) In order to preserve confidentiality when discarding old records, all documents should be destroyed.

(9) Before discarding old records, patients should be given an opportunity to claim the records or have them sent to another physician, if it is feasible to give them the opportunity.

Please Note:

a. North Carolina has no statute relating specifically to the retention of medical records.

b. Several North Carolina statutes relate to time limitations for the filing of malpractice actions. Legal advice should be sought regarding such limitations.

(Adopted May 1998)

DEPARTURES FROM OR CLOSINGS OF MEDICAL PRACTICES

Departures from (when one or more physicians leave and others remain) or closings of medical practices are trying times. They can be busy, emotional, and stressful for all concerned: practitioners, staff, patients, and other parties that may be involved. If mishandled, they can significantly disrupt continuity of care. 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 of changes in the practice, which is often done by newspaper advertisement and by letters to patients currently under care;
- patients are told how to access their medical records;
- patients are told how to reach any practitioner(s) remaining in practice; and
- patients clearly understand that the choice of a health care provider is the patients'.

Provide Continuity of Care

Practitioners continue to have obligations toward patients during and after the departure from or closing of a medical practice. Except in case of the death or other incapacity of the practitioner, practitioners may not abandon a patient or abruptly

withdraw from the care of a patient. Therefore, patients should be given reasonable advance notice to allow their securing other care. Good continuity of care includes preserving, keeping confidential, 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 the requirements for continuity of care are effectively addressed.

No practitioner, group of practitioners, or other parties that may be 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.

*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)

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 January 2001)

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) (1993) 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 representative has the fundamental right to control the decisions relating to the rendering of his own medical care, including the decision to have extraordinary means withheld or withdrawn in instances of a terminal condition.

They must also be aware that North Carolina law empowers any adult individual with understanding and capacity to make a Health Care Power of Attorney [NC Gen Stat §32A-17 (1995)] 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)(1995)].

□ 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 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 with the 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 prior to a terminal illness.

□ 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.

□ It is also the position of the Board that 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 withdrawal of life prolonging technologies 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 July 1993)
(Amended May 1996)

AVAILABILITY OF PHYSICIANS TO THEIR PATIENTS AFTER HOURS

□ 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. If the physician is not generally available outside normal office hours and does not have an arrangement whereby another physician is available at such times, this fact must be clearly communicated to the patient, verbally and in writing, along with written instructions for securing care at such times.

□ If the condition of the patient is such that the need for care at a time the physician cannot be available is anticipated, the physician should consider transfer of care to another physician who can be available when needed.

(Adopted July 1993)
(Amended May 1996, January 2001)

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 physicians. In order to prevent such misunderstandings, the Board offers the following guidelines.

1. Sensitivity to patient dignity should be considered by the physician 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 physician. 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 physician performs an examination of the breast(s), genitalia, or rectum. It is the physician's responsibility to have a staff member available at any point during the examination.
3. The physician 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 physician 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 physician 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)

SEXUAL EXPLOITATION OF PATIENTS

□ It is the position of the North Carolina Medical Board that entering into a sexual relationship with a patient, consensual or otherwise, is unprofessional conduct and is grounds for the suspension or revocation of a physician's license. Such conduct is not tolerated. As a guide in defining sexual exploitation of a patient by a licensee, the Board will use the language of the North Carolina General Statutes, Chapter 90, Article 1F (Psychotherapy Patient/Client Sexual Exploitation Act), §90-21.41.

□ As with other disciplinary actions taken by the Board, Board action against a medical licensee for sexual exploitation of a patient or patients 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.

□ This position also applies to mid-level health care providers

such as physician assistants, nurse practitioners, and EMTs authorized to perform medical acts by the Board.

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

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 paragraph below. Before prescribing a drug, a physician 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 physician 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 physician 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 physician 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.

It is the position of the Board that prescribing drugs to individuals the physician 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]

WRITING OF PRESCRIPTIONS

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

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

□ It is the position of the North Carolina Medical Board that, except for minor illnesses and emergencies, physicians should not treat, medically or surgically, or prescribe for themselves, their family members, or others with whom they have significant emotional relationships. The Board strongly believes that such treatment and prescribing practices are inappropriate and may result in less than optimal care being provided. A variety of factors, including personal feelings and attitudes that will inevitably color 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)

THE USE OF ANORECTICS IN TREATMENT OF OBESITY

□ It is the position of the North Carolina Medical Board that under particular circumstances certain anorectic agents may have an adjunctive use in the treatment of obesity. Good medical practice requires that such use be guided by a written protocol that is based on published medical data and that patient compliance and progress will be documented.

□ It remains the policy of the Board that there is no place for the use of amphetamines or methamphetamines in the treatment of obesity.

(Adopted October 1987)

(Amended March 1996)

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

General

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

The physician 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 vali-

dated basis for use should be studied under investigational protocols so as to assist in the establishment of evidence-based, scientific validity for such treatments.

Substances/Preparations with Anabolic Properties

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

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

The Board recognizes that most anabolic steroid abuse occurs outside the medical system. It wishes to emphasize the physician's 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)

MANAGEMENT OF CHRONIC NON-MALIGNANT PAIN

It has become increasingly apparent to physicians and their patients that the use of effective pain management has not kept pace with other advances in medical practice. There are several factors that have contributed to this. These include a history of relatively low priority given pain management in our health care system, the incomplete integration of current knowledge in medical education and clinical practice, a sparsity of practitioners specifically trained in pain management, and the fear of legal consequences when controlled substances are used—fear shared by physician and patient.

There are three general categories of pain.

Acute Pain is associated with surgery, trauma and acute illness. It has received its share of attention by physicians, its treatment by various means is widely accepted by patients, and it has been addressed in guidelines issued by the Agency for Health Care Policy and Research of the U.S. Department of Health and Human Services.

Cancer Pain has been receiving greater attention and more enlightened treatment by physicians and patients, particularly since development of the hospice movement. It has also been addressed in AHCPR guidelines.

Chronic Non-Malignant Pain is often difficult to diagnose, often intractable, and often undertreated. It is the management of chronic non-malignant pain on which the North Carolina Medical Board wishes to focus attention in this position statement.

□ The North Carolina Medical Board recognizes that many strategies exist for treating chronic non-malignant pain. Because such pain may have many causes and perpetuating factors, treatment will vary from behavioral and rehabilitation approaches to the use of a number of medications, including opioids. Specialty groups in the field point out that most chronic non-malignant pain is best managed in a coordinated way, using a number of strategies in concert. Inadequate management of such pain is not uncommon, however, despite the availability of safe and effective treatments.

The Board is aware that some physicians avoid prescribing controlled substances such as opioids in treating chronic non-malignant pain. While it does not suggest those physicians abandon their reservations or professional judgment about using opioids in such situations, neither does the Board wish to be an obstacle to

proper and effective management of chronic pain by physicians. *It should be understood that the Board recognizes opioids can be an appropriate treatment for chronic pain.*

□ It is the position of the North Carolina Medical Board that effective management of chronic pain should include:

- thorough documentation of all aspects of the patient's assessment and care;
- a thorough history and physical examination, including a drug and pain history;
- appropriate studies;
- a working diagnosis and treatment plan;
- a rationale for the treatment selected;
- education of the patient;
- clear understanding by the patient and physician of methods and goals of treatment;
- a specific follow-up protocol, which must be adhered to;
- regular assessment of treatment efficacy;
- consultation with specialists in pain medicine, when warranted; and
- use of a multidisciplinary approach, when indicated.

□ The Board expects physicians using controlled substances in the management of chronic pain to be familiar with conditions such as:

- physical dependence;
- respiratory depression and other side effects;
- tolerance;
- addiction; and
- pseudo addiction.

There is an abundance of literature available on these topics and on the effective management of pain. The physician's knowledge should be regularly updated in these areas.

□ No physician need fear reprisals from the Board for appropriately prescribing, as described above, even large amounts of controlled substances indefinitely for chronic non-malignant pain.

□ Nothing in this statement should be construed as advocating the imprudent use of controlled substances.

(Adopted September 1996)

END-OF-LIFE RESPONSIBILITIES AND PALLIATIVE CARE

Assuring Patients

Death is part of life. When appropriate processes have determined that the use of life-sustaining 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

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

A physician who provides palliative care, encompassing the full range of comfort care, should assess his or her patient's physical, psychological, and spiritual conditions. Because of the overwhelming concern of patients about pain relief, special attention should be given the effective assessment of pain. It is particularly important that the physician frankly but sensitively discuss with the patient and the family their concerns and choices at the end of life. As part of this discussion, the physician should make clear that, in some cases, there are inherent risks associated with effective pain relief in such situations.

Opioid Use

The Board will assume opioid use in such patients is appropriate if the responsible physician is familiar with and abides by acceptable medical guidelines regarding such use, is knowledgeable about effective and compassionate pain relief, and maintains an appropriate medical record that details a pain management plan. (See the Board's position statement on the Management of Chronic Non-Malignant Pain for an outline of what the Board expects of physicians in the management of pain.) Because the Board is aware of the inherent risks associated with effective pain relief in such situations, it will not interpret their occurrence as subject to discipline by the Board.

Selected Guides

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

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

(Adopted October 1999)

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

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

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

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

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

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

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

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

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

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

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

- education of the patient and family; and
- a clear understanding by the patient, the family and health-care 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 judgement and legal responsibilities of each licensed health professional as to what is in the patient's best interest.

(October 1999)

OFFICE-BASED SURGERY

Office-based surgery is surgery* performed outside a hospital or an outpatient facility accredited by the North Carolina Division of Facility Services. Although surgery is not a perfect science in any setting, office-based surgery is generally safe, effective, and efficient, provided certain measures are taken in the process. It is the position of the North Carolina Medical Board that the physician is responsible for creating a safe environment for office-based surgery.

The following guidelines are recommended for office-based surgery:

- **Training:** Any physician performing surgery in an office or a hospital, must have appropriate training and continuing education. This should be documented and that documentation be available to patients and the public. Those who perform surgery, such as prearranged emergency consultations, should have emergency consultation agreements in place.
- **Patient Selection:** Patients must be screened to determine if the office is an appropriate setting for surgery.
- **Patient Evaluation:** Patients undergoing surgery must have an appropriate physical examination, and any necessary laboratory tests.
- **Anesthesia:** When general anesthesia is used in the office setting, it must be administered by a qualified anesthesia personnel. Anesthesia personnel must be trained in variations in technique based on the patient's condition and the procedure, particularly those involving airway management. Patients must be monitored before, during, and after anesthesia. Anesthesiologists** for general anesthesia personnel is an anesthesiologist.
- **Office Setting:** The office should be set up with safety in mind. Safety issues should be considered, including accessibility, sterilization, storage of materials and supplies, and emergency equipment.
- **Emergency Planning:** Planning should include, but not be limited to, emergency medicines, emergency equipment, and transfer protocols. Practitioners should be trained and capable of managing complications related to the procedures they perform.
- **Follow-Up Care:** As with any surgical treatment or procedure, follow-up care by the responsible surgeon is requisite. Arrangements

This Statement Replaced at Press Time
See Board's Web site (www.ncmedboard.org/officebased.htm) for full text of new statement.

should be made for follow-up care and for treatment of problems or complications outside normal office hours.

■ **Quality Improvement:**

Continuous quality improvement should be a goal.

*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."

**"Guidelines for Office-Based Anesthesia," "Guidelines for Ambulatory Anesthesia and Surgery," "Basic Standards for Preanesthesia Care," "Standards in Basic Anesthetic Monitoring," "Standards for Postanesthesia Care," "Guidelines for Nonoperating Room Anesthetizing Locations." All available from the American Society of Anesthesiologists

[Adopted September 2000]

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 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 responsible supervising physician should be on site or readily available to the person actually performing the procedure.

*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)

CARE OF SURGICAL PATIENTS*

■ 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.

*This position statement was formerly titled, "*Ophthalmologists: Care of Cataract Patients.*"

(Adopted September 1991)

(Amended March 2001)

HIV/HBV INFECTED HEALTH CARE WORKERS

The North Carolina Medical Board supports and adopts the North Carolina Department of Environment, Health and Natural Resources Division of Epidemiology's rule for HIV and HBV Infected Health Care Workers (T15A:19A.0207), and its rule for Infection Control in Health Care Settings (T15A:19A.0206). It is the Board's position that all licensees should be familiar with the current requirements of those rules.

(Adopted November 1992)

(Amended May 1996)

PROFESSIONAL OBLIGATION TO REPORT INCOMPETENCE, IMPAIRMENT, AND UNETHICAL CONDUCT

It is the position of the North Carolina Medical Board that physicians 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, physicians have a duty to report the matter to the institution best positioned to deal with the problem. For example, impaired physicians and physician assistants should be reported to the North Carolina Physicians Health program. Incompetent physicians should be reported to the clinical authority empowered to take appropriate action. Physicians 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 physician's attention by a patient, the physician must give appropriate consideration to preserving the patient's confidences in deciding whether to report the colleague.

(Adopted November 1998)

ADVERTISING AND PUBLICITY*

It is the position of the North Carolina Medical Board that physician advertising or publicity that is deceptive, false, or misleading is unprofessional conduct. The key issue is whether advertising and publicity, regardless of format or content, are true and not materially misleading.

Information conveyed may include:

- a) the basis on which fees are determined, including charges for specific services;
- b) methods of payment;
- c) any other non-deceptive information.

Advertising and publicity that create unjustified medical expectations, that are accompanied by deceptive claims, or that imply exclusive or unique skills or remedies must be avoided. Similarly, a statement that a physician 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. If patient photographs are used, they should be of the physician's own patients and demonstrate realistic outcomes.

Consistent with federal regulations that apply to commercial advertising, a physician who is preparing or authorizing an advertisement or publicity item should ensure in advance that the communication is explicitly and implicitly truthful and not misleading. Physicians should list their names under a specific specialty in classified telephone directories and other commercial directories only if they are board certified or have successfully completed a training program in that specialty accredited by the Accreditation Council for Graduate Medical Education or approved by the Council on Postdoctoral Training of the American Osteopathic Association.

*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)

SALE OF GOODS FROM PHYSICIAN OFFICES

The physician-patient relationship constitutes a fiduciary relationship between the physician and the patient in the strictest sense of the word "fiduciary." In this fiduciary capacity, physicians have a duty to place the interests of their patients above their own financial or other interests. Inherent in the in-office sale of products is a perceived conflict of interest with regard to physicians' fiduciary duty. Further, the for-profit sale of goods by physicians to patients raises ethical questions that should not intrude on the physician-patient relationship, as does the sale of products that can easily be purchased by patients locally.

On this issue, it is the position of the North Carolina Medical Board that the following guidelines should inform the conduct of physicians.

- Practice related items (such as ointments, creams, and lotions

by dermatologists; splints and appliances by orthopedists; eye glasses by ophthalmologists; etc) may be dispensed only after the patient has been told if those items, or generically similar items, can be obtained locally from another source. Any charge made should be reasonable.

- Due to the potential for patient exploitation, physicians are encouraged not to engage in exclusive distributorship and/or personal branding.

Physicians should not sell any non-health related goods from their offices or other treatment settings. (This does not preclude the selling of low-cost, non-health related items for the benefit of charitable or community organizations, provided the physician receives no share of the proceeds, that such sales are conducted only on an occasional basis, and that patients are not pressured into making purchases.)

(Adopted March 2001)

FEE SPLITTING

- The North Carolina Medical Board endorses the AMA Code of Medical Ethics Opinions 6.02, 6.03, and 6.04 condemning fee splitting. Fee splitting may be receipt of money or something else of value in return for referrals or remuneration from a drug or device manufacturer/distributor, a sales representative, or another professional as an incentive for the use of that interested party's product.

- Except in instances permitted by law (NC Gen Stat §55B-14(c)), it is the position of the Board that sharing profits between a non-physician or paraprofessional and a physician partner on a percentage basis is also fee splitting and is grounds for disciplinary action.

(Adopted November 1993)
(Amended May 1996)

UNETHICAL AGREEMENTS IN COMPLAINT SETTLEMENTS

It is the position of the North Carolina Medical Board that it is unethical for a physician 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)

NORTH CAROLINA MEDICAL BOARD

Board Orders/Consent Orders/Other Board Actions

August - October 2002

DEFINITIONS

Annulment:

Retrospective and prospective cancellation of the authorization to practice.

Conditions:

A term used for this report to indicate restrictions or requirements placed on the licensee/licensee.

Consent Order:

An order of the Board and an agreement between the Board and the practitioner regarding the annulment, revocation, or suspension of the authorization to practice or the conditions and/or limitations placed on the authorization to practice. (A method for resolving disputes through informal procedures.)

Denial:

Final decision denying an application for practice

authorization or a motion/request for reconsideration/modification of a previous Board action.

NA:

Information not available.

NCPHP:

North Carolina Physicians Health Program.

RTL:

Resident Training License.

Revocation:

Cancellation of the authorization to practice.

Summary Suspension:

Immediate temporary withdrawal of the authorization to practice pending prompt commencement and determination of further proceedings. (Ordered when the Board finds the public health, safety, or welfare requires emergency action.)

Suspension:

Temporary withdrawal of the authorization to practice.

Temporary/Dated License:

License to practice medicine for a specific period of time. Often accompanied by conditions contained in a Consent Order. May be issued as an element of a Board or Consent Order or subsequent to the expiration of a previously issued temporary license.

Voluntary Dismissal:

Board action dismissing a contested case.

Voluntary Surrender:

The practitioner's relinquishing of the authorization to practice pending or during an investigation. Surrender does not preclude the Board bringing charges against the practitioner.

ANNULMENTS

NONE

REVOCATIONS

HOWARD, Dennis Robert, MD

Location: Snellville, GA

DOB: 2/12/1937

License #: 0000-15800

Specialty: FP/PM (as reported by physician)

Medical Ed: University of Wisconsin (1962)

Cause: In the U.S. District Court for the Northern District of Georgia, Atlanta Division, Dr Howard pled guilty to one count of conspiracy to distribute controlled substances and one count of using a communications facility in aid of unlawful drug trafficking activity, both of which are felonies. Felony convictions are grounds for automatic revocation of the medical license unless the Board receives a request for a hearing within 60 days of the physician's being given notice. No such request was received from Dr Howard.

Action: 9/03/2002. Entry of Revocation executed: Dr Howard's license is revoked by operation of law effective 11/12/2001.

LUSTGARTEN, Gary James, MD

Location: North Miami Beach, FL

DOB: 2/26/1941

License #: 0000-25725

Specialty: NS (as reported by physician)

Medical Ed: University of Iowa (1965)

Cause: Following a hearing on 7/19/2002, the Board found Dr Lustgarten, when testifying as an expert witness in a medical liability case, had repeatedly made factual assertions without an evidentiary or good faith basis and had misrepresented the applicable standard of care. The Board determined this was unprofessional conduct.

Action: 8/22/2002. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Lustgarten's North Carolina medical license is revoked. [This Order became effective when legally served on Dr Lustgarten on 8/27/2002.]

See Consent Orders:

COPELAND, Deborah Swinney, Physician Assistant

SUSPENSIONS

See Consent Orders:

EURE, Luther Haywood, Jr, MD

PITTMAN, John Carl, MD

SUMMARY SUSPENSIONS

NONE

CONSENT ORDERS

BANIEWICZ, Frank John, MD

Location: Colorado Springs, CO

DOB: 2/01/1959

License #: 0097-01693

Specialty: OM/IM (as reported by physician)

Medical Ed: Northeastern Ohio University (1987)

Cause: On application for reinstatement of license. Dr Baniewicz admits to having committed boundary violations by engaging in inappropriate sexual relationships with two patients in 1998 and 1999. After investigating those boundary violations, the Board requested that he surrender his license, which he did on 10/05/2000. He underwent a psychiatric and physical evaluation in June 2000 at the Professional Renewal Center in Kansas, which resulted in a diagnosis of narcissistic personality disorder and a recommendation for treatment. He sought treatment before, during, and after the Board began its investigation. Dr Baniewicz reports he is presently compliant with his outpatient therapy.

Action: 10/16/2002. Consent Order executed: Dr Baniewicz's license is reinstated; should he resume practice in North Carolina, he shall notify the Board in advance, sign and maintain a contract with the NCPHP, follow any NCPHP recommendations, and practice in a setting approved by the president of the Board in writing; wherever he may practice, he shall ensure a female chaperone who has read this Consent Order is present when he is in an examination room with a female patient and that the chaperone documents she was present during the examination and that no boundary violations or other misconduct occurred; must comply with other conditions.

[BREWER, Thomas Edmund, Jr, MD

Location: Denton, NC (Davidson Co)

DOB: 11/04/1956

License #: 0000-28141

Specialty: GP/OM (as reported by physician)

Medical Ed: Bowman Gray School of Medicine (1983)

Cause: To amend Dr Brewer's Consent Order of 10/29/1999, which was issued following his surrender of his license on 9/18/1998 following a positive urine drug screen for cocaine. He has had a history of substance abuse. In 2001, he asked the Board to terminate the provision of the Consent Order limiting his license to a temporary period of time.

Action: 7/31/2001. Consent Order was executed: Dr Brewer was issued a license with no expiration date shown. Unless lawfully prescribed for him by someone other than himself, he was to refrain from the use of all mind- or mood-altering substances and all controlled substances, and to refrain from the use of alcohol; he was to notify the Board within two weeks of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he was to supply bodily fluids or tissues for screening to determine if he had used any of the substances noted above; he was to maintain and abide by a contract with the NCPHP and attend AA, NA, and/or Caduceus meetings as recommended by the NCPHP; he was to continue his relapse therapy and have his therapist provide quarterly reports of his progress to the Board; he was to provide the Consent Order to all prospective employers; he was not to supervise PAs or NPs; he was to obtain and report to the Board 50 hours of relevant Category I CME each year; was to comply with other conditions.

NOTE: On 6/17/2002, Dr Brewer voluntarily surrendered his North Carolina medical license.]

CARBALLO, Frank Edward, MD

Location: Lumberton, NC (Robeson Co)

DOB: 4/30/1963

License #: 0000-35291

Specialty: IM (as reported by physician)

Medical Ed: University of South Florida (1989)

Cause: Application for reissuance of license. On 4/14/2002, in Lumberton, Dr Carballo, while traveling at a high rate of speed, passed two vehicles in the center turning lane. He then crossed over two lanes of traffic and ran off the road. He went about 114 feet on the shoulder, running over a stop sign and knocking down a utility pole, causing power lines to fall across the road. He continued on the shoulder another 77 feet, running over four highway signs, before reentering the lane of travel. He then hit the rear of a vehicle, spinning it around to hit another vehicle. Dr Carballo's blood alcohol level at the time was .16, twice the legal limit. He was arrested and charged with driving while impaired. On 7/10/2002, he pled guilty to that charge. On 6/27/2002, he voluntarily surrendered his medical license. He has completed a 12-week inpatient treatment program for his alcohol abuse and has entered into a contract with the NCPHP. The NCPHP reports Dr Carballo has been compliant with his contract.

Action: 10/04/2002. Consent Order executed: the Board reissues Dr Carballo's license to expire on the date shown on the license [3/04/2003]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind- or mood-altering substances, and he shall refrain from the use of alcohol; he shall notify the Board within ten days of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

COPELAND, Deborah Swinney, Physician Assistant

Location: Charlotte, NC (Mecklenburg Co)

DOB: 7/18/1957

License #: 0001-02046

PA Education: Hannemann University (1990)

Cause: Regarding information that Ms Copeland practiced medicine without a license and issued prescriptions for controlled substances without a current DEA registration number. Ms Copeland was originally issued a DEA number that expired 8/31/1999 and was retired in April 2000. Her PA license became inactive on 10/25/2000 for failure to register. About 8/02/2001, she began prescribing hydrocodone to her neighbor and converted a portion of her neighbor's hydrocodone to her own use.

Action: 10/18/2002. Consent Order executed: Ms Copeland's PA license is revoked.

DOSHI, Vasant Narottam, MD

Location: Raleigh, NC (Wake Co)

DOB: 1/14/1946

License #: 0000-29736

Specialty: IM/FP (as reported by physician)

Medical Ed: Bj Medical College, India (1970)

Cause: This matter came before the Board on information Dr Doshi issued prescriptions for controlled substances without a current DEA registration number. At the times relevant to this action, Dr Doshi practiced in Greenville, NC. He was first issued a DEA number in 1985. It expired in 1986. He was issued a new DEA number in 1995, though he continued on occasion to use the 1985 number. The number issued in 1995 expired in 1998, though he continued, knowingly and intentionally, to use the 1995 number for over a year after it expired.

Action: 8/29/2002. Consent Order executed: Dr Doshi is reprimanded for issuing prescriptions for controlled substances without a current DEA number.

EURE, Luther Haywood, Jr, MD

Location: Reidsville, NC (Rockingham Co)

DOB: 9/11/1963

License #: 0093-00102

Specialty: OBG (as reported by physician)

Medical Ed: Bowman Gray School of Medicine (1989)

Cause: Regarding Dr Eure's application for reinstatement of his license and resolution of the outstanding Notice of Charges and Allegations. The Board finds and Dr Eure admits that he had an intimate and sexual relationship with Patient A for about two years, from 1999 to 2001; that Dr Eure had an intimate and sexual relationship for about ten months with Patient B, whom he treated during 1999-2001. Dr Eure notified the Board of his unprofessional conduct and surrendered his license on 9/11/2001. He was diagnosed with and began treatment for his depression and bipolar II disorder in September 2001 under the care of Dr M. Nunn, and he continued treatment at the Professional Renewal Center in Kansas on the recommendation of the NCPHP. Under the direction of the PRC, Dr Eure alternated between therapy at the PRC and his home, where he was under the care of Dr Nunn, between October 2001 and his discharge from the PRC on 6/20/2002. He voluntarily returned to the PRC in August 2002 for three days for additional treatment and evaluation and to confirm his commitment to medical practice. Dr Eure accepts personal and professional responsibility for his misconduct. He is currently under the care of Dr Nunn. He has also entered into a contract with the NCPHP that includes regular monitoring and treatment by C. Norris, PhD. The NCPHP reports Dr Eure has complied with his contract.

Action: 10/28/2002. Consent Order executed: Dr Eure is issued a license to expire on the date shown on the license [4/30/2003]; his license is suspended indefinitely effective 9/11/2001, however, that suspension is stayed on the terms

and conditions contained in the Consent Order; Dr Eure shall maintain and abide by a contract with the NCPHP; he shall continue his therapy with Dr Nunn or a licensed counselor approved by the Board's president; he shall direct Dr Norris or his successor to report on his progress to the Board on a quarterly basis; he shall meet with the Board as requested; he shall provide a copy of the Consent Order to all current and prospective employers; he shall post a copy of the "Principles of Medical Practice" on various walls in his office; he shall ensure a female chaperone who has read the Consent Order is present when he examines a female patient, and the chaperone shall document she was present and no misconduct occurred and on a quarterly basis her documentation will be provided to Dr Norris for his reports to the Board; he shall ask three members of his staff who have read the Consent Order to complete a "Staff Surveillance Form," which shall also be provided to Dr Norris; he shall, on the recommendation of Dr Norris in consultation with the NCPHP, enter into a bi-monthly psychotherapy process with a psychodynamically trained psychotherapist that shall continue until Dr Norris and the NCPHP believe it is no longer needed; during one week each quarter he shall have his staff ask all patients seen that week to complete a "Patient/Patient's Family Satisfaction Form," which shall be provided to Dr Norris for his report; he shall not enter into solo practice without the consent of the Board; must comply with other conditions.

GARTLING, John Kenneth, Physician Assistant

Location: Greensboro, NC (Guilford Co)

DOB: 9/22/1952

License #: 0001-01451

PA Education: Cincinnati Tech (1976)

Cause: Regarding inappropriate conduct. In 2000, a patient of Mr Gartling's accompanied him to Lake Norman to assist Mr Gartling in painting a house, for which the patient was to receive \$200. Mr Gartling and the patient shared a room in a hotel while at Lake Norman. While at the hotel, Mr Gartling made inappropriate comments and advances toward the patient. During physical examinations of the patient, Mr Gartling made inappropriate and obscene comments to the patient. Mr Gartling admits he routinely kissed male patients on the mouth during clinical visits. He voluntarily surrendered his license on 2/05/2001.

Action: 9/19/2002. Consent Order executed: The Board accepts the surrender of Mr Gartling's license as a PA dated 2/05/2001. He shall deliver his license and registration certificates to the Board within 10 days.

GOUBRAN, Michel Zaki, MD

Location: Morrisville, NC (Wake Co)

DOB: 2/15/1935

License #: 0000-21039

Specialty: OBG/REN (as reported by physician)

Medical Ed: University Ein Shams, Egypt (1962)

Cause: On consideration of Dr Goubran's application for reactivation of his license. As a result of a hearing on 7/19/2002, the Board decided to issue Dr Goubran a six-month temporary license and to terminate his May 2000 Consent Order once he signed a new Consent Order.

Action: 8/29/2002. Consent Order executed: Dr Goubran is reprimanded for failing to timely comply with certain requirements in his Consent Order of May 2000; he is issued a license to expire on the date shown on the license [2/28/2003]; he shall practice only in a setting first approved in writing by the Board's president, if the site is located in North Carolina; the terms and conditions in the May 2000 Consent Order are no longer in effect; must comply with other conditions.

HARVEY, Bertha Bowen, MD

Location: New Bern, NC (Craven Co)

DOB: 7/15/1957

License #: 0000-31994

Specialty: P (as reported by physician)

Medical Ed: Medical University of South Carolina (1982)

Cause: On application for reissuance of license. In April 2000, Dr Harvey met with the NCPHP and admitted she had a history of alcoholism and had been unable to maintain sobriety. She signed a five-year contract with NCPHP and entered an inpatient alcohol treatment program. She was an anonymous participant in the NCPHP program until July 2001, when the NCPHP broke her anonymity and reported her continued problems with alcohol to the Board. As a result of meetings with members of the Board in July and November 2001, Dr Harvey surrendered her license effective November 15, 2001. She received several weeks of inpatient treatment for alcoholism between November 2001 and February 2002, after which she entered the treatment program at Pine Grove Next Step in Mississippi, successfully completing that program in June 2002. She reports she has abstained from alcohol since the day before she entered the Pine Grove program. She has maintained her contract with the NCPHP and the NCPHP reports she is in compliance with the contract. The Board has no evidence that any of Dr Harvey's patients received substandard care as a result of her alcoholism.

Action: 8/14/2002. Consent Order executed: The Board reissues Dr Harvey's license to expire on the date shown on the license [12/31/2002]; unless lawfully prescribed for her by someone other than herself, she shall refrain from the use of all mind- or mood-altering substances, and she shall refrain from the use of alcohol; she shall notify the Board within 10 days of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, she shall supply bodily fluids or tissues for screening to determine if she has used any of the substances noted above; she shall maintain and abide by a contract with the NCPHP; she shall attend AA and/or Caduceus meetings; she shall provide a copy of the Consent Order to all current and prospective employers; must comply with other conditions.

JOHNSON, James Carl, MD

Location: Brevard, NC (Transylvania Co)

DOB: 7/17/1936

License #: 0000-33685

Specialty: ORS (as reported by physician)

Medical Ed: Medical College of Wisconsin (1964)

Cause: When practicing in Cashiers, NC, from 1995 through at least 2001, Dr Johnson prescribed narcotics to various patients without documentation of, among other things, the patient's history and physical examination, appropriate studies, a working diagnosis and treatment plan, and a rationale for prescribing narcotics.

Action: 10/28/2002. Consent Order executed: Dr Johnson shall immediately surrender his DEA registration and may not hereafter prescribe controlled substances; he shall not reapply for a DEA registration unless permitted by the Board; he shall notify all local pharmacies that he has surrendered his DEA registration and shall advise them they should not fill any prescriptions for controlled substances purportedly from him; he shall limit his practice to independent medical examinations and disability examinations; he shall strictly comply with the Board's position statement entitled Medical Record Documentation; he shall obtain at least 50 hours of CME each calendar year, at least 20 of which shall be in North Carolina Category 1; must comply with other conditions.

KEEVER, Richard Alan, MD

Location: High Point, NC (Guilford Co)
 DOB: 6/11/1941
 License #: 0000-16400
 Specialty: OTO (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1969)
 Cause: On application for reinstatement of Dr Kever's license. Dr Kever has a history of alcoholism and abuse of and dependence on opioid drugs. In November 1997, he entered into a Consent Order with the Board. He complied with all the terms and conditions of that Consent Order and the Board terminated the Consent Order in May 2001. On 10/26/2001, High Point Regional Hospital summarily suspended Dr Kever's privileges on evidence he had relapsed. He surrendered his license on 11/05/2001 and entered inpatient treatment for his abuse of and dependence on alcohol and drugs at the Talbott Recovery Campus in Atlanta from November 2001 to February 2002. He reports he has abstained from alcohol, opioid drugs, and all other mind-altering substances since then. He signed a five-year contract with the NCPHP on 2/21/2002 and the NCPHP reports he is in compliance with the contract.

Action: 8/29/2002. Consent Order executed: Dr Kever is issued a license to expire on the date shown on the license [2/28/2003]; he shall maintain and abide by a contract with the NCPHP; he shall work no more than 30 hours in any calendar week; he shall complete 25 hours of Category I CME in primary care medicine prior to January 2003 and he shall be supervised by another physician until he completes that CME; he shall maintain a Controlled Substance Prescribing Log and send a copy to the Board every three months; he shall abide by all recommendations of his treatment program and therapist, and he shall attend AA and/or NA meetings on a weekly basis; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind- or mood-altering substances and he shall refrain from the use of alcohol; he shall notify the Board within 10 days of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; must comply with other conditions.

KOHER, Grant Franklin, DO

Location: Chapel Hill, NC (Orange Co)
 DOB: 7/01/1956
 License #: 0000-35399
 Specialty: FSM/EM (as reported by physician)
 Medical Ed: Philadelphia College of Osteopathic Medicine (1982)
 Cause: Dr Koher issued prescriptions to patients without first performing a physical examination. He acted as an independent contractor and provided services through Virtual Medical Group of Morrisville, NC. VMG renders medical services, including prescriptions, over the Internet. On 12 occasions between September 2000 and August 2001, Dr Koher issued prescriptions to various patients without a physical examination and without any prior physician-patient relationship with the patients. He offered the Board evidence he prescribed to no more than five patients in North Carolina, the prescriptions being limited to lifestyle drugs. Because of certain VMG representations in this matter, he misunderstood the Board's position on this issue. In September 2001, upon reading the Board's position statement in the Forum, he immediately and voluntarily ceased issuing further prescriptions without physical examinations and accepted no compensation from VMG for his services. VMG, through Dr Koher, rendered medical care to patients in North Carolina and, thus, likely engaged in the unauthorized practice of medicine.

Action: 10/10/2002. Consent Order executed: Dr Koher is reprimanded; he shall not prescribe for any person in North

Carolina without first physically examining that person, except where he has a physician-patient relationship with the person or where the Board otherwise permits such activity; he shall not assist VMG or any other entity in the unauthorized practice of medicine; must comply with other conditions.

LIVINGSTON, James L., MD

Location: Fayetteville, NC (Cumberland Co)
 DOB: 8/23/1956
 License #: 0000-32769
 Specialty: FP/OBS (as reported by physician)
 Medical Ed: East Carolina University School of Medicine (1985)
 Cause: Dr Livingston forged an attendance certificate to make it appear he attended a 19-hour update course on internal medicine presented by the Lloyd Nolan Foundation in July 2001.

Action: 10/10/2002. Consent Order executed: Dr Livingston is reprimanded.

LOVETTE, Kenneth Maurice, MD

Location: Tarboro, NC (Edgecombe Co)
 DOB: 12/27/1949
 License #: 0000-24606
 Specialty: GYN (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1979)
 Cause: On Dr Lovette's application for reinstatement of his license. The Board finds and Dr Lovette admits that between 1983 and 1987 Dr Lovette engaged in a sexual relationship with an adult female who eventually became his patient (Patient A). In 1993, he engaged in a sexual relationship with another of his patients (Patient B) over a four to five month period. In about 1995-1996, he examined and treated Patient C and then referred her to his partner. Patient C returned to Dr Lovette's care and treatment eight months later. In the spring of 1997, Dr Lovette engaged in mutual kissing with Patient C. In 1997, he delivered the baby of Patient D, a patient of his partner. Patient D returned to the care of his partner. In about 1999-2000, Dr Lovette engaged in mutual kissing and caressing with Patient D. He voluntarily surrendered his license on 9/17/2001. He completed an evaluation at the Behavioral Medicine Institute of Atlanta and is being treated by a psychologist for his anxiety and depression. He has entered into a contract with the NCPHP and the NCPHP reports he has been compliant.

Action: 10/30/2002. Consent Order executed: Dr Lovette is issued a license to expire on the date shown on the license [2/28/2003]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind- or mood-altering substances and he shall refrain from the use of alcohol; he shall notify the Board within 10 days of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he may not supervise physician extenders; must comply with other conditions.

PETERSON, Wanda Mitchell, MD

Location: Yadkinville, NC (Yadkin Co)
 DOB: 8/28/1956
 License #: 0000-28433
 Specialty: FP/GP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1983)
 Cause: From January 2001 to April 2002, Dr Peterson dispensed narcotic drugs to a patient for detoxification treatment without obtaining the separate DEA registration required for dispensing narcotics to an individual for maintenance or detoxification treatment.

Action: 9/26/2002. Consent Order executed: Dr Peterson is reprimanded.

PITTMAN, John Carl, MD

Location: Raleigh, NC (Wake Co)

DOB: 1/15/1959

License #: 0000-31614

Specialty: OS/GPM (as reported by physician)

Medical Ed: Mercer University (1986)

Cause: Regarding the Notice of Charges and Allegations of May 15, 2002, against Dr John Carl Pittman. Dr Pittman admits and the Board finds and concludes the following: in December 1998, after trying several other forms of treatment for immune dysfunction, Dr Pittman began treating Patient A with ozone and a diluted form of hydrogen peroxide, administered intravenously; a well-known though uncommon risk of this treatment is hemolysis, which can lead to a potentially life-threatening anemia; because of the risk, it is important to be aware of a patient's hemoglobin and hematocrit lab values before beginning and during IV hydrogen peroxide treatment; though Dr Pittman had tested Patient A's H&H both 20 months and 7 months prior to this treatment and found her values normal, he did not order the tests immediately prior to beginning treatment; he waited until Patient A's fifth treatment before ordering an H&H test; he and his nurse had explained to the patient the risk of the therapy, but he and the patient disagree on whether he told her that a blood transfusion would be the treatment of first choice should severe anemia develop; his consent form and record make no mention of his so advising her; the patient had indicated on her intake form that she was a Jehovah's Witness and Dr Pittman should have known there was a good chance she would not accept a transfusion; Patient A's hemoglobin dropped to 5.8, half the normal value, on the day of her fifth treatment; her husband took Patient A to the hospital, where her level fell further to as low as 3.8 and where she was treated with IV fluids; she remained in the hospital for six days until her hemoglobin returned to a safe level; Dr Pittman's treatment of Patient A departed from, or failed to conform to, the standards of acceptable and prevailing medical practice.

Action: 9/07/2002. Consent Order executed: Dr Pittman's North Carolina medical license is suspended indefinitely; all but 60 days of that suspension is stayed on condition he comply with the terms of the Consent Order. Terms include the following: he shall not use IV ozone or hydrogen peroxide therapy in his practice until the Board explicitly orders otherwise; he will use procedures in his practice to prominently identify patients who refuse blood transfusions or blood products; he may not, in a primary or back-up role, supervise PAs, NPs, or clinical pharmacist practitioners; must comply with other conditions. This Consent Order shall take effect three weeks from the date of execution and shall remain in effect until specifically ordered otherwise by the Board. [Effective date of suspension: 9/29/2002-11/28/2002.]

WOLEBEN, Martyn Dean, MD

Location: High Point, NC (Guilford Co)

DOB: 11/13/1956

License #: 0097-00428

Specialty: OBG (as reported by physician)

Medical Ed: University of Mississippi School of Medicine (1988)

Cause: On application for reissuance of Dr Woleben's license. Dr Woleben entered into a Consent Order with the Mississippi State Board of Medical Licensure in February 1997 in which he admits he has a chemical dependency and engaged in sexual misconduct with a patient/employee. In March 1997, the North Carolina Medical Board entered into a Consent Order with Dr Woleben wherein he was issued a license conditioned, among other things, on his signing and maintaining a contract with the NCPHP, complying with all recommendations for follow-up care as made by the Pine Grove Recovery Center, complying with all recommendations for follow-up care made by Dr Irons of the Menninger Clinic, limiting his prescribing practices,

refraining from treating himself or family members, and submitting to random drug screens. In December 1998, the Board terminated the March 1997 Consent Order. In October 2001, staff at High Point Regional Health System reported smelling alcohol on Dr Woleben's breath. As a result of this incident, Dr Woleben tested positive for alcohol in his body and, in December 2001, the hospital summarily suspended his privileges. In November 2001, Dr Woleben met with the NCPHP, which recommended he obtain an inpatient assessment at a professional center. He did obtain an assessment at the Palmetto Center, which recommended he undergo 4-6 week inpatient relapse prevention program and sign and maintain a 3-5 year NCPHP contract after completing treatment. In February, Dr Woleben surrendered his North Carolina license. In September 2002, Dr Woleben reported to the Board that he had successfully completed a 28-day inpatient treatment program at Pavilion Renewal and Recovery Center and had signed a 5-year monitoring contract with the NCPHP. 10/16/2002. Consent Order executed: The Board reissues Dr Woleben's license to expire on the date shown on the license [4/30/2003]; unless lawfully prescribed for him by someone other than himself, he shall refrain from the use of all mind- or mood-altering substances, and he shall refrain from the possession or use of alcohol; he shall notify the Board within ten days of any such use and include the name of the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues for screening to determine if he has used any of the substances noted above; he shall maintain and abide by a contract with the NCPHP; he shall provide a copy of this Consent Order to all prospective employers; must comply with other conditions.

Action:

MISCELLANEOUS ACTIONS**GOUBRAN, Michel Zaki, MD**

Location: Morrisville, NC (Wake Co)

DOB: 2/15/1935

License #: 0000-21039

Specialty: OBG/REN (as reported by physician)

Medical Ed: University Ein Shams, Egypt (1962)

Cause: A hearing was held on 7/19/2002 on Dr Goubran's application for reactivation of his license. On May 1, 2000, Dr Goubran signed a Consent Order with the Board that said, in part, that he would obtain at least 40 hours of CME in epidemiology and infectious disease prevention within one year. He failed to comply. He also agreed to successfully complete a sensitivity course within one year. He failed to comply with this requirement as well. In July 2001, Dr Goubran's license became inactive due to his failure to register with the Board as required. As of the date of the hearing on 7/19/2002, Dr Goubran had completed the sensitivity training course and had obtained 37 of the 40 hours of required CME.

Action: 8/09/2002. Findings of Fact, Conclusions of Law, and Order issued by the Board. The Board will issue Dr Goubran a six-month temporary license and terminate the May 2000 Consent Order when he signs a Consent Order that reprimands him for failing to comply with the May 2000 Consent Order, requires he work only at a practice site approved by the Board's president, if the site is located in North Carolina, and requires he meet with the Board or members of the Board as requested.

NUSHOLTZ, Marc Sheldon, DO

Location: Fort Wayne, IN

DOB: 6/01/1948

License #: NONE

Specialty: None cited

Medical Ed: Des Moines College of Osteopathic Medicine (1976)

Cause: Initial application denied due to Dr Nusholtz' failure to provide the Board a copy of an assessment report from the

Colorado Personalized Education for Physicians program. At a hearing on that denial on 7/19/2002, Dr Nusholtz presented the report in question but asked permission to withdraw his application for a license in North Carolina.

Action: 9/19/2002. Findings of Fact, Conclusions of Law, and Order issued: following a hearing on 7/19/2002, at which Dr Nusholtz presented the CPEP report, the Board rescinded its earlier decision to deny Dr. Nusholtz' application for a license; it approves his request to withdraw his application.

DENIALS OF RECONSIDERATION/MODIFICATION

LUSTGARTEN, Gary James, MD

Location: North Miami Beach, FL
 DOB: 2/26/1941
 License #: 0000-25725
 Specialty: NS (as reported by physician)
 Medical Ed: University of Iowa (1965)
 Action: 8/22/2002. Following a hearing, the Board denied a motion to reopen the case concerning Dr Lustgarten that was decided by the Board on 7/19/2002.

DENIALS OF LICENSE/APPROVAL

DEBNAM, George Clyde, MD

Location: Raleigh, NC (Wake Co)
 DOB: 11/05/1927
 License #: 0000-08749
 Specialty: FP/OBG (as reported by physician)
 Medical ed: Meharry Medical College (1951)
 Cause: Dr Debnam failed to satisfy the Board of his qualifications for a medical license in that he lacks the professional competence required to practice and/or is unable to practice by reason of illness or by reason of any physical or mental abnormality.
 Action: 8/05/2002. Letter issued denying license application.

GARMISE, David Bruce, MD

Location: New Bern, NC (Craven Co)
 DOB: 3/01/1935
 License #: 0000-11852
 Specialty: OTO (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1960)
 Cause: Dr Garmise failed to satisfy the Board of his qualifications in that he did not complete the amount of continuing medical education required by law.
 Action: 8/05/2002. Notification of denial of application for North Carolina medical license.

SURRENDERS

DAY, Philip Mark, MD

Location: Grover, NC (Cleveland Co)
 DOB: 11/14/1951
 License #: 0000-28164
 Specialty: FP (as reported by physician)
 Medical Ed: Michigan State University (1982)
 Action: 10/31/2002. Voluntary surrender of medical license.

HARVEY, Bertha Bowen, MD

Location: New Bern, NC (Craven Co)
 DOB: 7/15/1957
 License #: 0000-31994
 Specialty: P (as reported by physician)
 Medical Ed: Medical University of South Carolina (1982)
 Action: 10/17/2002. Voluntary surrender of medical license.

NEWTON, Jimmie Isaac, MD

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 11/29/1938
 License #: 0000-14269
 Specialty: OBG (as reported by physician)

Medical Ed: University of North Carolina School of Medicine (1964)
 Action: 8/12/2002. Voluntary surrender of North Carolina medical license.

SAPPINGTON, John Shannon, MD

Location: Linville, NC (Avery Co)
 DOB: 1/30/1962
 License #: 0094-00628
 Specialty: P/CHP (as reported by physician)
 Medical Ed: University of Texas (1989)
 Action: 8/05/2002. Voluntary surrender of North Carolina medical license.

SEBHAT, Berhan, MD

Location: Asheboro, NC (Randolph Co)
 DOB: 10/22/1966
 License #: 2001-01395
 Specialty: IM (as reported by physician)
 Medical Ed: Medical College of Ohio (1998)
 Action: 10/28/2002. Voluntary surrender of medical license.

TAYLOR, Carolyn Rose, MD

Location: Clinton, NC (Sampson Co)
 DOB: 1/18/1948
 License #: 0000-24876
 Specialty: GP (as reported by physician)
 Medical Ed: New Jersey College of Medicine (1976)
 Action: 8/13/2002. Voluntary surrender of North Carolina medical license.

See Consent Orders:

GARTLING, John Kenneth, Physician Assistant

COURT APPEALS/STAYS

LUSTGARTEN, Gary James, MD

Location: North Miami Beach, FL
 DOB: 2/26/1941
 License #: 0000-25725
 Specialty: NS (as reported by physician)
 Medical Ed: University of Iowa (1965)
 Cause: Following a hearing on 7/19/2002, the Board found Dr Lustgarten, when testifying as an expert witness in a medical liability case, had repeatedly made factual assertions without an evidentiary or good faith basis and had misrepresented the applicable standard of care. The Board determined this was unprofessional conduct.
 Actions: 8/22/2002. Findings of Fact, Conclusions of Law, and Order of Discipline issued: Dr Lustgarten's North Carolina medical license is revoked. [This Order became effective when legally served on Dr Lustgarten on 8/27/2002.]
 9/11/2002. Dr Lustgarten filed a Notice of Appeal and Petition for Judicial Review of the Board's decision with the Superior Court of Wake County.
 9/18/2002. Dr Lustgarten filed a Motion for Stay of the Board's decision with the Superior Court of Wake County.
 9/25/2002. Superior Court of Wake County granted Dr Lustgarten's Motion for Stay but directed Dr Lustgarten not to practice medicine or testify as a medical expert in North Carolina while his appeal of the Board's decision is pending.

CONSENT ORDERS LIFTED

ANDRINGA, Richard Cornell, MD

Location: Greensboro, NC (Guilford Co)
 DOB: 12/23/1946
 License #: 0000-20463
 Specialty: AN/PD (as reported by physician)
 Medical Ed: University of Wisconsin (1974)
 Action: 9/11/2002. Order issued lifting Consent Order of 1/31/2001.

CROMER, William Browning, MD

Location: Kinston, NC (Lenoir Co)
 DOB: 11/16/1931
 License #: 0000-10448
 Specialty: GP/OS (as reported by physician)
 Medical Ed: Bowman Gray School of Medicine (1956)
 Action: 9/07/2002. Order issued lifting Consent Order of 10/27/2000.

DECLERCK, Paul A., MD

Location: Kinston, NC (Lenoir Co)
 DOB: 10/07/1947
 License #: 0000-24240
 Specialty: FP (as reported by physician)
 Medical Ed: University of Brussels, Belgium (1975)
 Action: 10/16/2002. Order issued lifting Consent Order of 4/16/2001.

HARRIS, Inez Michelle, Emergency Medical Technician

Location: Kinston, NC (Lenoir Co)
 DOB: 12/09/1973
 Action: 8/09/2002. Order issued lifting Consent Order of 6/08/2001.

KOLASKI, Kathleen M., MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 4/12/1961
 License #: 0095-00121
 Specialty: PM/PD (as reported by physician)
 Medical Ed: Hershey College of Medicine (1988)
 Action: 10/16/2002. Order issued lifting Consent Order of 6/08/2001.

POOLE, James Morrison, MD

Location: Wake Forest, NC (Wake Co)
 DOB: 9/13/1950
 License #: 0000-23168
 Specialty: PD (as reported by physician)
 Medical Ed: Medical University of South Carolina (1976)
 Action: 10/16/2002. Order issued lifting Consent Order of 1/02/2000.

See Consent Orders:

GOUBRAN, Michel Zaki, MD

TEMPORARY/DATED LICENSES:

ISSUED, EXTENDED, EXPIRED, OR REPLACED
BY FULL LICENSES

ANDRINGA, Richard Cornell, MD

Location: Greensboro, NC (Guilford Co)
 DOB: 12/23/1946
 License #: 0000-20463
 Specialty: AN/PD (as reported by physician)
 Medical Ed: University of Wisconsin (1974)
 Action: 8/21/2002. Full and unrestricted license reinstated.

BERRY, David Don, MD

Location: Winston-Salem, NC (Forsyth Co)
 DOB: 4/20/1952
 License #: 0000-30288
 Specialty: NPM/PD (as reported by physician)
 Medical Ed: University of Texas, Galveston (1978)
 Action: 9/19/2002. Temporary/dated license extended to expire 3/31/2003.

BJORK, Paul Edward, Jr, MD

Location: Hamlet, NC (Richmond Co)
 DOB: 3/06/1954
 License #: 0000-36146
 Specialty: GN (as reported by physician)
 Medical Ed: University of South Carolina, Columbia (1983)
 Action: 10/21/2002. Temporary/dated license extended to expire 4/30/2003.

CONNINE, Tad Robert, MD

Location: Great Mills, MD
 DOB: 1/19/1964
 License #: 0099-00193
 Specialty: RO (as reported by physician)
 Medical Ed: University of South Florida (1992)
 Action: 10/18/2002. Temporary/dated license extended to expire 4/30/2003.

CROMER, William Browning, MD

Location: Kinston, NC (Lenoir Co)
 DOB: 11/16/1931
 License #: 0000-10448
 Specialty: GP/OS (as reported by physician)
 Medical Ed: Bowman Gray School of Medicine (1956)
 Action: 8/21/2002. Full and unrestricted license reinstated.

LOCK, George Joseph, Physician Assistant

Location: Morrisville, NC (Wake Co); Princeton (Johnston Co)
 DOB: 8/26/1958
 License #: 0001-01050
 PA Education: Bowman Gray (1987)
 Action: 10/21/2002. Temporary/dated license extended to expire 4/30/2003.

PRESSLY, Margaret Rose, MD

Location: Sylva, NC (Jackson Co)
 DOB: 5/05/1956
 License #: 0000-34548
 Specialty: FP (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1990)
 Action: 8/21/2002. Temporary/dated license extended to expire 12/31/2002.

SHIVE, Robert MacGregor, MD

Location: Charlotte, NC (Mecklenburg Co)
 DOB: 11/02/1933
 License #: 0000-13226
 Specialty: P (as reported by physician)
 Medical Ed: University of North Carolina School of Medicine (1961)
 Action: 8/21/2002. Temporary/dated license extended to expire 8/30/2003.

WARD, David Townsend, MD

Location: Kernersville, NC (Forsyth Co)
 DOB: 4/07/1960
 License #: 0095-00473
 Specialty: OTR (as reported by physician)
 Medical Ed: West Virginia University (1986)
 Action: 6/20/2002. Temporary/dated license extended to expire 10/31/2002.
 10/21/2002. Temporary/dated license extended to expire 4/30/2003.

See Consent Orders:

CARBALLO, Frank Edward, MD
EURE, Luther Haywood, Jr, MD
GOUBRAN, Michel Zaki, MD
HARVEY, Bertha Bowen, MD
KEEVER, Richard Alan, MD
WOLEBEN, Martyn Dean, MD

DISMISSALS**INABNET, William Barlow, MD**

Location: Greensboro, NC (Guilford Co)
 DOB: 2/28/1932
 License #: 0000-14092
 Specialty: OTO/HNS (as reported by physician)
 Medical Ed: Louisiana State University, New Orleans (1958)
 Action: 9/14/2002. Dr Inabnet having died, the Board dismisses with prejudice the case initiated by the Notice of Charges and Allegations dated 4/16/2002.

CHANGE OF ADDRESS FORM

Mail Completed form to: North Carolina Medical Board
1201 Front Street, Suite 100, Raleigh, NC 27609

Please print or type. Date: _____

Full Legal Name of Licensee: _____

Social Security #: _____ License/Approval #: _____

(Check preferred mailing address)

☐ Business: _____

Phone: (____) _____ Fax: (____) _____

☐ Home: _____

Phone: (____) _____ Fax: (____) _____

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 60 days of a move.

North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: January 22-24, 2003; February 19-20, 2003; March 19-21, 2003;
April 23-24, 2003; May 14-17, 2003

Residents Please Note USMLE Information

United States Medical Licensing Examination Information (USMLE Step 3)

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the North Carolina Medical Board's Web site at <http://www.ncmedboard.org/exam.htm>. If you have additional questions, please e-mail Tammy O'Hare, GME/Examination Coordinator, at tammy.ohare@ncmedboard.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.

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