Primum Non Nocere

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NORTH CAROLINA MEDICAL BOARD — Primum Non Nocere — April 15, 1859

forum

NC MEDICAL BOARD

Clinicians Can Have Significant Impact on Major Preventable Health Problem with Minimal Time Commitment
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President's Message

Physical Health of Our Licensees

Charles L. Garrett, Jr, MD
(Now)

In the four years that it has been my privilege to serve on your Medical Board, I have been amazed at the number of licensees who do not have personal physicians and who do not have an active plan to take care of their personal health. In our many interviews with licensees and license applicants, we ask the person being interviewed some of the following questions: How is your health? Do you have a personal physician? When was your last annual physical? Everyone answers "great" to the first question, but an alarming number answer "no" to the second question and "I can't remember" to the third question.

We are supposed to be role models for our patients! Most of us have quit smoking (except for occasional good cigars with single malt scotch). The majority of us wear our motor vehicle restraints at all times and some of us even exercise. But it amazes me, once again, how many of us are overweight, don't know our cholesterol profile numbers, get a colleague to sign off on our physical exams for renewal of our hospital privileges, or just put our heads in the sand when it comes to our own health. We do the same things we would give our patients hell about doing.

In these four years, I have seen the terrible toll that our inattention to our health care has taken on the licensees of this Board. I am not talking about those that have had problems with substance abuse and mental illness, but those licensees that have suffered major catastrophic events due to heart disease, stroke, diabetes mellitus, and a variety of disorders that could have been significantly impacted by early detection and/or preventive measures.

Dr Garrett
(Then)

If you compare my picture in this *Forum* (left) with the older one that appeared on the Board's Web site until recently (right), you will see that I was one of the most guilty, but you will also see that I am one of the most repentant. Thanks to my good wife, Ann, with whom I celebrated our 40th wedding anniversary on the day after Christmas, I had an annual physical in March 2004 (not necessarily annual). My FBS was 212 mg/dl. Thanks be to modern medicine and metformin 500ER at bedtime, my sugars now run in the 80s and my HgbA1C is within normal range. Voluntarily, I have lost 80 pounds (EAT NO WHITE STUFF!), have walked at least two miles a day on my treadmill, and got religious about taking my baby aspirin and increasing my fiber intake. If I can do it, so can you.

Have a REAL physical exam. Get a personal physician and listen to him or her. Know your cholesterol profile numbers and, if necessary and if prescribed by your personal physician, take statin drugs. If you are over 50, have a colonoscopy and, most of all, develop a daily exercise program. We have a shortage of physicians, PAs, and FNPs in our state. Rather than increase the numbers we are training, help us

In This Issue of the FORUM

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keep the ones we have in good working order.

Obesity is the "buzzword" of the day. It affects us all but is most alarming in our youth. My good friend and colleague, Chuck Willson, MD, of Greenville, NC, has related to me numerous horror stories of morbidly obese teenagers dying of sleep apnea and other disorders. He and his colleagues have had to resort to gastric bypass in some of these individuals to save their lives, but readily admit they have no idea what the long-term results will be.

A recent task force of the AMA recommended that we become role models for physical activity and healthy eating and that body mass index be promoted as the fifth vital sign in physical exams. Please help your Board to keep you healthy and continue to do the same for your patients. In the next issue of the *Forum,* we will include a body mass index calculator for your personal use and for you to use with your patients. Unfortunately, I am not there yet, but I am trying.

NCMB Panel of Expert Reviewers Being Updated

The North Carolina Medical Board evaluates a large number of quality of care issues each year. To accomplish this, the Board draws on the knowledge and experience of expert reviewers from all fields of medicine. These reviewers analyze medical records and report their opinions and conclusions to the Board for its consideration. On occasion, a reviewer may be asked to offer testimony at a formal hearing of the Board. Generally, these evaluations are confidential and are handled by mail. Because the issues involved must be dealt with in a timely manner, evaluation reports are required to be completed in six weeks. Compensation is provided at the rate of $125 per hour.

The Board began developing its panel of expert reviewers six years ago and recognizes the importance of updating its list of experts from time to time. We would like to invite North Carolina licensed physicians and physician assistants and approved nurse practitioners who might be interested in assisting the Board as a part of its panel of experts to contact the Board's medical director by regular mail. Please include a detailed CV. Direct correspondence to:

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Implementation of the HIPAA Security Rule

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Ms Satinsky

The passage of the Health Insurance Portability and Accountability Act (HIPAA) in 1996 gave the federal government the ability to mandate the ways in which health care plans, providers, and clearinghouses store and transmit individuals' personal health care information. Until HIPAA's passage, no national or industry standards governed the privacy and security of an individual's health information.

HIPAA has four parts: the Privacy Rule, the Security Rule, Transactions and Code Sets Standards, and National Identifiers. There is overlap between the Privacy and Security Rules, so if your practice meets HIPAA's definition of a Covered Entity and you already comply with the Privacy Rule, you have a head start on the Security Rule.

The deadline for Security Rule implementation for health care providers is April 21, 2005. If you are one of a handful of practices that does not file claims electronically, but are a health plan administrator, your compliance date is not until 2006. If you are like most of my clients, you are procrastinating about beginning the process of assessing your current status and taking steps that are appropriate for your practice. To help you meet that compliance date, in this article I compare and contrast the Security and Privacy Rules and tell you why I find Security to be the more challenging of the two. I provide a brief refresher on HIPAA as well as descriptions of the goals and important sections of the Security Rule. Finally, I make suggestions for successful implementation and tell you what pitfalls to avoid. At the end of the article, I provide a list of helpful resources and a glossary.

Comparison Between the Privacy and Security Rules

The Privacy and Security Rules complement each other. Privacy protects personal health information (PHI), and Security protects a subset of PHI, electronic protected health information (EPHI). Examples of EPHI are electronic data transactions, e-mail communications, practice management systems, personal digital assistants, text pagers, and Web site portals. Paper-to-paper faxes are not considered to be EPHI, but computer-generated faxes are. Voice telephone communications are not considered to be EPHI, but computer-based voice response units are.

Although there are general similarities in the implementation of both the Privacy and Security Rules, you need to be aware of the differences as well. To implement both Rules, you need to compare your current practice with specific standards, identify gaps between your existing situation and the standards, take corrective action, document your actions, monitor compliance on an ongoing basis, and train your staff regularly. Both Rules include written policies and procedures, Business Associate Agreements, a concept called "minimum necessary" need to know, employee sanctions for breach, designated responsibility, and preventive safeguards.

Although the two Rules have many areas of overlap, I think that the differences between them make the implementation of the Security Rule more challenging. These differences are: breadth of coverage, degree of direction, allowable management discretion, and responsibility(ies) for implementation.

With respect to breadth of coverage, the Privacy Rule deals primarily, although not exclusively, with your business operations, and so you can satisfy the Privacy requirements by designating responsibility and by developing and implementing specific policies and procedures. The Security Rule covers administrative, physical, and technical safeguards, as well as parts of your business operations, so compliance goes well beyond responsibility and policies and procedures. Depending on what you learn about your practice during the gap and risk analyses steps in your process, you may decide to make major modifications in your physical facility and technical data security.

"If your practice meets HIPAA's definition of a Covered Entity and you already comply with the Privacy Rule, you have a head start on the Security Rule"

With respect to direction, the Security Rule is more directive about securing EPHI than the Privacy Rule is about securing PHI. In my opinion, this difference is related to the complexity of security. Think about the many ways in which information technology might support your practice. You might have a practice management system, electronic health records, Web-based interactive functions, a lab computer, and many other functions.

The Security Rule allows more management discretion than does the Privacy Rule in two important ways. First, the Security Rule was written to acknowledge differences among practices. It is organized into standards and implementation specifications. The standards contain broad issues that all practices should address, and the implementation specifications support those standards. Implementation specifications can be *required* or *addressable*, giving you a great deal of discretion in what you do. The meaning of *required* specifications is clear; you must meet them. The meaning of *addressable* specifications can be confusing. Addressable doesn't mean optional; it means you must review each specification and implement it or document why you can't. If you can't implement a

particular specification, you must implement another measure that meets the related standard in some other way.

The Security Rule gives you more management discretion than does the Privacy Rule in a second way. Rather than prescribe what you *should* do, it encourages you to determine what you *could* do and then make decisions about what is appropriate for your practice. After you have identified any gaps between your practice and the standards, the likelihood of the occurrence of adverse events, and the estimated cost of fixing your problems, it is up to you to decide what, if anything, you will do and in what order. Thus, the Security Rule relies on your judgment more than the Privacy Rule does, making your job more difficult.

Finally, in my opinion, the two Rules differ with respect to responsibility for taking corrective action. Without exception, the 40 medical practices I have trained about the HIPAA Privacy Rule had the internal ability to develop the policies and procedures that were needed for compliance. These practices sought guidance and feedback from an external consultant, and they did the work themselves. Security is different. Not all practices have the internal expertise to perform comprehensive gap and risk analyses and take corrective action. Many practices will rely on outside experts for some or all of the work.

"Improper use or disclosure of either PHI or EPHI can result in both civil and criminal penalties"

HIPAA Refresher

Before I turn to the substantive part of the Security Rule, I want to remind you about the purpose of the HIPAA legislation and subsequent regulations. HIPAA addressed two major problems in health care. One of those problems was the portability of health insurance, and the difficulty that employees had in taking health insurance with them when they changed jobs. 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 that is transmitted by both electronic and non-electronic means.

With respect to compliance with HIPAA, the Department of Health and Human Services gave the Office of Civil Rights (OCR) responsibility for implementing HIPAA. The OCR has the right to investigate complaints from individuals and organizations that believe a covered entity (such as your practice) is not complying with Security or Privacy Rule standards, assist covered entities in achieving compliance with both Rules, and make determinations regarding exemptions to state law preemption.

The goal for HIPAA compliance is voluntary compliance through technical assistance. The OCR never intended to make regularly scheduled site visits to physician offices or perform practice audits. Rather, if the OCR receives a complaint about your practice within 180 days of an alleged occurrence, it will respond to the complaint and may investigate your practice. Improper use or disclosure of either PHI or EPHI can result in both civil and criminal penalties, including fines and imprisonment. As of the end of September 2004, the OCR had received approximately 9,000 complaints, many of which have been dismissed because they were inappropriate. The first criminal prosecution recently occurred in Seattle.

The relationship between HIPAA and state laws is more of an issue with the Privacy Rule than it is with the Security Rule. The Privacy Rule is a federal regulation, and in most states, including North Carolina, state privacy laws already exist. When the federal and state requirements differ, one of two things happens. In most but not all cases, if the state law is more stringent or restrictive than federal regulations, the state law applies. In some instances, however, the federal requirements "preempt" state law, and you are obligated to abide by the federal standards.

Security Rule Goals

The Security Rule sets forth four goals for covered entities such as your practice. You are required to:

- ensure the confidentiality, integrity, and availability of EPHI that you create, receive, maintain, or transmit;
- protect against any reasonably anticipated threats or hazards to the security, integrity, or availability of EPHI;
- protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required; and
- assure compliance by your workforce.

Making Decisions About Security Measures

I've mentioned that you have discretion in implementing the Security Rule. When you make your decisions, you can take into account the following factors.

- Size, complexity, and capabilities. (For example, small, mid-size, and large practices will have very different characteristics.)
- Technical infrastructure, hardware and software security capabilities.
- Costs of security measures that you estimate
- Probability and criticality of potential risks to EPHI. (For example, in eastern North Carolina, the probability of hurricane damage is great. If there were a hurricane, there would be a significant risk to EPHI.)

Administrative, Physical, and Technical Safeguards

The standards and specifications in the Security Rule are divided into three groupings: administrative, physical, and technical safeguards. The regulation itself contains a good matrix with detailed information on

each section that you can use as a reference. Here's a summary of the three sections. (The manuals and other resources referenced at the end of this article contain specific details.)

Administrative Safeguards

- Standards (9): security management process, assigned security responsibility, workforce security, information access management, security awareness and training, security incident procedures, contingency plan, evaluation, Business Associate contracts and other arrangements
- Required implementation specifications (11): risk analysis, risk management, sanction policy, information system activity review, assigned security responsibility, isolating health care clearinghouse function, response and reporting, data backup plan, disaster recovery plan, emergency mode operation plan, written contracts for Business Associates and other arrangements
- Addressable implementation specifications (11): authorization and/or supervision, workforce clearance procedure, termination procedures, access authorization, access establishment and modification, security reminders, protection from malicious software, log-in monitoring, password management, testing and revision procedure, applications and data criticality analysis

Physical Safeguards

- Standards (4): facility access, workstation security, workstation use, and device and media controls
- Required implementation specifications (2): disposal of EPHI and/or hardware on which it is stored, media reuse
- Addressable implementation specifications (6): contingency operations, facility security plan, access control and validation procedures, maintenance records, accountability, data back up and storage

Technical Safeguards

- Standards (5): access control, audit controls, integrity, person or entity authentication, transmission security
- Required implementation specifications (2): unique user identification, emergency access procedure
- Addressable implementation specifications (5): automatic log-off, encryption and decryption, mechanism to authenticate EPHI, integrity controls, encryption

Getting Started with Security

Here are practical steps you can take to comply with the Security Rule by the April 2005 deadline.

- **Designate a Security Official for your practice.** Your Security Official may or may not be the same person as your Privacy Official. You can outsource all or part of the responsibility to someone outside your practice.
- **Form a Security Team.** As with Privacy, Security Rule compliance is not a one-person show. Involve people from different parts of your practice in a team project. I recommend bringing together representatives of administration, a physician, a nurse, a front-office person, and a back-office person.
- **Do your homework.** Attend informational sessions and read about the Security Rule so you are familiar with the purpose, the overall approach, the three safeguards, and the organizational requirements. (I have listed some good resources at the end of this article.)
- **Develop your Work Plan.** One of the major obstacles to successful implementation of the Privacy Rule was failure to organize the work process. I'm convinced that the same will hold true with the Security Rule. Identify what you want to do and who will do it before you start, and keep track of your progress.
- **Take inventory of what's in place.** Every practice is starting from a different place, so begin with a comprehensive "gap analysis." I recommend the *HIPAA Security Tool Kit™ for Small Medical Practices*, available from Simplified Training Solutions, and resources available from the American Medical Association (AMA), Gates Moore & Company, the MGMA, and the North Carolina Information and Communications Alliance, Inc (NCHICA).
- **Analyze potential risks and vulnerabilities** and evaluate the likelihood and cost of each. Remember that an estimated cost that is more than you want to pay does not justify non-compliance.
- **Determine the priorities for your practice.** I saw what happened with the Privacy Rule. Practices saved money by copying policies and procedures from each other without really understanding the essence of what they were doing. This approach won't work for the Security Rule, since the solutions will be different for each practice. Make sure you work through your own issues.
- **Develop a budget for security.** Assume that implementation of the Security Rule will cost money. Make sure you spend your hard-earned dollars wisely. Once you know the priorities for your practice, develop a budget for the various tasks that could be done. Include the cost of allowing your current employees to spend time on implementation. Budget for external consultants if you need them. Include the cost of inexpensive software that you can purchase at your local office supply store and the cost of any physical modifications that you want to make to your of-

"As with Privacy, Security Rule compliance is not a one-person show"

fice. After you have completed your budget, decide what you will do and in what order, taking cost into consideration.

- **Develop, implement, and maintain appropriate security measures.**
- **Train your staff.**
- **Monitor what you have done on an ongoing basis.**

Ensuring Success

Given the complexity of the Security Rule, I think successful compliance in your practice depends on four factors: ensuring physician commitment; starting early; managing the project in an organized and accountable manner; and integrating your Security Policies and Procedures into your ongoing practice operations.

Physician Commitment

"The Security Rule is complex, and successful management requires good organization and accountability"

Physician commitment to compliance with the Security Rule sets the tone for the entire practice. If you understand the importance of the Rule and make it clear to both clinical and non-clinical staff that compliance is mandatory, not optional, you'll motivate your team to do a good job. In my experience with Privacy Rule implementation, I encountered many physicians who took a laissez-faire attitude about compliance, and their staff didn't bother to take the Rule seriously. The results were not surprising: practices that are sadly out of compliance and at great risk. Given the dependence of most practices on information technology to support practice operations, lack of physician commitment to compliance with the Security Rule and the likelihood of lack of compliance can have serious consequences. Conversely, physician support for compliance can reduce the potential of your experiencing problems relating to confidentiality, integrity, and availability of EPHI.

Starting Early

Given the scope of the Security Rule, April 2005 isn't far away. I think it's imperative to get started as quickly as possible so you can organize your work and set a timetable that's reasonable for you. If you designate your practice manager or someone else within your practice as the Security Official, that person is likely to have other responsibilities as well as security, so give him/her adequate time to organize and implement the project. If you outsource some or all of the Security Official responsibilities, getting an early start will ensure that your outside consultant makes your practice a priority.

Managing the Project in an Organized and Accountable Manner

The Security Rule is complex, and successful management requires good organization and accountability. Help your Security Official structure the tasks methodically and regularly report progress back to you as the owner(s) of the practice.

Integrating Security Policies and Procedures into Your Ongoing Practice Operations

The final key to successful implementation of the Security Rule is the understanding that your Policies and Procedures need to be integrated into your ongoing practice operations. Given the speed with which information technology is changing, you'll need to regularly reevaluate what you have and make ongoing improvements.

Pitfalls

Successful compliance with the Security Rule requires not only attention to important success factors, but also the ability to avoid common pitfalls. I encourage you to avoid making these mistakes as you move along: underestimating the effort that Security Rule compliance requires; not knowing when to ask for help and who to ask; not making compliance participatory.

Underestimating the Required Effort

Your Security Official has a big job. He/she needs to understand the Security Rule, assess your current situation, identify risks and vulnerabilities, assess the cost associated with each problem area, guide you in deciding what to do, develop a budget, do the work, implement corrective action, train your staff, and monitor your program on an ongoing basis. The undertaking isn't small, so you need to allocate sufficient time and money to do the job for your internal staff, external consultants (if you use them), or combination of the two. In my opinion, your Security Official should expect to spend 10 percent of his/her time on security between now and April 2005, and 3 percent thereafter.

Asking for the Right Help at the Right Time

More and more practices are using information technology to help them manage their practices. There is great variety in their approaches and timetables. Likewise, there will be great variety in the ways in which practices approach the Security Rule. Many small practices lack the expertise to do all that is necessary, and so they'll need help from one or more external consultants. I'm not talking about a general information technology consultant, but about a consultant with expertise in security. Other practices will outsource the entire Security Rule compliance function, and still others will outsource just part of it. Seek help at an early stage from a qualified consultant if you think you will need it.

Making the Compliance Process Participatory

I can't say enough for engaging your entire staff in the Security Rule compliance process. Sending a few people out for training and/or making a video avail-

able doesn't do the trick. A more effective approach is identification of not only a Security Official, but of a Security Rule Compliance Team. Let the team deal with the details, and then train the rest of the staff on the essentials. During the team activities and the staff training, encourage questions; you'll get a better result.

Conclusion

It is clear to me, and I hope to you, that you need to address Security Rule compliance immediately. If you take the right steps in a logical order, you'll not only comply with the Rule, but also give yourself the assurance that the information security that supports your practice is safe and sound.

Helpful Resources on HIPAA and the Security Rule

Manuals and Security Risk Assessment Tools

Gates, Moore & Company
www.gatesmoore.com
Authors of *HIPAA Security Rule Manual* that can be purchased on line from the company or through the North Carolina Medical Society.

American Medical Association
www.amapress.com
Handbook for HIPAA Security Implementation available directly from AMA Press or from *Amazon.com.*

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

MGMA
www.mgma.com
Tennant, R.M. and Krupp, A.N. (2004) *HIPAA Toolbox Tool 4. Standards for Electronic Security.* Debuque, IA. Kendall/Hunt Publishing Company.

Simplified Training Solutions
www.simplifiedtraining.com
HIPAA Security Tool Kit (2004) Kirby, J.D

Sites That Have Useful HIPAA/Security Rule Information

American National Standards Institute (ANSI)
www.ansi.org
ANSI standards information and HIPAA-related articles

American Society for Testing and Materials (ASTM)
www.astm.org
Standard guides for health information access, individual rights, data security, CPR, and more

California HealthCare Foundation
www.chcf.org
Free

Centers for Medicare and Medicaid Services (CMS)
www.cms.hhs.gov and ***www.cms.hhs.gov/medlearn*** and ***www.cms.hhs.gov/mailinglists***

Electronic Healthcare Network Accreditation Commission (EHNAC)
www.ehnac.org
HIPAA Security Accreditation information

Department of Health and Human Services (DHHS)
www.hhs.gov
HIPAA rules, comments, listservs

MGMA
www. mgma.com

Massachusetts Health Data Consortium
www.mahealthdata.org
Summaries of rules, compliance checklist, legislative background, HIPAA acronyms

Medicare
www.medicare.gov
Medicare EDI information

North Carolina Healthcare Information and Communications Alliance, Inc. (NCHICA)
www.nchica.org
Multiple HIPAA resources including pre-emption analysis and tools for assessing current Security status of your medical practice

North Carolina Medical Society
www.ncmedsoc.org
Recommended HIPAA reference materials and consultants

Phoenix Health Systems
www.phoenixhealth.com
HIPAAdvisory contains information, tools, updates, glossary of terms, and links

U.S. General Printing Office
www.access.gpo.gov
Numerous databases including the *Federal Register, Congressional Record,* and *Code of Federal Regulations*

Workgroup for Electronic Data Interchange (WEDI)
www.wedi.org
Industry technical reports, HIPAA security matrix, and more. See the Risk Analysis White Paper Working Draft Version1.0, July 2004.

"Let the team deal with the details, and then train the rest of the staff on the essentials"

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Glossary

Access: the ability or the means necessary to read, write, modify, or communicate data/information or otherwise use any system resource that creates, maintains, or transmits EPHI.

Access Control: mechanisms and methods of providing access to authorized users while restricting access to others.

Addressable Specification: one of two types of implementation specifications contained in the Security Rule. A covered entity has several choices. It must implement an addressable specification if it is reasonable and appropriate. If not, the covered entity *must document* why it is not reasonable and appropriate and then : (1) implement an equivalent alternative measure, (2) implement a combination of the specification and an alternative, or (3) not implement the specification.

Administrative Safeguards: policies and procedures designed to prevent, detect, contain, and manage security violations. Examples are the selection and execution of security measures and the management of personnel as it relates to protecting EPHI.

Administrative Simplification (AS): Title II, Subtitle F of HIPAA. This section authorizes HHS to (1) adopt standards for transactions and code sets that are used to exchange health data; (2) adopt standard identifiers for health plans, health care providers, employers, and individuals for use on standard transactions; and (3) adopt standards to protect the security and privacy of personally identifiable health information.

Audit Controls: mechanisms employed to record and examine system activity.

Authentication: verification of the identity of a user or other entity as a prerequisite to allowing access to information systems.

Business Associates: a person or entity outside of your practice's workforce who uses or discloses individually identifiable health information (IIHI) or who provides services to a covered entity that involves the disclosure of IIHI. HIPAA Privacy and Security Rules require a Business Associate Contract with these persons or entities.

Centers for Medicare & Medicaid Services (CMS): the agency within HHS that administers the Medicare and Medicaid programs and that is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards.

Covered Entities: the types of organizations to which HIPAA ap-

plies, including health plans, clearinghouses, and providers who conduct electronic transactions.

Computer Security Incident: an unusual occurrence or adverse event that occurs on any part of an information system and network.

Demilitarized Zone (DMZ): a network segment outside the internal network that has some security controls in place that are less restrictive than those in the internal network.

Disaster Recovery: a process by which a practice would restore any loss of data in the event of fire, vandalism, natural disaster, or system failure.

Electronic Data Interchange (EDI): electronic exchange of formatted data.

Electronic Protected Health Information (EPHI): individually identifiable health information protected by HIPAA that is transmitted by or stored in electronic media.

Emergency Mode Operation: procedures that enable a covered entity to continue to operate in the event of fire, vandalism, natural disaster, or system failure.

Encryption/Decryption: a method for securing data at rest and electronic transmissions, including e-mail, data files, and electronic transactions by transforming plain text into ciphertext that cannot be accessed without the proper encryption keys.

Facility Security Plan: a plan to safeguard the premises and building(s) (interior and exterior) of a covered entity from unauthorized physical access and to safeguard the equipment therein from unauthorized physical access, tampering, and theft.

Gap Analysis: comparison between the requirements of the HIPAA Security and Privacy Rules with the practices, policies, and safeguards that are currently in place.

Firewall: a device that examines traffic entering and leaving a network and that keeps some type of traffic from passing from one network to another network based on a set of rules. For example, a firewall can restrict traffic from the Internet to your practice's internal network.

Health Insurance Portability and Accountability Act of 1996 (HIPAA): a federal law that allows persons to qualify immediately for comparable health insurance when they change their employment relationships. Title II, Subpart F of HIPAA gives the Department of Health and Human Services (DHHS) the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans), and employers (or sponsors); and to specify the types of measures that are required to protect the security and privacy of personally identifiable health care information

Individually Identifiable Health Information (IIHI): Any health information (including but not limited to demographic information) that is collected from the patient and (1) is created or received by a health care provider or other covered entity or employer and (2) that related to the past, present, or future physical or mental health or condition of an individual; OR the provision of health care to an individual, or the past, present, or future payment for the provision of health care at your practice; AND that could potentially identify an individual.

Intrusion Detection System (IDS): security alarms that warn of possible inappropriate attempts to access networks, hosts, programs, or data by examining (ie, sniffing) network traffic.

Physical Safeguards: provisions of the Security Rule that protect unauthorized disclosure, modification, or destruction. These safeguards apply to facility access controls, workstation use and security, and standards for device and media controls.

Protected Health Information (PHI): any information in any form or medium that is created or received and that relates to the past, present, or future physical or mental health or condition of an individual or that can be used to identify an individual.

Required Standards: some of the standards in the Security Rule are specifically required. Those that are not are addressable. Covered entities must comply with required and addressable standards.

Risk: probability that a threat will exploit a vulnerability and expose an asset to a loss.

Risk Analysis: identification of vulnerabilities in resources and the threats to those resources in order to determine appropriate safeguards or controls. A risk analysis can enhance a gap analysis, and it is the foundation of a risk management program.

Risk Management: the ongoing process of ensuring that security risks are kept under control. A risk management program should follow a risk analysis.

Safeguards: risk-reducing measures that act to detect, prevent, or minimize loss associated with the occurrence of a specified threat or category of threats.

Scalable: capable of being scaled. The HIPAA Security Rule permits scalability to the needs of individual practices.

Secure Electronic Environment: an environment that has administrative procedures, physical safeguards, and technical security services and mechanisms in place to prevent unauthorized access to EPHI.

Technical Safeguards: technical safeguards apply to access control, audit controls, integrity, person/entity authentication, and transmission security. Four safeguards are required, and the others are addressable.

Technology Neutral: the Security Rule standards are based on the premise that technology changes on an ongoing basis. The Rule is stable yet flexible.

Virtual Private Network (VPN): method for providing secure remote access to the internal network or information systems behind a firewall by establishing a secure tunnel in a public network such as the Internet.

Vulnerability: an inherent weakness or absence of a safeguard that could be exploited by a threat that produces risk in a system.

Workforce: under HIPAA, employees, volunteers, trainers, and others under the direct control of a covered entity, whether or not they are paid by the covered entity.

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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). The *Forum* has published several articles by Ms Satinsky, including "Managing the Implementation of HIPAA and the Privacy Rule," in #4, 2002; "How to Determine If Your Practice Could Use a Professional Practice Administrator," in #2, 2003; "Using Information Technology to Improve Patient Care and Communication: A Practical Guide – Part 1," in #1, 2004; "Using Information Technology to Improve Patient Care and Communication: A Practical Guide – Part 2," in #2, 2004; and "Electronic Medical Records and the Development of Electronic Health Records and Electronic Patient Records," in #3, 2004. An adjunct faculty member at the University of North Carolina School of Public Health, Ms Satinsky is a member of the Medical Group Management Association. She may be reached at (919) 383-5998 or *margie@satinskyconsulting.com*.

GOVERNOR'S INSTITUTE
ON ALCOHOL & SUBSTANCE ABUSE, INC.

Clinicians Can Have Significant Impact on Major Preventable Health Problem with Even Minimal Time Commitment

Sara B. McEwen, MD, MPH, and Jacob A. Lohr, MD

Dr McEwen

Dr Lohr

Substance abuse and dependence is a major preventable public health problem contributing to over 120,000 deaths in the U.S. each year and costing society over 300 billion dollars annually. Affecting individuals across the lifespan, alcohol and other drug abuse has been associated with a host of medical disorders (eg, gastritis, hepatitis, hypertension, sexual dysfunction), fetal alcohol syndrome/effects, fatal and non-fatal injuries from motor vehicle accidents, violent crime, suicide attempts, burns and drownings, psychiatric disorders, and risky sexual practices. According to the Robert Wood Johnson Foundation, there are more deaths, illnesses, and disabilities from substance abuse than from any other preventable health condition. Yet, of the 13 to 16 million people who need treatment for alcoholism or drug addiction each year, only 3 million receive care. In many cases, physicians fail to identify a substance abuse problem, missing the opportunity to intervene or refer the patient for treatment.

No Age Exempt from Substance Abuse

Infants and Children

Alcohol use during pregnancy is known to cause fetal alcohol syndrome, the leading preventable cause of mental retardation. According to 2003 CDC figures, U.S. prevalence rates range from 0.3 to 2.2 cases per 1,000 births. At least three times that many are born with fetal alcohol effects. In addition, child abuse and neglect are prevalent among children of substance abusing parents. Children in families with substance abusing parents are at increased risk of substance abuse themselves and are more likely to have problems with delinquency, poor school performance, and emotional difficulties such as aggression and hyperactivity.

Adolescents/Young Adults

Adolescent substance abuse is a well-documented problem with a number of consequences resulting from poor decision making and risky behaviors, leading to academic failure, falls, disruption to others, arguments, fights, property damage, crime, vehicular and other accidents, alcohol poisoning, unwanted and/or unprotected sex, and the spread of infectious diseases. Alcohol is linked to the top three causes of teen death: suicide, homicide, and accidents. According to new research, the brain appears to be particularly susceptible to damage during the high school and college years: damage at this time can be long-term and irreversible. Short-term or moderate drinking impairs learning and memory far more in youth than adults: adolescents need only drink half as much to suffer the same negative effects.

Terminological "Map"

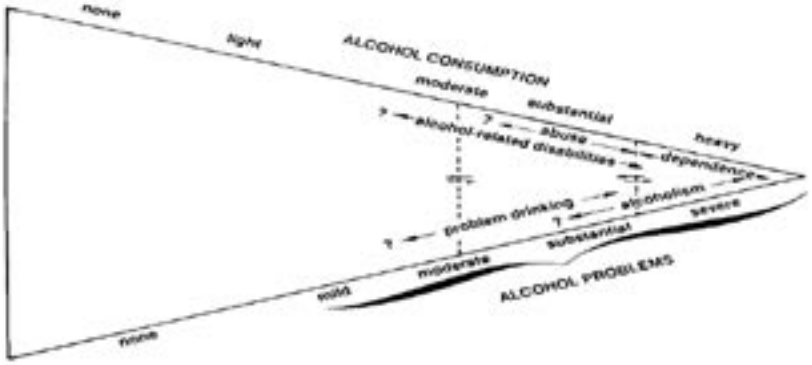

Figure: The triangle represents the population of the U.S. The alcohol consumption of the population ranges from "none" to "heavy" and the problems experienced in association with alcohol consumption range from "none" to "severe". The two-way arrows and the dotted lines indicate that, both from an individual and a population perspective, consumption levels and the degree of problems vary from time to time. The scope of terms that are often used to refer to individuals and groups according to their consumption levels and the degree of their problems are illustrated; question marks indicate that the lower boundary for many of the terms is uncertain.

Broadening the Base of Treatment for Alcohol Problems, IOM, 1990

Adults

Substance abuse has a devastating impact on the health of the adult population as well, leading to more death, illness, and disability than any other preventable health condition. In addition, there is a strong association between substance abuse and crime and between substance abuse and domestic violence. Late-life alcohol abuse can lead to reduced mental and physical functioning and quality of life and to premature insti-

tutionalization.

Problems associated with alcohol use are not limited to heavy drinkers, however; in fact, "moderate" drinkers cause more problems for society than heavy drinkers because there are vastly greater numbers of moderate drinkers. The Institute of Medicine's terminological "map" (see Figure) represents the relationship between alcohol consumption by the population and the associated problems experienced by the population. In the U.S., nondrinkers and light or moderate drinkers make up approximately three-quarters of the population. Twenty percent of the population consume substantial amounts and five percent are considered heavy drinkers.

Substance Abuse Often Not Diagnosed

A 2001 survey revealed that Americans believe alcohol and other drug addiction to be the country's most pressing health issue. There is widespread agreement that primary care physicians should provide screening, brief intervention, and referral for their patients. Yet, study after study shows a huge gap between what is recommended and what actually occurs in practice. In general, physicians are not adequately addressing substance use issues with their patients. This lack of attention to substance use extends across all specialties.

"Overall, treatment of addiction is as successful as treatment of other chronic diseases, such as diabetes, hypertension, and asthma"

Certainly there are a number of reasons that substance use issues are neglected. Barriers include constraints caused by a high volume of patients in a restricted period of time; overhead expense/inadequate reimbursement for time and effort required; fear of alienating the patient; inadequate training and education in substance abuse; research on positive treatment outcomes not effectively disseminated to physicians; research on negative effects of failing to intervene early not effectively disseminated to physicians; and inadequate information about how to access treatment and refer patients. Another important barrier is that screening for substance abuse is not integrated into the delivery system in most situations. Ideological obstacles also exist, including the long-standing notion on the part of some clinicians that substance-abusing patients are resistant to change, unmotivated, and in denial of problems associated with substance use disorders. The harm- or risk-reduction focus of brief interventions may be objectionable to some clinicians despite the fact that any move toward moderation and lowered risk can be seen as one step toward the goal of abstinence.

Physicians Can Make a Difference

Treatment Works

Numerous studies have documented the efficacy of alcoholism treatment. About 70 percent of treated patients manifest a reduction in the number of days of drinking and improved health status after six months. Other research has shown that 30-50 percent of patients remain abstinent for at least one year after completing treatment. Findings in an ongoing project reviewing clinical trials of treatment for alcohol use disorders indicate that among psychosocial treatments, strongest evidence of efficacy was found for brief interventions, social skills training, the community reinforcement approach, behavior contracting, behavioral marital therapy, and case management. Substance abuse treatment leads to decreased general medical care: with treatment, primary drug use decreases by one-half and alcohol-related medical visits decline by more than 50 percent. Overall, treatment of addiction is as successful as treatment of other chronic diseases, such as diabetes, hypertension, and asthma.

Brief Interventions Are a Critical Strategy

Brief interventions can be incorporated into most patient encounters. A substantial body of research indicates that this strategy is effective for reducing patients' problems with alcohol. One study, analyzing 32 trials of brief interventions, showed a reduction of alcohol use by up to 30 percent. Another analysis of 12 controlled trials found that drinkers who received brief interventions were almost twice as likely as those not receiving an intervention to reduce or moderate their drinking in the subsequent 6 to 12 months. This effect was consistent in both men and women and in various clinical settings.

North Carolina Physicians' Leadership Council Addresses Problem

The North Carolina Physicians' Leadership Council on Substance Abuse is committed to coordinating the efforts of physicians across specialties to increase their effectiveness in dealing with substance abuse. Physician leaders from seven North Carolina medical specialty societies serve on the Council and have developed (and are implementing) an action plan to address substance abuse in medical practices. The action plan, which addresses substance abuse prevention, recognition, and treatment through education, clinical care, and community service/advocacy, will be further explored in a subsequent Forum article. The participating specialty societies include:

NC Academy of Family Physicians,
NC Chapter of AAP/NC Pediatric Society,
NC College of Emergency Physicians,
NC College of Internal Medicine,
NC Medical Society,
NC Psychiatric Association,
NC Society for Obstetrics and Gynecology.

As physicians, we provide a critical link in the substance abuse prevention and treatment chain. By detecting substance abuse issues and intervening, we provide better care for our patients and their families by addressing the cause of their problems, not just the symptoms.

Sara B. McEwen, MD, MPH, is consultant to the Governor's Institute on Alcohol and Substance Abuse and the Division of Mental Health, Development Disabilities, and Substance Abuse Services. Jacob A. Lohr, MD, is executive director of the Governor's Institute on Alcohol and Substance Abuse. This is the first in a series of articles addressing substance abuse/dependence issues. Other articles in the series will address substance abuse (SA) in adults, SA in the child/adolescent population, fetal alcohol syndrome/effects, prescription drug dependence, SA in physicians, and the Council's Action Plan.

NCMB Installs Officers: Charles L. Garrett, Jr, MD, President; Robert C. Moffatt, MD, President Elect; H. Arthur McCulloch, MD, Secretary; Janelle A. Rhyne, MD, Treasurer

On November 1, 2004, Charles L. Garrett, Jr, MD, of Jacksonville, took office as president of the North Carolina Medical Board and Robert C. Moffatt, MD, of Asheville, became president elect. H. Arthur McCulloch, MD, of Charlotte, assumed the office of secretary, and Janelle A. Rhyne, MD, of Wilmington, became treasurer. Their terms will run until October 31, 2005.

Charles L. Garrett, Jr, MD, President

Dr Garrett

The Board's new president, Dr Charles L. Garrett, Jr, was first named to the Board in January 2001. He served as the Board's secretary/treasurer from February 2002 through October 2002 and served as president elect of the Board from November 1, 2002, until assuming the office of president on the death of Dr John T. Dees in February 2003. He again served as president elect from November 2003 through October 2004. Besides his service as a Board officer, he has chaired the Board's Policy and Investigative Committees, and is a member of the Executive and Legal Committees. He succeeds Dr Stephen M. Herring, of Fayetteville.

Dr Garrett is director of laboratories emeritus at Onslow Memorial Hospital; managing senior partner of Coastal Pathology Associates, PA; medical director and adjunct faculty member at the School of Medical Laboratory Technicians at Coastal Carolina Community College; medical examiner of Onslow and Jones Counties; southeastern regional pathologist for the Office of the Chief Medical Examiner of North Carolina; and executive director of the Onslow County Medical Society. A native of South Carolina, he received his undergraduate education at Wofford College in Spartanburg, SC, and took his MD, *magna cum laude,* at the Medical College of South Carolina in Charleston.

Dr Garrett did his postgraduate training at the Medical University Teaching Hospitals in Charleston, SC, and a fellowship at the Medical College of Virginia and in the Office of the Chief Medical Examiner of Virginia. He is certified by the American Board of Pathology in anatomic and forensic pathology. He also served in the U.S. Navy, from which he was honorably discharged as a lieutenant commander.

A fellow of the College of American Pathologists, the American Society of Clinical Pathology, and the American Academy of Forensic Sciences, Dr Garrett is active in a large number of professional organizations and served as president of the North Carolina Medical Society in 1998. He continues his work with the Medical Society today in several capacities and is a past Society delegate to the American Medical Association . He is also a past member of the Board of Directors of the AMA's Political Action Committee.

Among his many other professional activities, Dr Garrett has presented a number of papers on forensic medicine to legal groups in North Carolina and other states. In 1998, Governor Hunt presented him the Order of the Long Leaf Pine. He is very active in church and civic affairs in Jacksonville.

Robert C. Moffatt, MD, President Elect

Dr Moffatt

Dr Robert C. Moffatt, president elect of the Board, is a native of Tennessee and took his BA degree from East Tennessee State University. He earned his MD degree at the University of Tennessee Center for Health Sciences, Memphis, and did his internship at Memorial Mission Hospital in Asheville. He completed his residency training in surgery at the University of Georgia College of Medicine and did a surgical oncology fellowship at Memorial Sloan Kettering Cancer Center. He holds

certification from the American Board of Surgery, is a fellow of the American College of Surgeons, and is licensed in North Carolina, Georgia, and Mississippi. He was appointed to the Board in 2001 and has served on the Investigative, Licensing, and Physicians Health Program Committees. He was first elected secretary in February 2003.

Dr Moffatt holds appointments at Memorial Mission Hospital and St Joseph's Hospital in Asheville. His practice is focused on surgical oncology. He has served as president of the Buncombe County Medical Society and is a member of the North Carolina Medical Society, the American Medical Association, and numerous other professional organizations. He was also Buncombe County medical examiner for seven years. Active in community affairs, over the years he has been on the Asheville Symphony Society Board, the King College (Bristol, TN) Board of Visitors and Board of Trustees, and the Mountain Ramparts Health Planning Council. He has also served as president of the Asheville Lyric Opera. Among other honors, he was made a member of the Governor's Order of the Long Leaf Pine by Governor Hunt.

He served previously as the Board's secretary.

H. Arthur McCulloch, MD, Secretary

Dr McCulloch

A native of Ohio, Dr H. Arthur McCulloch, the Board's secretary, 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 current president elect. He is a member of the House of Delegates of the American Society of Anesthesiologists. He was appointed to the Board in 2002 and has served as the Board's treasurer.

Dr McCulloch is co-author of three journal articles.

Janelle A. Rhyne, MD, Treasurer

Dr Rhyne

Dr Janelle A. Rhyne, of Wilmington, the Board's new treasurer, earned a BA degree in anthropology from the University of North Carolina at Chapel Hill and continued her education at Arizona State University, where she took an MA degree in physical anthropology. Following graduation, she returned to UNC Chapel Hill where she completed additional studies and worked in neuropathology research. She earned her MD at Wake Forest University School of Medicine. She did her internship in internal medicine, her residency training, and a fellowship in infectious diseases at Wake Forest University Baptist Medical Center.

Dr Rhyne currently serves as clinical associate professor in the Department of Medicine at the University of North Carolina School of Medicine and has served Wilmington's New Hanover Regional Medical Center in many capacities, including chair of numerous medical staff committees, chief of staff, and member of the Board of Trustees. She also practices at Wilmington Health Associates, PLLC, and is medical consultant for New Hanover County Health Department.

Following the completion of her medical education, Dr Rhyne began teaching responsibilities, some of which she still performs today, including giving conferences and precepting medical students and residents. She is certified by the American Board of Internal Medicine in the specialty of internal medicine and subspecialty of infectious diseases.

Dr Rhyne is a member of numerous professional societies, including, among others, the American College of Physicians, of which she is a fellow, Infectious Disease Society of America, the New Hanover-Pender County Medical Society, and the North Carolina Medical Society, where she chairs the Ethical and Judicial Affairs Committee and is a New Hanover-Pender County Delegate. She has been the recipient of numerous honors and awards. In 1998, she was named Physician Scholar for the North Carolina Medical Society Foundation Leadership Symposium. In 1995, she was Professor of the Year at New Hanover Regional Medical Center, and in 1994, Physician of the Year at Wilmington Health Associates. She was recently presented the Ralph E. Snyder, MD, Award of Excellence in Healthcare Quality Improvement from Medical Review of North Carolina, Inc.

In the past, Dr Rhyne has served as president of the North Carolina Chapter of the American College of Physicians, president of the North Carolina Society of Internal Medicine, chief of staff at New Hanover Regional Medical Center, president of the New Hanover-Pender County Medical Society, and governor of the North Carolina Chapter for the American College of Physicians. She has also co-authored scientific publications and given scientific presentations.

Janelle A. Rhyne, MD, Receives Award of Excellence in Healthcare Quality Improvement

Dena M. Marshall

Dr Rhyne

Janelle A. Rhyne, MD, treasurer of the North Carolina Medical Board, recently received the Ralph E. Snyder, MD, Award of Excellence in Healthcare Quality Improvement presented by the Medical Review of North Carolina, Inc. (MRNC). Dr Rhyne, who practices in Wilmington, accepted the award in Greensboro at the fourth annual Ralph E. Snyder, MD, Healthcare Leadership Forum. The award was given for her contributions to the Changing Practice, Changing Lives Project to improve the quality of health care provided to Medicare consumers in North Carolina physicians' offices.

"It is my honor to present Dr Rhyne with this award," said Dr Donald K. Wallace, president, MRNC Board of Directors. "Dr Rhyne is a committed and caring physician and is absolutely dedicated to providing the highest quality care to not only her patients, but to all citizens of our state."

Nearly 300 health care professionals from across the state attended the daylong conference, titled "Leading Beyond the Boundaries," that was developed to examine many of the health care challenges faced by North Carolinians today. Participants addressed quality of care issues and strategized about ways to create a seamless continuum of care. The conference was named for Ralph E. Snyder, MD, former director of medical affairs at MRNC, for his 15 years of distinguished service to improve quality health care for Medicare consumers.

Dr Rhyne earned her MD at Wake Forest University School of Medicine. She currently serves as clinical associate professor in the Department of Medicine at the University of North Carolina School of Medicine. She was appointed to the North Carolina Medical Board in November 2003.

NCMB Schedules Review of Position Statements

The Policy Committee of the North Carolina Medical Board will be examining the Board's various Position Statements over the next 18 months or so. The Board's licensees and others interested in the subjects dealt with by the statements are invited to offer comments in writing to the Board, by e-mail or post, for consideration as part of the review process. Comments should be addressed to the attention of the Policy Committee of the North Carolina Medical Board and posted to PO Box 20007, Raleigh, NC 27619, or e-mailed to *info@ncmedboard.org*.

In sessions open to the public, the Policy Committee will discuss the statements being considered at regularly scheduled meetings of the Board. Interested parties are invited to attend those sessions as observers. The schedule currently set for statement evaluation is noted below, though those wishing to attend should check dates and times on the Board's agenda, which is posted on the Board's Web site several days before each meeting. They may also telephone the Board's office for information concerning meeting times.

January 19, 2005
- "Laser Surgery"
- "HIV/HBV Infected Health Care Workers"

March 16, 2005
- "Writing of Prescriptions"
- "Management of Chronic Non-Malignant Pain"

May 18, 2005
- "Advertising and Publicity"
- "Fee Splitting"

July 20, 2005
- "Retention of Medical Records"
- "Medical Record Documentation"
- "The Retired Physician"

September 21, 2005
- "Prescribing Legend or Controlled Substances . . ."
- "Self-Treatment and Treatment of Family Members. . ."

November 16, 2005
- "Sexual Exploitation of Patients"
- "The Physician-Patient Relationship"

Position Statements of the North Carolina Medical Board

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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 relationship with a health care entity. The Board believes

the interests and health of the people of North Carolina are best served when the physician-patient relationship remains inviolate. The physician who puts the physician-patient relationship at risk also puts his or her relationship with the Board in jeopardy.

Elements of the Physician-Patient Relationship

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

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

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

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

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

Termination of the Physician-Patient Relationship

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

The decision to terminate the relationship must be made by the physician personally. Further, termination must be accompanied by appropriate written notice given by the physician to the patient or the patient's representative sufficiently far in advance (at least 30 days) to allow other medical care to be secured. Should the physician be a member of a group, the notice of termination must state clearly whether the termination involves only the individual physician or includes other members of the group. In the latter case, those members of the group joining in the termination must be designated. It is advisable that the notice of termination also include instructions for transfer of or access to the patient's medical records.

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

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

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 caregiver 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 caregivers 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 MEDICAL RECORDS

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

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

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

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

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

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

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

Physicians should not relinquish control over their patients' medical records to third parties unless there is an enforceable agreement that includes adequate provisions to protect patient confidentiality and to ensure access to those records.[1]

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

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

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

RETENTION OF MEDICAL RECORDS

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

• 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, sufficiently far in advance (at least 30 days) to allow other medical care to be secured. 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.

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

(Adopted January 2000)
(Amended August 2003)

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

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.

The surgeon is responsible for postoperative care of the patient, including complications. This responsibility extends through the period of convalescence until the residual effects of the surgical procedure are minimal, and the risk of complications of the operation is predictably small.

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

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 pre-signed prescription blanks.

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

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

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

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

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

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

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

Substances/Preparations with Anabolic Properties

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

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

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

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

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

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

(October 1999)

OFFICE-BASED PROCEDURES

Preface

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

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

General Guidelines

The Physician's Professional and Legal Obligation

The North Carolina Medical Board has adopted the guidelines con-

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

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

Exemptions

These guidelines do not apply to Level I procedures.

Written Policies and Procedures

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

Emergency Procedure and Transfer Protocol

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

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

Infection Control

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

Performance Improvement

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

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

Medical Records and Informed Consent

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

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

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

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

Credentialing of Physicians

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

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

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

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

Accreditation

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

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

Patient Selection

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

ASA Physical Status Classifications

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

Candidates for Level II Procedures

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

Candidates for Level III Procedures

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

Surgical or Special Procedure Guidelines

Patient Preparation

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

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

The physician performing the surgical or special procedure also should:

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

Discharge Criteria

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

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

Information to the Patient

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

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

Reportable Complications

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

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

Equipment Maintenance

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

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

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

Compliance with Relevant Health Laws

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

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

Patient Rights

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

Enforcement

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

Level II Guidelines

Personnel

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

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

Surgical or Special Procedure Guidelines

Intraoperative Care and Monitoring

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

1. direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
2. pulse oximetry should be performed continuously (an alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness);
3. an electrocardiogram monitor should be used continuously on the patient;
4. the patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes; and
5. the body temperature of a pediatric patient should be measured continuously.

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

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

Postoperative Care and Monitoring

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

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

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

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

Equipment and Supplies

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

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

Level III Guidelines

Personnel

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

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

Surgical or Special Procedure Guidelines

Intraoperative Monitoring

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

1. direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
2. pulse oximetry should be performed continuously. Any alternative method of measuring oxygen saturation may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness;
3. an electrocardiogram monitor should be used continuously on the patient;
4. the patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes;
5. monitoring should be provided by a separate health care professional not otherwise involved in the surgical or special procedure;
6. end-tidal carbon dioxide monitoring should be performed on the patient continuously during endotracheal anesthesia;
7. an in-circuit oxygen analyzer should be used to monitor the oxygen concentration within the breathing circuit, displaying the oxygen percent of the total inspiratory mixture;
8. a respirometer (volumeter) should be used to measure exhaled tidal volume whenever the breathing circuit of a patient allows;
9. the body temperature of each patient should be measured continuously; and
10. an esophageal or precordial stethoscope should be utilized on the patient.

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

Postoperative Care and Monitoring

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

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

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

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

Equipment and Supplies

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

1. full and current crash cart at the location where the anesthetizing is being carried out (the crash cart inventory should include appropriate resuscitative equipment and medications for surgical, procedural or anesthetic complications);
2. age-appropriate sized monitors, resuscitative equipment, supplies, and medication in accordance with the scope of the surgical or special pro-

cedures and the anesthesia services provided;
3. emergency power source able to produce adequate power to run required equipment for a minimum of two (2) hours;
4. electrocardiographic monitor;
5. noninvasive blood pressure monitor;
6. pulse oximeter;
7. continuous suction device;
8. endotracheal tubes, and laryngoscopes;
9. positive pressure ventilation device (e.g., Ambu);
10. reliable source of oxygen;
11. emergency intubation equipment;
12. adequate operating room lighting;
13. appropriate sterilization equipment;
14. IV solution and IV equipment;
15. sufficient ampules of dantrolene sodium should be emergently avail able;
16. esophageal or precordial stethoscope;
17. emergency resuscitation equipment;
18. temperature monitoring device;
19. end tidal CO2 monitor (for endotracheal anesthesia); and
20. appropriate operating or procedure table.

Definitions

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

AAAHC – the Accreditation Association for Ambulatory Health Care

ABMS – the American Board of Medical Specialties

ACGME – the Accreditation Council for Graduate Medical Education

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

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

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

Anesthesia provider – an anesthesiologist or CRNA

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

AOA – the American Osteopathic Association

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

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

ASA – the American Society of Anesthesiologists

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

Board – the North Carolina Medical Board.

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

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

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

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

FDA – the Food and Drug Administration.

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

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

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

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

Immediately available – within the office.

JCAHO – the Joint Commission for the Accreditation of Health Organizations.

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

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

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

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

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

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

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

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

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

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

OSHA – the Occupational Safety and Health Administration.

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

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

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

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

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

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

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

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

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

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.

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*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 para-professional 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)

THE MEDICAL SUPERVISOR-TRAINEE RELATIONSHIP

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

(Adopted April 2004)

NORTH CAROLINA MEDICAL BOARD
Board Orders/Consent Orders/Other Board Actions
August - September - October 2004

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/license.

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 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 from bringing charges against the practitioner.

ANNULMENTS

NONE

REVOCATIONS

HAYES, Joseph Steven, MD

Location:	Johnson City, TN
DOB:	4/23/1945
License #:	0000-21963
Specialty:	EM/FP (as reported by physician)
Medical Ed:	Medical University of South Carolina (1972)
Cause:	Dr Hayes' medical license was revoked by Tennessee in June 2001 based on findings he was convicted of three misdemeanor counts of assault by offensive touching. In August 2002, the South Carolina Board indefinitely suspended his license based on the Tennessee convictions. In May 2002, Virginia summarily suspended his license on the action of Tennessee and South Carolina.
Action:	9/10/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 8/19/2004: Dr Hayes' license is revoked, effective immediately.

JOHNSON, Willie Lee, Jr, MD

Location:	Franklin, TN
DOB:	9/05/1962
License #:	0094-01229
Specialty:	US (as reported by physician)
Medical Ed:	Meharry Medical College (1990)
Cause:	Conviction of a felony in California.
Action:	9/02/2004. Entry of Revocation issued: Revocation of North Carolina medical license by operation of law effective 8/29/2004.

McCONATHA, Buford Dotridge, Physician Assistant

Location:	Wilmington, NC (New Hanover Co)
DOB:	3/10/1949
License #:	0001-00224
PA Education:	Medical University of South Carolina (1976)
Cause:	Mr McConatha provided false information to the Board on his annual registration; provided false information to Blue Cross Blue Shield to obtain insurance benefits; and provided medical treatment to a person with whom he had a significant emotional relationship. He also threatened on numerous occasions to kill an individual with whom he had a relationship.
Action:	9/02/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 8/18/2004: Mr McConatha's North Carolina physician assistant license is revoked; the previous Order of Summary Suspension against him shall remain in effect until the Order of Discipline of 9/02/2004 is served.

MEREDITH, George Minor, MD

Location:	Baltimore, MD
DOB:	1/27/1940
License #:	0000-15732
Specialty:	Not reported
Medical Ed:	University of Virginia (1966)
Cause:	In 2001, the Kansas Board of Healing Arts revoked Dr Meredith's medical license for willful disclosure of confidential patient information, falsified patient records, billing for services not performed, and practice below the standard of care.
Action:	9/10/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 8/19/2004: Dr Meredith's North Carolina medical license is revoked.

REAUX, John Malcolm, MD

Location:	Baton Rouge, LA
DOB:	5/16/1948
License #:	0000-25740
Specialty:	FSM/EM (as reported by physician)
Medical Ed:	Louisiana State University, Shreveport (1973)
Cause:	In June 2003, the Louisiana Board revoked Dr Reaux's

medical license for numerous instances of improper prescribing and unprofessional conduct.

Action: 10/22/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 10/21/2004: Dr Reaux's North Carolina medical license is revoked.

RODRIGUEZ, James Jay, MD

Location: Chattanooga, TN
DOB: 3/14/1948
License #: 0000-02235
Specialty: IM (as reported by physician)
Medical Ed: University of Texas, San Antonio (1974)
Cause: Dr Rodriguez was convicted of a felony in the U.S. District Court, Western District of Tennessee, in United States of America v. James Jay Rodriguez. The Board sent notice to his last address of record with the Board informing him that his license would be automatically revoked unless he requested a hearing on the matter within 60 days. No such request was received.
Action: 10/06/2004. Entry of Revocation issued: The Board revoked Dr Rodriguez North Carolina medical license by operation of law as of 9/28/2004.

STETLER, Robert Howard, MD

Location: Galax, VA
DOB: 2/14/1954
License #: 0000-27742
Specialty: GS (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1979)
Cause: In October 2002, Virginia accepted Dr Stetler's surrender of his Virginia license in lieu of further administrative proceedings against him based on findings that he had received treatment for substance abuse.
Action: 9/23/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 8/19/2004: Dr Stetler's North Carolina medical license is revoked.

URBAN, Edward John, DO

Location: Cortland, OH
DOB: 2/05/1956
License #: 0000-27410
Specialty: FP/GP (as reported by physician)
Medical Ed: Chicago College of Osteopathy (1982)
Cause: Conviction of a felony in Ohio.
Action: 8/27/2004. Entry of Revocation issued: Revocation of North Carolina medical license by operation of law effective 12/22/2003.

VINSON, David, Jr, MD

Location: Bowling Green, OH
DOB: 3/30/1959
License #: 0095-00261
Specialty: GS (as reported by physician)
Medical Ed: Case Western Reserve University (1986)
Cause: In June 2003, the Ohio Board revoked Dr Vinson's Ohio medical license after concluding his treatment of eight patients did not meet minimal standards of medical practice.
Action: 10/21/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 10/20/2004: Dr Vinson's North Carolina medical license is revoked

SUSPENSIONS

CLARK, Carl Victor, MD

Location: Danville, VA
DOB: 9/01/1949
License #: 0000-24367
Specialty: Not reported
Medical Ed: Medical College of Virginia (1977)
Cause: In October 2001, the Virginia Board placed Dr Clark's Virginia medical license on suspension. Suspension was stayed on conditions, which included a requirement he pass the SPEX. In March 2003, Virginia entered another order in which Dr Clark's Privilege to Renew his license was suspended, with suspension stayed on further conditions.
Action: 9/07/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 8/19/2004: Dr Clark's North Carolina medical license is indefinitely suspended.

KNIGHT, Robert M., MD

Location: Fort Myers, FL
DOB: 3/11/1948
License #: 0000-34373
Specialty: OS (as reported by physician)
Medical Ed: State University of New York, Brooklyn (1979)
Cause: In June 2002, the Florida Department of Health suspended Dr Knight's medical license for one year for substandard care, inappropriate prescribing, and inadequate records.
Action: 9/10/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 8/19/2004: Dr Knight's North Carolina medical license is indefinitely suspended effective immediately.

NATHAN, Paul Eli, MD

Location: New Orleans, LA
DOB: 12/22/1960
License #: 0000-35712
Specialty: C/IM (as reported by physician)
Medical Ed: St George's, Grenada (1987)
Cause: In May 2002, Dr Nathan entered a Consent Order with the Louisiana State Board of Medical Examiners regarding his substance abuse and addiction to opiates. His license was suspended for six months and he was placed on five-years probation.
Action: 10/28/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 10/21/2004: Dr Nathan's North Carolina license is suspended for six months, that suspension being stayed.

WILSON, Daniel Joseph, MD

Location: Rochester, MN
DOB: 3/20/1949
License #: 0000-23988
Specialty: NEP/IM (as reported by physician)
Medical Ed: Rush Medical College (1974)
Cause: In June 2003, pursuant to a Minnesota statute, the Minnesota Board suspended Dr Wilson's license for an outstanding state tax liability.
Action: 10/21/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 10/20/2004: Dr Wilson's North Carolina medical license is indefinitely suspended.

WOODARD, Dean Harris, MD

Location: Staunton, VA
DOB: 12/03/1953
License #: 0000-38868
Specialty: EM (as reported by physician)
Medical Ed: Marshall University (1985)

Cause: In June 2003, Dr Woodard's Virginia license was indefinitely suspended through a Consent Order with the Virginia Board. He agreed not to petition for reinstatement for at least 15 months. The Virginia Board found he had engaged in inappropriate sexual contact with at least two patients.

Action: 10/22/2004. Findings of Fact, Conclusions of Law, and Order of Discipline issued following a hearing on 10/21/2004: Dr Woodard's North Carolina medical license is indefinitely suspended.

See Consent Orders:

BROWN, Michael Osbourne, MD
CAMPBELL, Jeffrey Paul, MD
CHRISTENSEN, Tracy Lee, Physician Assistant
COLLINS, Natalear Rolline, MD
DEONARINE, Denis T., MD
LONG, James Randall, MD
LUCAS, Charles Clement, Jr, MD
MORTER, Gregory Alan, MD
NGUYEN, Tuong Dai, MD
SEBHAT, Berhan, MD
SHANTON, Gregory Damon, Physician Assistant
SMITH, David Lewis, Physician Assistant
STEPHENS, Kathryn Johnson, MD
WARREN, Michael Forrester, MD

SUMMARY SUSPENSIONS

NONE

CONSENT ORDERS

BARBER, Robert Anthony, DO

Location: Morehead City, NC (Carteret Co)
DOB: 9/30/1954
License #: 2003-00222
Specialty: FP (as reported by physician)
Medical Ed: University of Health Sciences College of Osteopathic Medicine (1989)

Cause: Regarding application for reinstatement of Dr Barber's North Carolina medical license, which was voluntarily surrendered in December 2003. Prior to being licensed in North Carolina in March 2003, Dr Barber practiced in Pennsylvania and was a participant in the Pennsylvania Physician Health Program because he is an alcohol and drug abuser. When applying for a license in North Carolina in 2003, he reported to the North Carolina Board that he had been sober since August 1999. He signed a contract with the NCPHP to continue his treatment for alcoholism and drug addiction. In November 2003, the Board learned Dr Barber had been involuntarily committed to a hospital in Fayetteville following an unusual episode involving a reaction to an overdose of dextromethorphan, an over-the-counter medication found in cough syrup. He had become confused, removed his clothing, and began wandering about Fayetteville. Police found him nude, with multiple cuts on his arms, and transported him to the local ER. While in the ER, he had a positive drug test, but the results of that test later proved to be false. He was committed to the psychiatric unit of the hospital out of concern for himself and others. He was released from the involuntary commitment order two days later when it was found he was not suffering from any psychosis. He stayed in the hospital on a voluntary basis. He reported to the NCPHP for further testing and for assessment at a drug treatment facility. Drug tests were negative, and the drug treatment facility opined Dr Barber likely had a psychotic reaction to a higher than recommended dose of dextromethorphan. The NCPHP and the treatment facility believe Dr Barber is abstinent. It was determined that, given his history, he must be more aware of the potential adverse effects of self-medicating. He has signed a contract the NCPHP and is reported to be compliant with that contract.

Action: 8/25/2004. Consent Order executed: Dr Barber's license is reissued to expire on the date shown on the license [1/31/2005]; unless lawfully prescribed by someone other than himself, he shall refrain from mind- or mood-altering substances and alcohol; he shall notify the Board within 10 days of using any such substances or alcohol and include the name of the prescriber and the pharmacy; at the Board's request, he shall provide bodily fluid or tissue for drug and alcohol testing; he shall maintain and abide by his NCPHP contract; must comply with other conditions.

BELANGER, Marie Cerve Ilero, Nurse Practitioner

Location: Jacksonville, NC (Onslow Co)
DOB: 12/02/1957
Approval #: 0002-01425
NP Education: Not recorded

Cause: In August 2003, the North Carolina Board of Nursing reprimanded Ms Belanger for writing a prescription for methylphenidate for a minor patient outside the scope of her practice and without the knowledge of her supervising physician. In doing this, Ms Belanger performed a medical act not authorized by her written protocols and collaborative practice agreement.

Action: 9/28/2004. Consent Order executed: Ms Belanger is reprimanded for her conduct in this instance.

BROWN, Michael Osbourne, MD

Location: Kernersville, NC (Forsyth Co)
DOB: 8/09/1955
License #: 0000-29728
Specialty: OCC/FP (as reported by physician)
Medical Ed: Meharry Medical College School of Medicine (1980)

Cause: In Wake County District Court, Dr Brown pled guilty to five counts of attempting to evade or defeat income tax, which is a violation of North Carolina law and a felony. He was sentenced to three years of supervised probation. He has been compliant with the terms of his probation and the Board is satisfied he is competent to practice safely.

Action: 6/16/2004. Consent Order executed: Dr Brown's license is suspended for 12 months, which suspension is stayed subject to conditions; he agrees to abide by all federal, state, and local laws and all rules and regulations affecting the practice of medicine; he agrees to continue to successfully abide by his supervised probation; must comply with other conditions; the Consent Order shall continue in effect for 12 months from the date of execution.

BUZZANELL, Charles Anton, MD

Location: Asheville, NC (Buncombe Co)
DOB: 9/23/1956
License #: 0098-00481
Specialty: AN/APM (as reported by physician)
Medical Ed: Georgetown University School of Medicine (1984)

Cause: To amend the Consent Order of 1/15/2004, which was an amended version of the original Consent Order of 9/16/2003 between the Board and Dr Buzzanell.

Action: 8/03/2004. Consent Order Amendment executed: the amended Consent Order of 1/15/2004 is further amend-

ed to allow Dr Buzzanell to work 40 hours a week; all other terms of the 1/15/2004 Consent Order remain in effect**.**

CAMPBELL, Jeffrey Paul, MD
Location: Fremont, NE
DOB: 10/14/1962
License #: 0000-38308
Specialty: OTO/FPS (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1988)
Cause: In February 2003, Dr Campbell and the Kentucky Board of Medical Licensure entered into an Agreed Order of Probation placing conditions on Dr Campbell related to his history of substance abuse. In January 2004, Dr Campbell agreed to surrender his Nebraska license based on the Kentucky Board's action and his failure to bring that action to the attention of the Nebraska DHHS. Dr Campbell has not practiced in North Carolina since before the action by Kentucky. He signed a contract with the NCPHP and has successfully complied with that contract to date.
Action: 8/18/2004. Consent Order executed: Dr Campbell's license is suspended retroactively from 2/25/2003; this suspension is lifted on the effective date of this Consent Order (8/18/2004) on condition that, unless lawfully prescribed by someone other than himself, he refrain from use of all mind- or mood-altering substances, including alcohol, that, on request by the Board, he supply bodily fluids or tissues for screening purposes, that he maintain and abide by a contract with the NCPHP, and that he comply with other conditions.

CEDERQUIST, Clarence Hugh, Physician Assistant
Location: Middlesex, NC (Nash Co)
DOB: 11/27/1939
License #: 0001-00197
PA Education: Duke University (1971)
Cause: Mr Cederquist began a romantic relationship with Patient A by inviting her on a trip to the beach in February 2003. For the year following, he and Patient A engaged in a sexual relationship while he had a PA-patient relationship with Patient A-specifically, he provided prescription refills for her on 4/10/2003 and 2/02/2004.
Action: 8/18/2004. Consent Order executed: Mr Cederquist is reprimanded; he shall appear before the Board at such times as requested by the Board; must comply with all laws and rules related to medical practice.

CHRISTENSEN, Tracy Lee, Physician Assistant
Location: Erwin, NC (Harnett Co)
DOB: 6/25/1966
License #: 0001-03714
PA Education: Not recorded
Cause: Having ordered an injection of Bicillin for a patient with a strep throat and having waited to ensure there was no adverse reaction to the injection, Mr Christensen began to write a record of the patient encounter when he noticed the triage nurse had noted in the record that the patient was allergic to penicillin. He and the nurse who administered the injection discussed this with the patient and, given her lack of reaction to the injection, told her they did not feel she was allergic to penicillin. Mr Christensen then replaced the triage note with a new one indicating the patient had no known allergies. He then signed the triage nurse's name to the chart without her knowledge. This action constituted unprofessional conduct.
Action: 9/24/2004. Consent Order executed: Mr Christensen's license is suspended for six months beginning December 1, 2004. Beginning December 22, 2004, the remainder of the suspension is stayed on conditions. He shall obey all laws and regulations related to PA practice and must comply with other conditions.

COLLINS, Natalear Rolline, MD
Location: Franklinton, NC (Franklin Co)
DOB: 10/22/1955
License #: 0000-27108
Specialty: GP (as reported by physician)
Medical Ed: East Carolina University School of Medicine (1981)
Cause: Over the years, Dr Collins has suffered from alcohol and drug abuse. As a result, Dr Collins and the Board have entered into Consent Orders (in August 1996, February 1997, and July 1997) restricting and/or limiting her practice. In July 2000, she was relieved of the restrictions of the Consent Orders based on evidence of her progress in fighting alcohol and drug abuse. In January 2003, a Board investigator and Raleigh police officers interviewed Dr Collins regarding a suspicious prescription for Vicodin® that Dr Collins had written for Patient A. She first claimed the prescription was justified. She then admitted she wrote the prescription for Patient A and was with the patient when the drug was dispensed. She and the patient shared the medication. On 1/27/2003, Dr Collins surrendered her medical license. In February 2003, she was arrested. In May 2003, she pled guilty in Wake County District Court to one felony count of attempting to obtain a controlled substance by fraud. In October 2003, the Board issued a Notice of Revocation to Dr Collins informing her of its intent to revoke her license due to the felony conviction. Dr Collins filed a request for a hearing on this matter in December 2003. She is presently in treatment for her alcohol and substance abuse problem in a residential treatment program.
Action: 8/18/2004. Consent Order executed: Dr Collins' medical license is indefinitely suspended and she may not reapply for a license for at least two years; unless lawfully prescribed by someone other than herself, she shall refrain from use of all mind- or mood-altering substances, including alcohol; on request by the Board, she shall supply bodily fluids or tissues for screening purposes; she shall maintain and abide by a contract with the NCPHP; must comply with other condition**s.**

CURTIN, Michael James, MD
Location: Southport, NC (Brunswick Co)
DOB: 12/19/1938
License #: 0099-00809
Specialty: AN/FP (as reported by physician)
Medical Ed: Stritch School of Medicine (1964)
Cause: Between 5/01/2003 and 5/13/2003, Dr Curtin wrote prescriptions for himself for several medications. The Board has taken into consideration that he prescribed those medications for legitimate health reasons after consultation with and under the supervision and direction of his primary treating physician.
Action: 10/19/2004. Non-Disciplinary Consent Order executed: The Notice of Charges and Allegations issued 9/19/2003 is resolved; Dr Curtin shall comply with the Board's Position Statements on Writing Prescriptions and on Self-Treatment and Treatment of Family Members. . . .

DEONARINE, Denis T., MD
Location: Jupiter, FL

DOB: 12/22/1944
License #: 0099-00815
Specialty: FP (as reported by physician)
Medical Ed: University of the West Indies, Jamaica (1973)
Cause: In July 2001, Florida issued an emergency suspension of Dr Deonarine's Florida medical license based on findings that he improperly prescribed controlled substances to three patients. In December 2001, New York suspended his New York license based on Florida's action. In May 2002, South Carolina followed suit, issuing a temporary suspension of his South Carolina license based on the Florida action.
Action: 9/24/2004. Consent Order executed: Dr Deonarine's North Carolina medical license is suspended indefinitely; he may reapply on completion of all disciplinary matters pending against him in Florida.

GAY, Robert Milton, MD
Location: Greensboro, NC (Guilford Co)
DOB: 10/20/1937
License #: 0000-17628
Specialty: PTH/MM (as reported by physician)
Medical Ed: Tulane University (1963)
Cause: Dr Gay misinterpreted an esophageal biopsy, resulting in an incorrect diagnosis of esophageal cancer. As a result, the patient underwent a partial resection of the esophagus. Surgery revealed the patient did not have a malignancy. Dr Gay admits he had difficulty reading the biopsy and he should have sought consultation prior to rendering a diagnosis. He no longer practices surgical pathology.
Action: 8/18/2004. Consent Order executed: Dr Gay is reprimanded; he shall meet with the Board at such times as requested by the Board; must comply with all laws and rules related to medical practice.

HOOPER, Jeffrey Curtis, MD
Location: Greensboro, NC (Guilford Co)
DOB: 9/21/1964
License #: 0097-00286
Specialty: FP (as reported by physician)
Medical Ed: Vanderbilt University School of Medicine (1995)
Cause: On application for restoration of the medical license. Dr Hooper has a history of alcohol abuse and he surrendered his license in March 2004. He has been a participant with the NCPHP and has been compliant with his NCPHP contract. He has also successfully completed a residential treatment program. In May 2004, he entered a Consent Order with the Board that indefinitely suspended his license.
Action: 10/18/2004. Consent Order executed: Dr Hooper's license is reissued to expire on the date shown on the license [2/28/2005]; he shall practice only in a setting approved by the Board's president and the NCPHP; unless lawfully prescribed by someone else, he shall refrain from the use of mind- or mood-altering substances, including alcohol, and he shall inform the Board within 10 days of such use, noting the prescriber and the pharmacy filling the prescription; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; must comply with other conditions.

KEEHAN, Michael Francis, MD
Location: San Diego, CA
DOB: 3/17/1943
License #: 0000-30183
Specialty: GS (as reported by physician)
Medical Ed: University of Southern California, Los Angeles (1969)
Cause: In February 2002, the California Board entered a Stipulated Surrender of License and Order in which Dr Keehan's California license was surrendered. His license has been inactive in North Carolina since 1987, and he does not intend to practice in North Carolina or to reapply for a North Carolina license.
Action: 10/21/2004. Non-Disciplinary Consent Order executed: Dr Keehan surrenders his inactive North Carolina medical license; the Notice of Charges and Allegations of 5/10/2004 is resolved without further action.

LONG, James Randall, MD
Location: Lexington, NC (Davidson Co)
DOB: 2/05/1960
License #: 0000-33456
Specialty: IM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1986)
Cause: Dr Long first met Patient A in 1990 when she was a nursing student at Lexington Memorial Hospital. He established a physician-patient relationship with Patient A in 1998. That relationship went on for several years, during which time he wrote numerous prescriptions for controlled substances for her. He failed to document the majority of those prescriptions in her file. While she was still under his care, a sexual relationship began between Dr Long and Patient A. In June 2003, Patient A, then a registered nurse, was terminated from employment at Lexington Memorial Hospital as a result of an inquiry that found she had diverted drugs for her personal use and had tested positive for opiates. Dr Long ended his physician-patient relationship with Patient A in 2003 but continues his personal relationship with her.
Action: 10/30/2004. Consent Order executed: Dr Long's license is suspended for one year, but that suspension is stayed for all but 30 days on terms and conditions; he shall maintain and abide by a contract with the NCPHP; he shall meet with the Board when requested; must comply with other conditions.

LUCAS, Charles Clement, Jr, MD
Location: Larchmont, NY
DOB: 8/30/1942
License #: 0000-16905
Specialty: FP/IM (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1969)
Cause: In 1998, the Board entered a Consent Order with Dr Lucas after learning the New York Board had suspended his New York license for three years on findings that he was an habitual user of alcohol or drugs. Under the Consent Order, his license was suspended in North Carolina, the suspension being stayed on conditions, including that he comply with his New York probation. In July 2001, New York imposed an additional five-year suspension on Dr Lucas after he tested positive for a proscribed substance. That suspension was stayed. In October 2001, his sanction was increased to include six months active suspension. Dr Lucas now practices in New York and expects his probationary period to end in January 2005.
Action: 9/03/2004. Consent Order executed: Dr Lucas' North Carolina medical license is suspended for the period of his probation in New York. Suspension is stayed on conditions; he agrees not to resume practice in North Carolina until his New York probation is complete and he is in good standing in New York; prior to resuming

practice in North Carolina, he will submit to assessment by the NCPHP, which will be authorized to report to the Board, and will request practice site approval from the Board president.

McCLELLAND, Scott Richard, DO

Location: Wilmington, NC (New Hanover Co)
DOB: 7/19/1948
License #: 0000-29064
Specialty: P (as reported by physician)
Medical Ed: Kirksville College of Osteopathic Medicine (1980)
Cause: Amendment of Consent Order of 4/22/2003.
Action: 9/23/2004. Consent Order executed: Dr McClelland's Consent Order of 4/22/2003 is amended to allow him to practice at a site approved by the Board where he may examine female geriatric patients without a chaperone being present; all other terms and conditions of the 4/22/2003 Order remain in effect.

MORTER, Gregory Alan, MD

Location: Newport News, VA
DOB: 12/03/1959
License #: 0000-36401
Specialty: PD (as reported by physician)
Medical Ed: University of Pittsburgh (1986)
Cause: In December 2000, the Virginia Board entered a Consent Order with Dr Morter reprimanding him for abusing various controlled substances and related improper prescribing but allowing him to continue practicing subject to certain terms and conditions. In October 2001, Dr Morter surrendered his Virginia license because of a relapse in his substance abuse problem. In February 2003, he pled guilty in the U.S. District Court for the Eastern District of Virginia to one felony count of conspiracy to obtain a controlled substance. He has been a participant in the Virginia Health Practitioner's Intervention Program. The VHPIP reports he has been sober for three years and it believes he is safe to practice as long as he continues to comply with monitoring. Virginia reinstated Dr Morter's license in September 2003. His application for reactivation of his North Carolina license has been stayed pending resolution of the Board's Notice of Revocation to him arising from his plea of guilty to a felony.
Action: 10/21/2004. Consent Order executed: Dr Morter's North Carolina medical license is suspended indefinitely; his pending application for reactivation of his North Carolina license may now proceed and it is understood that the Board will decide that application on its merits unaffected by any provision of this Consent Order.

NGUYEN, Tuong Dai, MD

Location: Charlotte, NC (Mecklenburg Co)
DOB: 4/11/1967
License #: 2000-00566
Specialty: IM (as reported by physician)
Medical Ed: Temple University (1996)
Cause: During examination of Patient A in June 2003, Dr Nguyen engaged in inappropriate conduct of a sexual nature. Patient A complained to the local police and, as a result, on 8/06/2004 Dr Nguyen was charged with one count of misdemeanor simple assault. In January 2004, Dr Nguyen conducted an inappropriate physical examination of Patient B and, as a result, was arrested and charged with one count of misdemeanor sexual battery and one count of misdemeanor simple assault. In February 2004, Dr Nguyen surrendered his North Carolina medical license. In July 2004, he entered an agreement with the Mecklenburg County DA's Office to defer prosecution of the charge involving Patient A. If he complies with the agreement for 15 months, the pending charge would be dismissed. Any and all charges involving Patient B were voluntarily dismissed by the DA's Office in June 2004. From 3/22/2004 to 4/30/2004, Dr Nguyen attended and successfully completed treatment from the Professional Renewal Center's Professional Sexual Misconduct Treatment Team and he has obtained continuing cognitive-behavioral treatment and monitoring on an outpatient basis. In July 2004, he attended and successfully completed a three-day course called Maintaining Proper Boundaries sponsored by Vanderbilt University and Sante Center for Healing. He has also undergone assessment by the NCPHP and the NCPHP reports he is compliant, appears to be making progress, and will be safe to return to practice in the near future.
Action: 10/21/2004. Consent Order executed: Dr Nguyen's medical license is suspended indefinitely and he may not apply for reinstatement until 2/02/2005, one year from the date of the surrender of his license.

RHEUARK, Pamela Hardee, Physician Assistant

Location: Winston-Salem, NC (Forsyth Co)
DOB: 3/12/1951
License #: 0001-01012
PA Education: Bowman Gray (1987)
Cause: Following a change in practice location, Ms Rheuark practiced as a PA even though she had not submitted the required new Notice of Intent to Practice form. From September 1, 2001, to May 2004, she practiced without submitting such a form and without receiving the required acknowledgement of such a submission from the Board. In May 2004, she attempted to rectify her omission by submitting the required form. The Board did acknowledge that submission.
Action: 10/21/2004. Consent Order executed: Ms Rheuark is reprimanded.

SEBHAT, Berhan, MD

Location: Durham, NC (Durham Co)
DOB: 10/22/1966
License #: 2001-01395
Specialty: IM (as reported by physician)
Medical Ed: Medical College of Ohio (1998)
Cause: In July 2002, Dr Sebhat was convicted of driving under the influence. That was his third conviction for that offense in 10 years. In September 2002, he went to an assessment center and was diagnosed with alcohol abuse and dependence. Residential treatment with follow-up with the NCPHP was recommended. Dr Sebhat declined to enter residential treatment and voluntarily surrendered his North Carolina medical license in October 2002. In late 2003, he underwent a three-month residential treatment program for his alcohol abuse and dependence. In January 2004, he entered a contract with the NCPHP and he has complied with its terms. He has been clean and sober since October 2003.
Action: 9/03/2004. Consent Order executed: Dr Sebhat is issued a license to expire on the date shown on the license [1/31/2005]; his license is suspended indefinitely as of 10/28/2002, but suspension is stayed on conditions; he shall refrain from use of alcohol and use or possession of controlled substances unless lawfully prescribed by someone other than himself and he shall notify the Board within 10 days of any such use; he shall attend AA, NA, and Caduceus meetings as recommended by

the NCPHP; at the Board's request, he shall supply bodily fluid and tissue for screening ; he shall maintain and abide by his contract with the NCPHP; must comply with other conditions.

SHANTON, Gregory Damon, Physician Assistant
Location: Morehead City, NC (Carteret Co)
DOB: 2/17/1963
License #: 0001-01943
PA Education: Alderson-Broaddus (1992)
Cause: Between January 2003 and December 2003, Mr Shanton diverted numerous prescription medications to Patient C, a close family member. He did this by having a physician prescribe the medications to him. He then mailed those medications to Patient C in West Virginia. He also arranged to divert prescription medications to Patient E and Patient F, also close family members, by writing prescriptions himself for Patient D, who was unaware of what was being done, or asking a physician do so. Further, on two occasions, Mr Shanton asked an employee of the medical clinic where both worked to give him a teaspoon of hydrocodone, for which he did not have a prescription, while he was on duty.
Action: 10/21/2004. Consent Order executed: Mr Shanton's PA license is suspended for 12 months; all but 30 days of said suspension is stayed, with active suspension to begin 11/15/2004; the remaining period of suspension is stayed, requiring that within 12 months he reimburse Blue Cross/Blue Shield for that part of the cost of the medications furnished by it, that he strictly comply with the Board's position statement on Self-Treatment. . . , that within 12 months he attend the Prescribing Controlled Substances course at Vanderbilt, and that he comply with other conditions.

SMITH, David Lewis, Physician Assistant
Location: Rocky Mount, NC (Nash Co)
DOB: 9/19/1951
License #: 0001-01503
PA Education: Alderson Broaddus College (1992)
Cause: Mr Smith has a long history of substance abuse, not limited to addiction to opiates. As a result, he previously participated in the NCPHP. In February 2003, he presented a prescription for Ultram® to a pharmacist in Rocky Mount, NC. That prescription bore a fictitious name. The pharmacist recognized him and refused to fill the prescription. Mr Smith admitted to his supervising physician that he wrote the prescription in question. On 2/12/2003, he self-referred back to the NCPHP and signed a five year contract. On 4/02/2003, Mr Smith surrendered his North Carolina PA license and, in May 2003, he was discharged from an inpatient substance abuse program after successfully completing a 12 week treatment. He had since been compliant with his NCPHP contract.
Action: 10/11/2004. Consent Order executed: Mr Smith is issued a temporary PA license to expire on the date shown on the license [2/28/2005]; that license is suspended indefinitely, but is stayed on conditions; he shall be subject to and shall comply with random drug screening tests by the Board and he shall maintain and abide by his contract with the NCPHP; he must comply with other conditions.

STEPHENS, Kathryn Johnson, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 11/11/1952
License #: 0000-23993
Specialty: OBG (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1978)
Cause: Relative to Charges and Allegations preferred by the Board against Dr Stephens dated 9/02/2004. Following her performance of a C-section early in 2004, Dr Stephens placed a hemostat (surgical clamp) on the distal portion of each of the patient's fallopian tubes for 3 to 5 minutes without the patient's permission. There was no medical indication or justification for this action, and Dr Stephens' stated purpose was to slow down the rate at which the patient could become pregnant again, allowing her to consider sterilization. Her actions were discovered by Carolinas Medical Center medical staff and the hospital suspended her privileges for six months. During the hospital's review of the matter, it was found the patient's fallopian tubes were not damaged. In September 2004, Dr Stephens' hospital privileges in OB-GYN were restored, in part on representations by other physicians that she was competent to return to practice. All her hospital privileges were renewed for two years beginning October 1, 2004. The Board believes she is safe to practice.
Action: 10/29/2004. Consent Order executed: Dr Stephen's license is suspended indefinitely; that suspension is stayed for all but four months subject to terms and conditions; the four-month period of active suspension shall begin 11/01/2004; she shall abide by all laws, rules, and regulations; she shall provide quarterly reports to the Board from Theodore Boggs, MSW, LCSW; she shall provide semi-annual reports to the Board from her psychiatrist; she shall take 12 hours of CME on ethics for 2004 and 2005 (her completion of the Conflict and Conscience in Healthcare Bioethics Conference satisfies this requirement for 2004); must comply with other conditions.

WADDELL, Roger Dale, MD
Location: Aberdeen, NC (Moore Co)
DOB: 11/17/1954
License #: 0000-30105
Specialty: GP (as reported by physician)
Medical Ed: University of Colorado School of Medicine (1981)
Cause: Amendment to Dr Waddell's Consent Order of 6/23/2004 that related to his admission that without treatment for his alcoholism he is unable to practice with reasonable skill and safety. Dr Waddell is continuing to take steps to further his recovery and ensure he is able to practice safely. He requested the Consent Order's restriction on his hours of work be raised from 20 hours per week.
Action: 10/21/2004. Consent Order executed: Dr Waddell is issued a license to expire on the date shown on the license [1/31/2005]; unless lawfully prescribed by someone else, he shall refrain from the use of mind-or mood-altering substances, including alcohol; at the Board's request, he shall supply bodily fluids or tissues to allow screening for use of such substances; he shall maintain and abide by a contract with the NCPHP; he shall practice medicine no more than 30 hours per week; must comply with other conditions.

WARREN, Michael Forrester, MD
Location: Charleston, SC
DOB: 9/12/1951
License #: 0000-29809
Specialty: D/GP (as reported by physician)
Medical Ed: Medical University of South Carolina (1984)
Cause: The South Carolina Board of Medical Examiners temporarily suspended Dr Warren's license in February 2003

after learning of his arrest on three criminal charges of Eavesdropping and Peeping Tom. These charges arose from allegations he used a concealed camera to videotape females using a restroom in his office. In April 2003, South Carolina issued an Interim Order of Reinstatement allowing Dr Warren to resume practice under certain guidelines intended to monitor his practice. In December 2003, South Carolina issued a Final Order concluding Dr Warren sustained a physical or mental disability, as evidenced by his video recording of staff and a patient in the restroom. That Order reprimanded Dr Warren and suspended his license for one year. The suspension was stayed and he was fined $10,000. All criminal charges against Dr Warren have been dismissed and his record has been expunged.

Action: 8/18/2004. Consent Order executed: Dr Warren is reprimanded and his North Carolina license is suspended for one year, that suspension being stayed if (1) he will comply with all the terms and conditions of the South Carolina Final Order and if , before resuming practice in North Carolina, (2) he submits to assessment by the NCPHP, with the results released to the Board, and request site approval from the Board president.

WOELFEL, James Thomas, MD
Location: Banner Elk, NC (Avery Co)
DOB: 9/12/1934
License #: 0000-19569
Specialty: ABS (as reported by physician)
Medical Ed: Marquette University (1959)
Cause: Dr Woelfel semi-retired from practice in 1995 but maintained his active medical license. He did not maintain an active practice, however, and did not have an office. From 1995 to 2004, he continued to offer consultation and advice to some 20 patients, occasionally prescribing medications for them. On several occasions in 2003, he prescribed controlled substances for patients without appropriate documentation. On 1/01/2004, Dr Woelfel retired and his license was made inactive-retired. The executive director of the Board wrote Dr Woelfel letters on 1/08/2004 and 1/28/2004 reminding him that he could no longer practice medicine, nor could he write prescriptions. In February 2004, Dr Woelfel authorized refills of prescription medications previously prescribed to himself and a family member by another physician. He now agrees he will not reapply for a medical license in North Carolina, and should he ever do so the Board may use his admissions in the Consent Order to deny his application.
Action: 10/21/2004. Consent Order executed: Dr Woelfel voluntarily surrenders his North Carolina medical license.

MISCELLANEOUS ACTIONS

NONE

DENIALS OF RECONSIDERATION/MODIFICATION

NONE

DENIALS OF LICENSE/APPROVAL

PARIKH, Prashant Pramod, MD
Location: Lansdale, PA
DOB: 4/19/1962
Specialty: FP (as reported by physician)
Medical Ed: Grant Medical College, University of Mumbai (1984)
Cause: Dr Parikh provided false information to the Board in relation to the license application.
Action: 10/29/2004. Denial of application for medical license in North Carolina. [Dr Parikh has requested a hearing on this matter.]

SURRENDERS

ADKINS, Paula Clark, MD
Location: Southern Pines, NC (Moore Co)
DOB: 11/26/1965
License #: 0099-00715
Specialty: EM (as reported by physician)
Medical Ed: Marshall University (1996)
Action: 8/31/2004. Voluntary surrender of medical license.

BARR-HAIRSTON, Deborah Winifred, DO
Location: Yanceyville, NC (Caswell Co)
DOB: 3/17/1966
License #: 2001-00639
Specialty: FP (as reported by physician)
Medical Ed: Tulsa Oklahoma School of Osteopathic Medicine (1993)
Action: 10/27/2004. Voluntary surrender of medical license.

CHEEK, John Christopher, MD
Location: Smithfield, NC (Johnston Co)
DOB: 3/03/1957
License #: 0097-01906
Specialty: GP/CN (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1984)
Action: 10/08/2004. Voluntary surrender of medical license.

DiZOGLIO, Joseph David, MD
Location: Wilmington, NC (New Hanover Co)
DOB: 3/19/1938
License #: 2003-00773
Specialty: GN (as reported by physician)
Medical Ed: Tufts University School of Medicine (1963)
Action: 9/29/2004. Voluntary surrender of medical license.

JAWA, Gurpreet Singh, MD
Location: Raleigh, NC (Wake Co)
DOB: 5/03/1966
License #: 0097-00298
Specialty: P (as reported by physician)
Medical Ed: University of North Carolina School of Medicine (1992)
Action: 10/01/2004. Voluntary surrender of medical license.

SELLERS, Marc Timothy, Physician Assistant
Location: Andrews, NC (Cherokee Co)
DOB: 6/15/1963
License #: 0001-01580
Specialty: FP (as reported by physician)
PA Education: Bowman Gray (1992)
Action: 9/10/2004. Voluntary surrender of medical license.

SHAFTNER, Kimberly K., MD
Location: Princeton, NC (Johnston Co)
DOB: 12/09/1954
License #: 0000-25426
Specialty: FP/ABS (as reported by physician)
Medical Ed: Ohio State University (1980)
Action: 10/01/2004. Voluntary surrender of medical license.

SWANTON, Caroline H. Buie, MD
Location: Asheville, NC (Buncombe Co)
DOB: 4/05/1933
License #: 0000-13067

Specialty: PD (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1961)
Action: 8/12/2004. Voluntary surrender of medical license.

WILLIAMS, Warren Herbert, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 1/03/1951
License #: 0000-30111
Specialty: P (as reported by physician)
Medical Ed: Universidad Autonoma Guadalajara, Mexico (1980)
Action: 10/08/2004. Voluntary surrender of medical license.

See Consent Orders:
KEEHAN, Michael Francis, MD
WOELFEL, James Thomas, MD

COURT APPEALS/STAYS
NONE

CONSENT ORDERS LIFTED

BRYSON, Gary Keith, MD
Location: Bowling Green, KY
DOB: 11/12/1951
License #: 0000-25482
Specialty: OBG (as reported by physician)
Medical Ed: Bowman Gray School of Medicine (1979)
Action: 5/07/2004. Order issued lifting Consent Order of 3/17/1999.

HEINER, Daniel Edward, MD
Location: Charlotte, NC (Mecklenberg Co)
DOB: 7/06/1964
License #: Resident Training License
Specialty: ORS (as reported by physician)
Medical Ed: University of Kansas (1997)
Action: 8/04/2004. Order issued lifting Consent Order of 10/24/2001.

THOMPSON, Robert Bruce, MD
Location: Charlotte, NC (Mecklenburg Co)
DOB: 2/29/1956
License #: 0000-40006
Specialty: N/APM (as reported by physician)
Medical Ed: University of Miami School of Medicine (1987)
Action: 8/16/2004. Order issued lifting Consent Order of 7/25/2003 and 6/23/2004.

ZHANG, Howard Hao, MD
Location: Chapel Hill, NC (Orange Co)
DOB: 2/10/1970
License #: 2002-01208
Specialty: IM/GE (as reported by physician)
Medical Ed: Case Western Reserve University (2000)
Action: 9/14/2004. Order issued lifting Consent Order of 6/25/2003.

TEMPORARY/DATED LICENSES:
ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES

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)
Action: 9/23/2004. Full and unrestricted medical license issued.

MOIR, Ronald Jeffrey, MD
Location: Morganton, NC (Burke Co)
DOB: 12/30/1956
License #: 0000-31176
Specialty: AN (as reported by physician)
Medical Ed: East Carolina School of Medicine (1984)
Action: 9/23/2004. Temporary/dated license extended to expire 3/31/2005.

VAUGHAN, Howell Anderson, Physician Assistant
Location: Knightdale, NC (Wake Co)
DOB: 3/31/1958
License #: 0001-01513
PA Education: Wake Forest University (1992)
Action: 9/23/2004. Temporary/dated license allowed to expire on 9/30/2004.

WADDELL, Roger Dale, MD
Location: Aberdeen, NC (Moore Co)
DOB: 11/17/1954
License #: 0000-30105
Specialty: GP (as reported by physician)
Medical Ed: University of Colorado School of Medicine (1981)
Action: 9/23/2004. Temporary/dated license extended to expire 1/31/2005.

See Consent Orders:
HOOPER, Jeffrey Curtis, MD
SEBHAT, Berhan, MD
SMITH, David Lewis, Physician Assistant

DISMISSALS

TYLER, Brent Joseph, MD
Location: Durham, NC (Durham Co)
DOB: 10/01/1975
License #: RTL
Specialty: AN (as reported by physician)
Medical Ed: University of Illinois College of Medicine (2003)
Cause: Following a hearing on 10/21/2004, the Board determined there was good cause to grant a motion to dismiss the Notice of Charges and Allegations of 5/11/2004.
Action: 10/21/2004. Order issued: Notice of Charges and Allegations of 5/11/2004 dismissed without prejudice.

CHANGE OF ADDRESS FORM

Mail Completed form to: North Carolina Medical Board
PO Box 20007, Raleigh, NC 27619

Please print or type: Date:_____

Full Legal name of Licensee:_____

Social Security #:_____License/Approval #:_____

(Check preferred mailing address)

Æ Business:_____

_____

_____

Phone:(_____)_____Fax:(_____)_____

Æ 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.

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North Carolina Medical Board Meeting Calendar, Examinations

Meeting Dates: January 19-21, 2005; February 16-18, 2005; March 16-18, 2005; April 20-21, 2005; May 18-20, 2005

Residents Please Note USMLE Information

United States Medical Licensing Examination

Computer-based testing for Step 3 is available on a daily basis. Applications are available on the Federation of State Medical Board's Web site at *www.fsmb.org*. If you have additional questions, please e-mail Kelli Singleton, the Board's GME Coordinator, at *kelli.singleton@ncmedboard.org* or visit the Board's Web site at *http://www.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.

North Carolina Medical Board
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