



FROM THE PRESIDENT

A milestone for osteopathic medicine – and the NCMB

On November 18, 2009, an historic event took place at the offices of the North Carolina Medical Board in Raleigh. The first osteopathic physician to serve on the Board was sworn in as its president. His peers voted to give him the honor and privilege of serving the Board—and the citizens of North Carolina—in its highest capacity.

It has been a long struggle for the osteopathic profession (the physicians with “DO” after their names, rather than the more prevalent “MD”) to gain equality with the allopathic profession. In fact, it was just 14 years ago, in 1995, that the NCMB recognized the osteopathic board examinations as a gateway to licensure in North Carolina. Prior to that time, the DO had to be board certified by a specialty board approved by the American Board of Medical Specialties, or have taken the FLEX exam, to qualify for licensure in this state.

Osteopathic medicine was conceived in the late 1800s by an American frontier doctor, Andrew Taylor Still, MD. He recognized the limitations in the medical care of his day and approached patient care from an aspect of complete unity. He articulated a set of principles that have continued to guide the profession into its second century. In summary, those principles are:

1. The body is an integral unit, a whole. The structure of the body and its functions work together interdependently.
2. The body systems have built-in repair processes that are self-regulating and self-healing in the face of disease.
3. The circulatory system, with its distributive channels throughout the body, along with the nervous system, provides the integrating functions for the rest of the body.
4. The contribution of the musculoskeletal system to a person's health is much more than providing a framework and support. The musculoskeletal system, and disorders of the musculoskeletal system, may affect the function of other body systems.
5. While disease may be manifested in specific parts of the body, other body parts may contribute to restoration or correction of the disease.

The first school of osteopathic medicine was founded by Dr. Still in 1892. Today there are 23 colleges of osteopathic medicine and three branch campuses throughout the country. There are currently more than 67,000 DOs in the country, according to the American Osteopathic Association, and about 740 in the state of North Carolina.

Although the profession had been present here in the US since the late 1800s it wasn't until 1966 that osteopathic physicians attained equivalent status with their allopathic counterparts. That was the year the U.S. Department of Defense authorized the acceptance



NCMB President Donald Jablonski, DO, says “osteopaths in North Carolina have struggled over the years to gain acceptance here”

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PRESIDENT'S MESSAGE

of DOs into all the medical military services on the same basis as MDs. In 1996, Ronald Blanck, DO, was appointed Surgeon General of the Army. He was the first osteopathic physician to hold that post.

Osteopaths in North Carolina have struggled over the years to gain acceptance here. The profession owes a great debt to Barbara Walker, DO, who has been a tireless advocate for osteopaths in this state. She continues to practice in Wilmington.

Many of the MDs in our state work hand-in-hand with DOs across a wide range of specialties. Although the majority of osteopathic graduates select primary care as their specialty, DOs specialize in all areas of medicine.

There are two combined MD-DO family practice residencies here in the state. One is affiliated with the University of North Carolina and the Pikeville College of Osteopathic Medicine. The other is affiliated with Duke University and Nova-Southeastern University.

A distinctive aspect of the osteopathic medical curriculum is the instruction of osteopathic manipulative treatments (OMT). These maneuvers are used to correct not only musculoskeletal problems but also problems associated with the visceral organs. The procedures are taught from the first days of medical school and throughout the next four years. If the osteopathic graduate selects an os-

teopathic training program or a dually accredited program (MD-DO), the osteopathic manipulative skills are reinforced during postgraduate training.



Andrew Still, MD, founder of osteopathic medicine

Source: Still National Osteopathics Museum

Some osteopathic physicians sub specialize in OMT and basically provide these procedures as the main treatment regimen. Most osteopathic physicians blend both standard medical practices (evidence-based medicine) and proven osteopathic techniques to provide relief for a variety of medical conditions. In addition, there are many DOs who do no OMT in their practices.

Even today, osteopathic physicians have not yet attained complete equality with their allopathic counterparts.

In North Carolina there is one hospital system that does not recognize the osteopathic board certification as equivalent to the allopathic board certification. At this time there is a dialogue between that system and the American Osteopathic Association. Hopefully a mutually agreeable resolution will be reached shortly.

I am the fortunate "first" osteopathic physician who will have the privilege of "Protecting the Public and Strengthening the Profession." I wish to thank the members of the NCMB who elected me president and my colleagues in the osteopathic profession for their support over the course of my career.

NEW FORMAT FOR BOARD MEETINGS

Beginning with its January meeting, the Board introduced a new format for its regularly scheduled meetings.

Board committee meetings, informal interviews, licensure interviews and other routine Board business now will take place during meetings held in odd numbered months (e.g. January, March, May, etc.) All legal disciplinary work of the Board, including hearings and the presentation of Consent Orders, will take place during meetings held in even numbered months (e.g. February, April, June, etc.)

North Carolina Medical Board Forum Credits

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

Board elects new leadership team

The NC Medical Board recently installed its officers for the coming year. Donald Jablonski, DO, of Etowah, became president, Janice Huff, MD, of Charlotte, became president-elect and William Walker, MD, of Charlotte, took office as secretary/treasurer. Their terms will run until October 31, 2010.

Donald E. Jablonski, DO, President

Dr. Jablonski took his undergraduate degree at the University of Windsor, Windsor, Ontario, Canada, with graduate study at Oakland University, Rochester, Michigan. He received his DO degree from the Chicago College of Osteopathic Medicine. He did his internship at Lakeview General Hospital in Battle Creek, Michigan, where he served as chief intern.

He is currently the medical director of a community based outpatient clinic for the Department of Veterans Affairs in Rutherfordton. Appointed to the Board in 2005, he became the first DO to serve on the Board, and now the first to serve as its president. Dr. Jablonski chairs the Executive Committee. He was elected Board treasurer in 2007, in July 2008 he was elected secretary/treasurer and in November 2008 he was elected president-elect, a position he now vacates to serve as president.

Janice E. Huff, MD, President-Elect

Janice E. Huff, MD, graduated from Michigan State University, earning a BS degree in physiology. She earned her medical degree from Saint Louis University School of Medi-

cine. She completed her internship and residency training in the Department of Family Medicine at Carolinas Healthcare System in Charlotte.

Dr. Huff is a part-time faculty member of the Family Medicine Residency Program at Carolinas Medical Center in Charlotte and is an adjunct instructor in the Department of Family Medicine at the University of North Carolina, Chapel Hill. She practices part-time at Presbyterian Urgent Care, Mecklenburg Health Care Center and The Wellness and Recovery Center.

Dr. Huff was appointed to the Board in 2007. In November 2008, she was elected secretary/treasurer. She chairs the Licensing Committee and serves on Executive, Physicians Health Program and Best Practices Committees.

William A. Walker, MD, Secretary/Treasurer

William A. Walker, MD, earned his BA in chemistry and psychology and his MD from the University of North Carolina, Chapel Hill. He completed his internship and residency training in general surgery at the University of Michigan in Ann Arbor. He also completed a fellowship in colon and rectal surgery at the University of Minnesota in Minneapolis.

Dr. Walker currently practices at Charlotte Colon and Rectal Surgery Associates and is a community faculty member in the Department of Surgery at Carolinas Medical Center.

He was appointed to the Board in 2007, and chairs the Disciplinary and Policy Committees and serves on the Executive and Continued Competence Committees.

Governor fills three NCMB seats

The NC Medical Board has announced Governor Perdue recently named Dr. Ralph C. Loomis, of Asheville, as a physician member of the Board. In addition, the Governor reappointed Peggy R. Robinson, PA-C, of Durham, and Pamela Blizzard, of Raleigh. Their three-year terms began Nov 1.

Ralph C. Loomis, MD

Dr. Loomis took his undergraduate degree at Vanderbilt University, and his MD degree from Indiana University. He did his internship at Indiana and his residency in neurosurgery at the same institution.

Appointed to the Board in 2005, Dr. Loomis completed a three-year term in 2008. He serves on the Disciplinary, Licensing and Policy Committees. He has served as treasurer and secretary and was appointed to the Bylaws Committee of the Federation of State Medical Boards (2007-2010).

He practices at the Carolina Spine and Neurosurgery Center in Asheville, NC.

Peggy R. Robinson, PA-C

Ms. Robinson earned a BS degree in biology from Springfield College, in Springfield, MA. She attended the Medical

College of Virginia, where she received a master of science in microbiology. In 1992, she earned a master of health science and certificate of completion from Duke University School of Medicine's Physician Assistant Program in Durham, NC.

Ms. Robinson serves in the PA Program at Duke as an assistant professor in the Department of Community and Family Medicine. She has served on the Board's Allied Health, Continued Competence and Review Committees. She continues to serve on these committees, and is chair of the Continued Competence and Allied Health Committees.

Pamela Blizzard, Public Member

Pamela Blizzard earned her bachelor's degree in urban studies from Brown University in Providence, RI, and her MBA in marketing and finance from the University of Santa Clara in Santa Clara, CA.

She currently serves as executive director and founder of the Contemporary Science Center in Research Triangle Park, NC, where she established and now directs its science education non-profit program. She serves on the Board's Disciplinary, Licensing and Best Practices Committees.

The 'Six Core Competencies':

Keeping skills sharp to avoid problems

This issue of the *Forum* continues a special feature highlighting the ACGME's six core competencies. The Accreditation Council for Medical Education endorsed the competencies in 1999 to define the skills and qualities it expects all medical residents to demonstrate proficiency in. Since then, the competencies have gained acceptance among healthcare organizations as a means of evaluating clinician performance and knowledge.

The NCMB uses the six core competencies as a framework for discussing disciplinary cases. The Board hopes that making licensees more familiar with the competencies will help encourage compliance and possibly even prevent misconduct and/or substandard care.

In this issue: Practice-based Learning and Improvement and Interpersonal and Communication Skills

Read the detailed definitions for information on what behaviors and skills demonstrate proficiency within a particular competency. To read about the competencies covered in the previous issue of the *Forum*, visit www.ncmedboard.org Go to "Professional Resources" and select "Forum Newsletter" from the menu options. The first two competencies appeared in the Fall 2009 issue.

Practice-based Learning and Improvement: "How you get better"

Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:

- Analyze practice experience and perform practice-based improvement activities using a systematic methodology.
- Locate, appraise and assimilate evidence from scientific studies related to their patients' health problems.
- Obtain and use information about their own population of patients and the larger population from which their patients are drawn.
- Apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness.
- Use information technology to manage information, access on-line medical information and support their own education.

- Facilitate the learning of students and other health care professionals.

Interpersonal and Communications Skills: "How you interact with others"

Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients' families and professional associates. Residents are expected to:

- Create and sustain a therapeutic and ethically sound relationship with patients.
- Use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning and writing skills.
- Work effectively with others as a member or leader of a health care team or other professional group.

WHAT ARE THE SIX CORE COMPETENCIES?

A complete list of the six competencies appears below.

- Patient Care
- Medical Knowledge
- Practice-based Learning and Improvement
- Interpersonal and Communication Skills
- Professionalism

NCMB NEWS AND INFORMATION, DELIVERED TO YOUR BROWSER

Don't have time to check the NC Medical Board website for new information? Let us tell you when we have new content. Subscribe to one or more of our new RSS feeds to receive a heads-up when the Board posts its latest meeting agenda, uploads meeting minutes or issues disciplinary notices or news releases.

To sign up, visit www.ncmedboard.org and go to "Professional Resources" select "Subscriptions" from the menu and follow the instructions.

Important note for Internet Explorer users: If you use Internet Explorer to access the Web, you will need to download an RSS feed reader in order to sign up and view our feeds. The Board's website can direct you to a free RSS feed reader.



NC Medical Board Position Statements

A guide to the Boards' Position Statements as of 12/31/2009

If you keep just one issue of the *Forum* to refer to throughout the year, this should be it. The following pages contain the full texts of the Board's position statements. The positions provide licensees with important guidance on such topics as when it's acceptable to prescribe to a family member or significant other (see page 9 for answer) and how long a practitioner should retain copies of patient medical records (you'll find the answer on page 7). The position statements may also be found at www.ncmedboard.org.

This year, four of the Board's position statements were amended and include important changes. The amended statements are: Medical Record Documentation, Departures From and Closings of Medical Practices, Contact with Patients Before Prescribing and Capital Punishment.

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

Disclaimer

The NC Medical Board makes the information in this publication available as a public service. We attempt to update these printed materials often to ensure 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. The position statements can 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]

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POSITION STATEMENTS

THE PHYSICIAN-PATIENT RELATIONSHIP

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

Therefore, it is the position of the North Carolina Medical Board that any act by a physician that violates or may violate the trust a patient places in the physician places the relationship between physician and patient at risk.

This is true whether such an act is entirely self-determined or the result of the physician's contractual relationship with a health care entity. The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship remains inviolate. The physician who puts the physician-patient relationship at risk also puts his or her relationship with the Board in jeopardy.

Elements of the Physician-Patient Relationship

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

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

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

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

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

Termination of the Physician-Patient Relationship

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

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

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

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

MEDICAL RECORD DOCUMENTATION

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

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

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

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

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

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

(Adopted May 1994)

(Amended May 1996, May 2009)

POSITION STATEMENTS

ACCESS TO MEDICAL RECORDS

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

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

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

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

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

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

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

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

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

¹See also Position Statement on Departures from or Closings of Medical Practices. (Adopted November 1993) (Amended May 1996, September 1997, March 2002, August 2003)

RETENTION OF MEDICAL RECORDS

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

- State and federal laws require that records be kept for a minimum length of time including but not limited to:
 1. Medicare and Medicaid Investigations (up to 7 years);
 2. HIPAA (up to 6 years);
 3. Medical Malpractice (varies depending on the case but should be measured from the date of the last professional contact with the patient)—physicians should check with their medical malpractice insurer; North Carolina has no statute relating specifically to the retention of medical records;
 4. Immunization records always must be kept.
- In addition to existing state and federal laws, medical considerations may also provide the basis for deciding how long to retain medical records. Patients should be notified regarding how long the physician will retain medical records.
- In deciding whether to keep certain parts of the record, an appropriate

criterion is whether a physician would want the information if he or she were seeing the patient for the first time. The Board, therefore, recognizes that the retention policies of physicians giving one-time, brief episodic care may differ from those of physicians providing continuing care for patients.

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

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

(Adopted May 1998) (Amended May 2009)

DEPARTURES FROM OR CLOSINGS OF MEDICAL PRACTICES

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

Provide Continuity of Care

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

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

Permit Patient Choice

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

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

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

Written Policies

The Board recommends that practitioners and practices prepare written

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

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

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

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

(Adopted January 2000)

(Amended August 2003, July 2009)

THE RETIRED PHYSICIAN

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

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

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

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

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

(Adopted January 1997) (Amended September 2006)

ADVANCE DIRECTIVES AND PATIENT AUTONOMY

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

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

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

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

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

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

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

AVAILABILITY OF PHYSICIANS TO THEIR PATIENTS

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

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

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

GUIDELINES FOR AVOIDING MISUNDERSTANDINGS DURING PHYSICAL EXAMINATIONS

It is the position of the North Carolina Medical Board that proper care and sensitivity are needed during physical examinations to avoid misunderstandings that could lead to charges of sexual misconduct against 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

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

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

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

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

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

CONTACT WITH PATIENTS BEFORE PRESCRIBING

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

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

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

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

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

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

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

(Adopted November 1999) (Amended February 2001, November 2009)

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.ncmed-board.org).

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

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 affect judgment, will compromise the objectivity of the physician and make the delivery of sound medical care problematic in such situations, while real patient autonomy and informed consent may be sacrificed.

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

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

*This position statement was formerly titled, "Treatment of and Prescribing for Family Members."

(Adopted May 1991) (Amended May 1996; May 2000; March 2002; September 2005)

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THE TREATMENT OF OBESITY

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

The treatment of obesity should be based on sound scientific evidence and principles. Adequate medical documentation must be kept so that progress as well as the success or failure of any modality is easily ascertained. (Adopted [as The Use of Anorectics in Treatment of Obesity] October 1987) (Amended March 1996) (Amended and retitled January 2005)

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

General

It is the position of the North Carolina Medical Board that prescribing any controlled 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) (Reviewed November 2005)

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

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

Section I: Preamble

The North Carolina Medical Board recognizes that principles of quality medical practice dictate that the people of the State of North Carolina have access to appropriate and effective pain relief. The appropriate application of up-to-date knowledge and treatment modalities can serve to improve the quality of life for those patients who suffer from pain as well as reduce the morbid-

ity and costs associated with untreated or inappropriately treated pain. For the purposes of this policy, the inappropriate treatment of pain includes nontreatment, undertreatment, overtreatment, and the continued use of ineffective treatments.

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

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

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

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

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

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

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

Section II: Guidelines

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

Evaluation of the Patient—A medical history and physical examination

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

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

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

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

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

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

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

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

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

Compliance With Controlled Substances Laws and Regulations

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

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

Section III: Definitions

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

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

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

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

Pain —An unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

Physical Dependence —Physical dependence is a state of adaptation that is manifested by drug class-specific signs and symptoms that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist. Physical dependence, by itself, does not equate with addiction.

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

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

Tolerance —Tolerance is a physiologic state resulting from regular use of a drug in which an increased dosage is needed to produce a specific effect, or a reduced effect is observed with a constant dose over time. Tolerance may or may not be evident during opioid treatment and does not equate with addiction. (Adopted September 1996 as "Management of Chronic Non-Malignant Pain.") (Redone July 2005 based on the Federation of State Medical Board's "Model Policy for the Use of Controlled Substances for the Treatment of Pain," as amended by the FSMB in 2004.) (Amended 9/2008)

END-OF-LIFE RESPONSIBILITIES AND PALLIATIVE CARE

Assuring Patients

Death is part of life. When appropriate processes have determined that the use of life prolonging measures or invasive interventions will only prolong the dying process, it is incumbent on physicians to accept death "not as a failure, but the natural culmination of our lives."⁶

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

Palliative Care

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

- problems. Palliative care:
- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten nor postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;

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

Opioid Use

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

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

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

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

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

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

Through dialogue with members of the healthcare community and consumers, a number of perceived regulatory barriers to adequate pain management in end-of-life care have been expressed to the Boards of Medicine, Nursing, and Pharmacy. The following statement attempts to address these misperceptions by outlining practice expectations for 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 nonpharmacologic 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

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circumstance. The silence of the Position Statement on any particular matter should not be construed as the lack of an enforceable standard.

General Guidelines

The Physician's Professional and Legal Obligation

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

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

Exemptions

These guidelines do not apply to Level I procedures.

Written Policies and Procedures

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

Emergency Procedure and Transfer Protocol

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

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

Infection Control

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

Performance Improvement

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

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

Medical Records and Informed Consent

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

treatment, and document the outcome and required follow-up care.

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

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

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

Credentialing of Physicians

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

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

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

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

Accreditation

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

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

Patient Selection

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

ASA Physical Status Classifications

Patients that are considered high risk or are ASA physical status classification III, IV, or V and require a general anesthetic for the surgical procedure, should

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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:

- direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;
- pulse oximetry should be performed continuously (an alternative method of measuring oxygen saturation
- may be substituted for pulse oximetry if the method has been demonstrated to have at least equivalent clinical effectiveness);
- an electrocardiogram monitor should be used continuously on the patient;

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- the patient's blood pressure, pulse rate, and respirations should be measured and recorded at least every five minutes; and
- the body temperature of a pediatric patient should be measured continuously.

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

Postoperative Care and Monitoring

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

Care of the patient may then be transferred to the care of a qualified health care professional in the recovery area. A registered nurse or other health care professional practicing within the scope of his or her license or certification 1 See N.C. Gen. Stat. § 131E-145 et seq. and who is BCLS certified and has the capability of administering medications as required for analgesia, nausea/vomiting, or other indications should monitor the patient postoperatively.

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

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

Equipment and Supplies

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

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

Level III Guidelines

Personnel

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

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

Surgical or Special Procedure Guidelines | Intraoperative Monitoring

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

- direct observation of the patient and, to the extent practicable, observation of the patient's responses to verbal commands;

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

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

Postoperative Care and Monitoring

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

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

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

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

Equipment and Supplies

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

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

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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.

AAAH – 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 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

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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 physician who provides medical supervision is expected to provide adequate oversight of licensed and non-licensed personnel both before and after the procedure is performed. The Board believes that the guidelines set forth in this Position Statement are applicable to every licensee of the Board involved in laser hair removal, whether as an owner, medical director, consultant or otherwise.

It is the position of the Board that good medical practice requires that each patient be examined by a physician, physician assistant or nurse practitioner licensed or approved by this Board prior to receiving the first laser hair removal treatment and at other times as medically indicated. The examination should include a history and a focused physical examination. Where prescription medication such as topical anesthetics are used, the Board expects physicians to follow the guidelines set forth in the Board's Position Statement titled "Contact with Patients Before Prescribing." When medication is prescribed or dispensed in connection with laser hair removal, the supervising physician shall assure the patient receives thorough instructions on the safe use or application of said medication.

The responsible supervising physician should be on site or readily available to the person actually performing the procedure. What constitutes "readily available" will depend on a variety of factors. Those factors include the specific types of procedures and equipment used; the level of training of the persons performing the procedure; the level and type of licensure, if any, of the persons performing the procedure; the use of topical anesthetics; the quality of written protocols for the performance of the procedure; the frequency, quality and type of ongoing education of those performing the procedures; and any other quality assurance measures in place. In all cases, the Board expects the physician to be able to respond quickly to patient emergencies and questions by those performing the procedures.

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

(Adopted July 1999) (Amended January 2000; March 2002; August 2002; July 2005)

CARE OF PATIENT UNDERGOING SURGERY OR OTHER INVASIVE PROCEDURE*

The evaluation, diagnosis, and care of the surgical patient is primarily the responsibility of the surgeon. He or she alone bears responsibility for ensuring the patient undergoes a preoperative assessment appropriate to the

procedure. The assessment shall include a review of the patient's data and an independent diagnosis by the operating surgeon of the condition requiring surgery. The operating surgeon shall have a detailed discussion with each patient regarding the diagnosis and the nature of the surgery, advising the patient fully of the risks involved.

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

When identical procedures are done on a number of patients, individual notes should be done for each patient that reflect the specific findings and procedures of that operation.

(Invasive procedures includes, but is not limited to, endoscopies, cardiac catheterizations, interventional radiology procedures, etc. Surgeon refers to the provider performing the procedure.)

*This position statement was formerly titled, "Care of the Surgical Patients."

(Adopted September 1991) (Amended March 2001, September 2006)

HIV/HBV INFECTED HEALTH CARE WORKERS

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

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

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

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

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

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

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

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

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

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

- (1) Sterilization and disinfection, including a schedule for maintenance and microbiologic monitoring of equipment; the policy shall require documentation of maintenance and monitoring;

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

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

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

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

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

(b) All health care workers who perform surgical or obstetrical procedures or dental procedures and who know themselves to be infected with HIV or hepatitis B shall notify the State Health Director. Health care workers who assist in these procedures in a manner that may result in exposure of patients to their blood and who know themselves to be infected with HIV or hepatitis B shall also notify the State Health Director. The notification shall be made in writing to the Chief, Communicable Disease Control Branch, 1902 Mail Service Center, Raleigh, NC 27699-1902..

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

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

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

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

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

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

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

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

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

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

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.

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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) (Reviewed September 2005)

SALE OF GOODS FROM PHYSICIAN OFFICES

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

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

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

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

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

(Adopted March 2001) (Amended March 2006)

REFERRAL FEES AND FEE SPLITTING

Payment by or to a physician solely for the referral of a patient is unethical. A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company, or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source. In each case, the payment violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

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

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

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

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

UNETHICAL AGREEMENTS IN COMPLAINT SETTLEMENTS

It is the position of the North Carolina Medical Board that it is unethical for a 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 is offered with the aim of improving the educational experience and patient care should not be construed as abusive behavior.

(Adopted April 2004)

COMPETENCE AND RE-ENTRY TO THE ACTIVE PRACTICE OF MEDICINE

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

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

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

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

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

(Adopted July 2006)

CAPITAL PUNISHMENT

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

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

Relevant Provisions of AMA Code of Medical Ethics Opinion 2.06

An individual's opinion on capital punishment is the personal moral decision of the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a legally authorized execution. Physician participation in execution is defined generally as actions which would fall into one or more of the following categories:

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ries: (1) an action which would directly cause the death of the condemned; (2) an action which would assist, supervise or contribute to the ability of another individual to directly cause the death of the condemned; (3) an action which could automatically cause an execution to be carried out on a condemned prisoner.

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

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

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

(Created Jan 2007) (Amended July 2009)

PHYSICIAN SUPERVISION OF OTHER LICENSED HEALTH CARE PRACTITIONERS

The physician who provides medical supervision of other licensed health-care practitioners is expected to provide adequate oversight. The physician must always maintain the ultimate responsibility to assure that high quality care is provided to every patient. In discharging that responsibility, the physician should exercise the appropriate amount of supervision over a licensed healthcare practitioner which will ensure the maintenance of quality medical care and patient safety in accord with existing state and federal law and the rules and regulations of the North Carolina Medical Board. What constitutes an “appropriate amount of supervision” will depend on a variety of factors. Those factors include, but are not limited to:

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

(Adopted July 2007)

DRUG OVERDOSE PREVENTION

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

drug overdose.

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

* Naloxone is the antidote used in emergency medical settings to reverse respiratory depression due to opioid toxicity.

(Adopted September 2008)

MEDICAL TESTIMONY

The Board recognizes that medical testimony is vital to the administration of justice in both judicial and administrative proceedings. In order to provide further guidance to those physicians called upon to testify, the Board adopts and endorses the AMA Code of Medical Ethics Opinion 9.07 entitled “Medical Testimony.”³ In addition to AMA Ethics Opinion 9.07, the Board provides the following guidelines to those physicians testifying as medical experts:

- Physician expert witnesses are expected to be impartial and should not adopt a position as an advocate or partisan in the legal proceedings.
- The physician expert witness should review all the relevant medical information in the case and testify to its content fairly, honestly, and in a balanced manner. In addition, the physician expert witness may be called upon to draw an inference or an opinion based on evidence presented in the case. In doing so, the physician expert witness should apply the same standards of fairness and honesty.
- The physician expert witness is ethically and legally obligated to tell the truth. The physician expert witness should be aware that failure to provide truthful testimony constitutes unprofessional conduct and may expose the physician expert witness to disciplinary action by the Board pursuant to N.C. Gen Stat. § 90-14(a)(6).

The language of AMA Code of Medical Ethics Opinion 9.07 provides:

In various legal and administrative proceedings, medical evidence is critical. As citizens and as professionals with specialized knowledge and experience, physicians have an obligation to assist in the administration of justice.

When a legal claim pertains to a patient the physician has treated, the physician must hold the patient’s medical interests paramount, including the confidentiality of the patient’s health information, unless the physician is authorized or legally compelled to disclose the information.

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

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

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

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

(Adopted March 2008)

North Carolina Medical Board

Quarterly Disciplinary Report | August - October 2009

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

Name/license#/location	Date of action	Cause of action	Board action
REVOCATIONS			
ANDERSON, Eric Andres, PA-C (000102798) Charlotte, NC	09/23/2009	Felony conviction for Medicaid fraud and obtaining a controlled substance by fraud	Entry of revocation
COFFMAN, Donald Ralph, MD (000016272) Norlina, NC	09/28/2009	Felony conviction for unlawful disbursement of controlled substances	Entry of revocation
HAQUE, Ehteshamul, MD (009500929) Norfolk, VA	09/02/2009	Felony conviction for prescription fraud and Schedule IV controlled substance possession with intent to distribute	Entry of revocation
STOWELL, Steven Douglas, MD (009701607) Cranberry Township, PA	10/28/2009	Felony conviction for conspiracy and violation of the Controlled Substance, Drug Device and Cosmetic Act	Notice of revocation
SUSPENSIONS			
<i>(See Consent Orders)</i>			
SUMMARY SUSPENSIONS			
SWARNER, David Reynolds, MD (009400655) Washington, NC	10/09/2009	Irresponsible, excessive and below-standard prescribing of narcotics	Summary suspension of medical license
CONSENT ORDERS			
ABRAHAM, Kurian Chiramel, MD (200100821) Morganton, NC	10/08/2009	Failure to mention two DWI convictions on license application	Six-month suspension stayed except for 30 days active; six-month probation
ANDREWS, Thomas James, MD (000029206) Redding, CA	08/20/2009	Five year probation by CA medical board for a relationship with a patient	NC license on probation for five years to run concurrently with CA discipline
BLACKWELL, Michael Aldred, MD (009500290) North Wilkesboro, NC	09/10/2009	Hospital privileges to perform laparoscopic surgery suspended	Reprimand
BLACKWOOD, Hilary Susan, NP (00960053) Durham, NC	10/22/2009	NP wrote prescriptions for self, family and coworkers; Presigned prescription blanks for use by coworkers without prescriptive authority; improper billing	Suspended for 18 months, stayed. CME in prescribing; other conditions
BOOK, Roy Dewayne, MD (009701700) Greensboro, NC	08/31/2009	Self-reported DUI arrests in 2008 and 2009. Submitted self to treatment for alcohol dependence	Indefinite suspension of NC license
BROOKS, Werner Commodore, MD (009701705) Hendersonville, NC	09/08/2009	Pled guilty to assault and communicating threats. In conjunction with plea, MD attended classes in anger management	Reprimand
CARRUTHERS, Adam Michael, PA (000103109) Gastonia, NC	10/30/2009	Improper disposal of unused controlled substances returned to PA from patients	PA license suspended for 90 days. Attend CME course; other conditions
CLINTON, Robert Allen Jr., MD (200500848) Fayetteville, NC	10/22/2009	MD had a relationship with a patient and performed cosmetic surgical procedures on persons related to him	Four-month suspension to begin on May 29. MD shall not practice cosmetic surgery
DANIEL, Michael Page, MD (000034967) Burlington, NC	08/14/2009	Poor patient communication and record documentation; Self-prescribing	Reprimand
DOHERTY, Dennis Christopher, DO (000030548) Greensboro, NC	10/28/2009	GA board entered an order of summary suspension in October 2008; Quality of care issues	License is limited for three years to run concurrently with the limitations imposed by the GA board

DISCIPLINARY REPORT

Name/license#/location	Date of action	Cause of action	Board action
FREEMAN, Tyler Ira, MD (000025706) Charlotte, NC	09/18/2009	MD license suspended 10/19/2005; Suspension terminated 2/23/2007. MD has requested to work as a medical review officer	Work as medical review officer no more than 20 hours a week. Work limited to receiving/handling phone calls
FRUEH, Walter William, MD (200500820) Wilmington, NC	09/21/2009	Prescribing for family members and failing to maintain a medical record	Reprimand
GABRIEL, Pamela Simone, MD (009801270) Las Vegas, NV	10/28/2009	Failure to respond to Board inquiry; MD has since complied with Board requests	Reprimand
GODWIN, Patrick Lee Jr., MD (009501254) Roxboro, NC	08/07/2009	Failure to properly diagnose and treat patient; lack of proper documentation of care findings and care rendered	MD is reprimanded; Limit practice to 40 hrs/week not including hours MD takes call; Must document schedule; NCPHP assessment
HEDRICK, William Weston, MD (000010830) Raleigh, NC	10/05/2009	Deficiencies with MD's patient charts and documentation	Reprimand
KERR, John Martin (000033851) Bedford, VA	09/18/2009	Patient care fell below accepted standards. MD voluntarily inactivated license	MD's license shall remain on inactive status
KOTZEN, Rene Marlon, MD (200200937) Brooklyn, NY	09/08/2009	Incomplete records kept for patient; Failed to address factors leading to surgical decisions; Treatment of self and family members	MD's license is voluntarily surrendered
NOLAN, Clyde Jr., MD (000023067) Greensboro, NC	09/18/2009	Failed to renew license twice and practiced with inactive license	MD's license is reinstated; Suspended for one year, stayed all but six months.
ORTEGA, Agnes Lynett, MD (009900972) Decatur, AL	10/01/2009	Failed to renew license and it became inactive. MD requests license reactivation	Reprimand; MD's license is retroactively reactivated to 10/09/2007
ROLLINS, Curtis Edward, MD (200501895) Winston-Salem, NC	09/09/2009	Substance abuse history; MD surrendered license after testing positive for controlled substance	MD's license is indefinitely suspended
ROSENBERG, Larry Evans, MD (000034446) Asheville, NC	09/08/2009	Prescribing issues; MD voluntarily surrender DEA privileges for all Schedule II, III and IV controlled substances	MD shall not apply to reinstate DEA privileges indefinitely
SHAVER, Robin Michelle, PA (001002028) Jamestown, NC	09/21/2009	History of substance abuse as RN; Met with Board to discuss PA license application	Issued a PA license; Must comply with conditions
STONE, Todd Iverson, PA (000102282) Hendersonville, NC	09/18/2009	Unintentionally aided and abetted the unlicensed practice of medicine	Public letter of concern
SWARNER, David Reynolds, MD (009400655) Washington, NC	10/16/2009	Prescribing issues; October 2009 NC Board summarily suspended license	Summary suspension dissolved; NC license restricted
WEISS, Juli Stone, MD (000034199) Gastonia, NC	10/23/2009	VA board action; MD license reinstated with restrictions	MD's license is subject to compliance conditions of VA order
WOLF, Bradley Rex, MD (000026418) Cincinnati, OH	08/28/2009	Ohio board action; MD's license suspended indefinitely	MD's license is indefinitely suspended
<u>FINDINGS OF FACT, CONCLUSIONS OF LAW, ORDER OF DISCIPLINE</u>			
LOWE, James Edward, MD (000037887) Fayetteville, NC	10/22/2009	October 2007 suspension for improper medical record documentation and billing issues	Denial of MD license application
MCGHEE James Ernest, MD (009400578) Charlotte, NC	10/2/2009	Surrendered NC license in 2007. In Jan. 2008, license indef. suspended	Indefinite suspension resolved. NC license issued July 2009
<u>DENIAL OF LICENSE/APPROVAL</u>			
MAJOR, Ishmeal, MD (NA) Jacksonville, FL	10/20/2009	Gave false answers on license application	Denial of NC license application
WEBB, Stacey Johnson, MD (NA) Chesapeake, VA	09/01/2009	Gave false answers on license application	Denial of NC license application

DISCIPLINARY REPORT

Name/license#/location	Date of action	Cause of action	Board action
<u>SURRENDERS</u>			
CALDWELL, Chad Cameron, PA (00103163) Winston-Salem, NC	08/27/2009		Voluntary surrender of NC license
COOK, Raymond Dwight, MD (009900195) Raleigh, NC	09/15/2009		Voluntary surrender of NC license
RIVERA-ORTIZ, Epifanio, MD (009900123) Charlotte, NC	09/28/2009		Voluntary surrender of NC license
(See also Consent Orders)			
<u>PUBLIC LETTER OF CONCERN</u>			
BEAM, Daren Moss, MD (RTL) Charlotte, NC	08/13/2009	Failure to report arrest for damaged property on RTL license application	Public letter of concern
BERRY, Michael Brandon (200501463) Greenville, NC	09/22/2009	Incorrect procedure performed on a patient	Public letter of concern
Bower, Edward Birch, MD (000021453) Monroe, NC	10/08/2009	Failure to appropriately diagnose and treat a patient	Public letter of concern
CHANG, Paul Siu-Chang, MD (000031120) Asheville, NC	09/28/2009	Improper supervision of two PAs and a registered nurse	Public letter of concern
CRANSTON, Jay Wheeler, MD (009801223) Boone, NC	08/14/2009	Allegations regarding MDs evaluation and management of a patient's problems and medical records	Public letter of concern
DUNCAN, Richard Dean III, MD (009800519) Durham, NC	09/08/2009	Possible failure to recognize seriousness of the condition of an infant near the end of labor	Public letter of concern
ESENSOY, Taner, MD (009601603) Fayetteville, NC	09/04/2009	Care of an infant may have fallen below acceptable standards	Public letter of concern
HOMESLEY, Howard David, MD (000015495) Greenville, NC	10/28/2009	Quality of care issues	Public letter of concern
HUNT, John Robinson, MD (000018415) Anderson, SC	09/28/2009	Failure to perform appropriate follow up procedures on a patient	Public letter of concern
IMAM, Naiyer, MD (200500428) Roanoke, VA	09/08/2009	Misinterpretation of a patient's CT scan may have fallen below the standard of care	Public letter of concern
LEWIS, Karl Chester, MD (200000520) Lebanon, VA	10/15/2009	MD's license inactive; West VA Board action regarding DWI	Public letter of concern
MCEWEN, Luther Morris, III, MD (000017399) Charlotte, NC	09/23/2009	Treatment of patient did not consist of appropriate plan; inadequate charting of medications	Public letter of concern
MEYER, Paul Frederick, MD (000039034) Lexington, NC	09/08/2009	Failed to adequately supervise a PA	Public letter of concern
OENBRINK, Raymond Joseph, DO (200901584) Tequesta, FL	08/14/2009	Gave false answers on NC license application	Public letter of concern
ROGERS, Anita Ellen, PA (00101703)	10/20/2009	Diverted Adderall for own use and prescribed to a significant other	Public letter of concern
SIRINTRAPUN, Sahussapont Joseph, MD (200901877) Winston-Salem, NC	10/21/2009	Gave false answers on NC license application	Public letter of concern
SMITH, Erastus Jr., MD (000021313) Sanford, NC	9/02/2009	Failed to properly inform patients of his intention to close his practice	Public letter of concern
<u>TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED OR REPLACED BY FULL LICENSES</u>			
HENSLER, Rachel Hurst, PA (001000107) Wilmington, NC	07/16/2009		Full PA license issued
Morales, Sergio Eli, MD (200900131) Greenville, NC	07/16/2009		Temporary license issued to expire 11/30/2009
(See also Consent Orders)			

North Carolina Medical Board
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EXAMINATIONS

Residents Please Note USMLE Information

United States Medical Licensing Examination

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

Special Purpose Examination (SPEX)

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

BOARD MEETING DATES

February 18-19, 2010 (Hearings)

March 17-19, 2010 (Full Board)

April 15-16, 2010 (Hearings)

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

ncmedboard.org

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

Board publishes official guidance on reporting malpractice, other info

The North Carolina Medical Board has published detailed guidance to assist licensees who must report required information, including malpractice payments, under N.C.G.S. 90-5.2 and 90-5.3. These statutes direct the Board to gather and make public certain facts about its physician and physician assistant licensees. The Board unveiled expanded licensee information pages that include the new information on its public website in December.

Specifically, the law requires licensees of the Board to report criminal convictions, certain information about malpractice/professional liability insurance payments, actions taken by out-of-state medical boards and other regulatory authorities or healthcare agencies and final actions taken by hospitals or other healthcare institutions. Licensees must report this information to the Board in a process separate from the annual license renewal. Do not assume you are in compliance if you have already reported required information to the Board during the renewal process.

The Board has created an 18-page document that sets out its expectations for how this information should be reported. It addresses frequently asked questions and provides many helpful suggestions the Board hopes will be of use to its licensees.

Licensees may access the guidance document at www.ncmedboard.org. From the home page, click on "Professional Resources." Select "Licensee Info Pages" from the menu. Click the green button labeled "Guidance on Reporting Required Info" at the right of the screen.