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## Health

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The General Assembly considered a wide range of significant and complex health-related issues during the 2007 session. It enacted controversial legislation that prohibits smoking in state government buildings, establishes a high risk insurance pool, amends and harmonizes several state laws addressing end-of-life decision-making, and overhauls the laws governing the practice of medicine. This chapter summarizes all of the above, as well as the 2007 appropriations act provisions affecting public health and other noteworthy legislation including new laws affecting disclosure of confidential medical information, environmental health, and regulation of various health professions and health care facilities.

### **Public Health**

#### **Budget**

The 2007 appropriations act, S.L. 2007-323 (H 1473), provides funding to the Division of Public Health within the North Carolina Department of Health and Human Services (DHHS) to expand and continue several significant public health programs. Recurring funding was appropriated as follows:

- \$2.7 million to fund an additional 54 school nurse positions in 2007–08 and \$3.3 million to support an additional 66 school nurse positions in 2008–09. These new positions are in addition to the almost 200 new school nurse positions funded by the General Assembly since the School Health Nurse Initiative was launched in 2004.
- \$2 million in direct aid to local health departments to support the delivery of the ten essential services of public health.
- \$2 million to the Breast and Cervical Cancer Control Program to support additional screening and diagnostic services.
- \$2 million for HIV counseling and testing, to be distributed to local health departments, historically black colleges and universities, and other community organizations for counseling, testing, and early medical intervention. Some of the funding will also be used to implement community-based harm reduction programs and to support peer-to-peer counseling efforts.

- \$280,000 dedicated to food-borne and tick-borne diseases, which includes funding for two new consultant positions and tick control demonstration projects in both the Division of Public Health and the Division of Environmental Health within the Department of Environment and Natural Resources (DENR).
- \$235,000 to the Public Health Laboratory to support expanded testing for Human Papillomavirus (HPV), food-borne diseases, tick-borne diseases, and HIV testing for pregnant women.
- \$200,000 to fund the collection and surveillance of clinical data on birth defects and the linking of that data to other relevant data, such as vital statistics, newborn screenings, and children's health services. Three new positions associated with the existing birth defects monitoring registry were also established.
- \$200,000 to provide funding for family planning services for uninsured women.

Responding to recommendations of the Justus-Warren Heart Disease and Stroke Prevention Task Force, the General Assembly provided funding to several stroke-related projects: \$390,000 in recurring funds is dedicated to increasing hospital participation in the North Carolina Collaborative Stroke Registry; \$150,000 in recurring funds will go towards training health care providers regarding medical services for stroke victims, and \$360,000 in nonrecurring funds will support the continued work of the Task Force as well as a stroke public awareness campaign and a survey of the gaps and needs in the prevention and treatment of strokes.

The General Assembly also appropriated nonrecurring funds to support several public health programs and initiatives. Nonrecurring funds were appropriated as follows:

- \$8.25 million to purchase antivirals to treat influenza, with the expectation that the federal government would pay for 25 percent of the cost of purchasing the medications.
- \$5 million to fund competitive community health grants, which are available to local health departments, community and rural health centers, free clinics, and school-based clinics. The grant program was first funded in 2005 (\$2 million in recurring funds) and is designed to increase access to preventive and primary care services by uninsured or medically indigent patients, establish new health care services, and increase capacity to provide health care services.
- \$4 million in recurring funding for Child Development Service Agencies (CDSAs) was replaced with nonrecurring funding of \$4 million in 2007–08 and \$3 million in 2008–09. The CDSAs are expected to increase receipts from Medicaid and other insurance to offset the reductions.
- \$1 million to the Healthy Carolinians program in order to provide funding to local health departments to establish and maintain necessary infrastructure to reduce rates of diabetes, cancer, heart disease, obesity, injury, and infant mortality.
- \$500,000 to the Community-Focused Eliminating Health Disparities Initiative. The money is used for providing grants to local health departments, American Indian tribes, and faith-based or community-based organizations, to improve minority health status. This initiative received \$2 million in funding in both 2005 and 2006.
- \$200,000 to support a mobile dental provider to deliver services to the frail elderly and persons with disabilities in unserved areas.

Other programs, including the Safe-Sleep Awareness Campaign and Prevent Blindness North Carolina also received some nonrecurring funding in 2007–08.

In 2006 the General Assembly appropriated nearly \$10 million to the Division of Public Health to fund the development and implementation of the Health Information System (HIS), which is intended to replace the outdated Health Services Information System (HSIS). The purpose of HIS is to provide an automated means of capturing, monitoring, reporting, and billing services provided by local health departments, children's developmental services agencies, and the state public health laboratory. S.L. 2007-323 allocates an additional \$4.2 million in nonrecurring funds as well as \$775,000 in recurring funds to complete and implement HIS.

The Division of Environmental Health within DENR received nonrecurring funding to continue some of the work that it began in 2006 related to new statewide regulation of private

drinking water wells. First, it received \$300,000 to fund additional incentive grants for counties that are adopting local programs for enforcing the forthcoming statewide well construction standards. The statewide rules are expected to go into effect in July 2008. Second, the General Assembly added \$615,000 to the Emergency Drinking Water Fund, which was initially funded in 2006 with \$300,000 in nonrecurring funds. The fund is to be used to notify private well users of contamination, test private wells for contamination, and pay for alternative drinking water supplies.

### Smoking Regulation

Since 1993, the state has had several laws in place (G.S. Chapter 143, Article 64) that, subject to some exceptions, (1) require state and local government buildings to provide for smoking areas inside the buildings and (2) limit the ability of local governments to regulate smoking in public places (such as restaurants and bars) within their jurisdictions. Over the last several years, the General Assembly has made a few relatively minor changes to these laws. For example, in 2005, a bill passed allowing local governments to prohibit smoking in buildings housing local health departments and departments of social services and on the grounds surrounding those buildings (S.L. 2005-19; S.L. 2005-168). In 2006 smoking was prohibited in all legislative buildings (S.L. 2006-76).

Also in 2006, the U.S. Surgeon General concluded that “there is no risk-free level of exposure to secondhand smoke.”<sup>1</sup> Perhaps in response to the Surgeon General’s report, the General Assembly considered a flurry of bills in 2007 addressing exposure to secondhand smoke and regulation of smoking. The bill that received the most attention was House Bill 259, which would have prohibited smoking in most restaurants, lodging facilities, places of employment, and state government buildings and would have restored the authority of local governments to regulate smoking in public places and places of employment. The proposal failed, but several other less comprehensive bills passed.

S.L. 2007-193 (H 24), as amended by S.L. 2007-484 (S 613, sec. 31.7), is perhaps the most far-reaching of the bills that passed. It establishes a new Article 23 in the public health chapter of the General Statutes (Chapter 130A) to prohibit smoking in state government buildings and allow local governments to regulate smoking in local government buildings. The prohibition on smoking in state government buildings is effective January 1, 2008, and affects (1) buildings owned by the state, (2) buildings leased by the state as lessor (i.e., landlord), and (3) the area of any building leased and occupied by the state as lessee (i.e., tenant). With respect to implementation, the law requires the posting of signs and also directs the Commission for Public Health (formerly the Commission for Health Services; *see* discussion below) to adopt rules. Unlike violations of most other public health laws, a violation of this prohibition is not punishable as a misdemeanor. The Secretary of Health and Human Services and the jurisdiction’s local health director do, however, have the authority to request an injunction for any violations of the law (G.S. 130A-18).

As of January 1, 2008, local governments will have new authority to regulate smoking in the following places:

- Buildings owned by the local government,
- Buildings leased as lessor (i.e., landlord) by the local government,
- Areas of buildings leased as lessee (i.e., tenant) and occupied by the local government.

In addition, local governments retain their existing authority to regulate smoking in other places, including public transportation vehicles, libraries, museums, and buildings housing local health departments and departments of social services and the grounds (up to 50 feet) surrounding those

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1. U.S. Surgeon General, *The Health Consequences of Involuntary Exposure to Tobacco Smoke* 11 (June 27, 2006), available at <http://www.surgeongeneral.gov/library/secondhandsmoke/report/chapter1.pdf> (last visited August 13, 2007).

buildings.<sup>2</sup> Under the new law, the term local government is defined to include “any local political subdivision of this State, any airport authority, or any authority or body created by any ordinance, joint resolution, or rules of any such entity.” Therefore, this authority is available to a wide range of local government bodies including boards of county commissioners, city councils, and boards of health.

While the new prohibition on smoking in state government buildings applies to buildings that are part of the University of North Carolina (UNC) system, a separate bill also passed this session that allows UNC to prohibit smoking in its facilities and on its grounds (S.L. 2007-114, S 862). Many of the provisions of the UNC bill are irrelevant now that smoking is prohibited pursuant to S.L. 2007-193, but a few provisions will likely affect UNC’s operations in a way that is unique as compared to other state government buildings. First, the UNC bill authorizes UNC to prohibit smoking on the “grounds” of its facilities, which includes the area located and controlled by state government within 100 linear feet of a building owned and occupied by the state, owned by the state but leased to a third party, or owned by a third party and leased to state government. Second, the UNC bill allows the UNC and East Carolina University medical facilities to prohibit smoking on their grounds and walkways. Finally, most UNC institutions will be permitted to provide some smoking rooms in residence halls until the 2008–09 academic year.

Elementary and secondary schools are governed by a different set of tobacco-related state laws, found in G.S. Chapter 115C. Specifically, G.S. 115C-407 was enacted in 2003 to allow local boards of education to adopt policies governing the use of tobacco products in schools and at school events. This year, S.L. 2007-236 amends G.S. 115C-407 to require local boards of education to adopt policies prohibiting the use of tobacco at all times:

- in school buildings,
- in school facilities,
- on school campuses,
- in or on any other property owned by the local school administrative unit, and
- at school-sponsored events at other locations when in the presence of students or school personnel.

Local boards must adopt and implement these policies by August 1, 2008.

The final bill related to smoking in public places governs long-term care facilities, including nursing homes, adult care homes, and rest homes. S.L. 2007-459 (H 1294) prohibits smoking in all such facilities and authorizes DHHS to impose fines on facilities that fail to implement and enforce the prohibition. The law also requires licensed home care agencies to prohibit their employees from smoking in patients’ homes.

## **Environmental Health**

In 2006 legislation was enacted that significantly expanded the authority of state and local public health officials to embargo unsafe food and drink (S.L. 2006-80). Previously, the North Carolina Department of Agriculture and Consumer Services retained almost exclusive authority to embargo most types of food or drink in the state. This session, the General Assembly made a few relatively minor changes to the new law. First, it clarified that public health officials’ authority extends to any type of establishment regulated under either the public health statutes in G.S. Chapter 130A or rules issued by the Commission for Public Health. Previously, public health officials’ authority was limited to establishments regulated pursuant to G.S. Chapter 130A. By expanding the authority to encompass establishments regulated by the Commission, the authority of public health officials now reaches those establishments inspected pursuant to statutory authority found in other chapters of the General Statutes, such as local jails (Chapter 153A) and child care facilities (Chapter 110). The law was also amended to expand the list of individuals who have the authority to allow embargoed items to be removed or disposed of. Now, in addition to

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2. Local governments have the authority to regulate smoking in other places as well. For more information regarding the authority of local governments to regulate smoking, *see* <http://www.ncphlaw.unc.edu/SmokingRegulation/index.htm>.

representatives of the Department of Agriculture and Consumer Services, regional environmental health specialists, and the court, local health directors and the Director of the Division of Environmental Health or the director's designee have this authority.

Under current law, local environmental health specialists are required to conduct inspections of housing facilities for migrant agricultural workers in conjunction with the preoccupancy inspection conducted by the North Carolina Department of Labor (NCDOL). [G.S. 95-226(a)]. Typically, an operator requests an inspection from NCDOL and NCDOL notifies the local health department that an inspection has been requested. The health department's role is limited to evaluation of the housing facility's collection, treatment, and disposal of sewage and its water sanitation and quality (15A NCAC 18A .2117). S.L. 2007-548 (S 1466) amends G.S. 95-226(a) to allow an operator who has received a perfect compliance score (100 percent) for two consecutive years on NCDOL preoccupancy inspection to conduct a self-inspection in the third year. Although the NCDOL may not need to conduct its inspection in that third year, local health departments' duties continue. Therefore, any operator who plans to conduct a self-inspection must notify the health department in writing and the health department must conduct its inspection.

### **Child Safety**

In 2006 the National Highway Traffic Safety Administration (NHTSA) denied funding to North Carolina because the state's child restraint law, G.S. 20-137.1, did not require young children to be secured in a child restraint system "when the child's personal needs [were] being attended to." With the passage of S.L. 2007-6 (H 61), the General Assembly amended the law to remove that exemption and, as a result, the state expects to have federal NHTSA funding restored.

### **Communicable Disease**

In 2006 the U.S. Food and Drug Administration approved the first vaccine targeting certain types of human papillomavirus, a sexually transmitted virus that has been found to cause cervical cancer. S.L. 2007-59 (S 260) directs local boards of education and the Department of Public Instruction to ensure that schools provide parents and guardians of children in grades 5 through 12 with information about cervical cancer, cervical dysplasia, human papillomavirus, and the vaccines available to prevent these diseases. In addition, the Department of Administration is required to make this information available to nonpublic schools, including persons engaged in home schooling. The Division of Public Health within DHHS is required to make sample educational materials available for the schools and educators to use as part of this effort. These materials must be made available in the 2007-08 school year.

G.S. 15A-615 authorizes a court to order HIV testing of a defendant who is charged with a sex offense. S.L. 2007-403 (H 118) amends the law to provide that once such an order is issued, the test must be carried out within forty-eight hours. It further specifies the particular test (HIV-RNA Detection Test) that must be used.

S.L. 2007-99 (S 982) clarifies the state law requiring that people attending colleges or universities comply with certain immunization requirements. The amendments to the law clarify the exceptions, which are students (1) attending community colleges or (2) residing off campus and registering for any combination of off-campus course, evening course, weekend course, and up to four traditional day credit hours in on-campus courses.

### **Public Health Authorities**

Under current state law, counties are required to provide public health services within their jurisdictions. Counties may provide these services in various ways, including through a single county health department, a district (multi-county) health department, or a public health authority. S.L. 2007-229 (H 1132) amends the laws governing public health authorities to allow board members to receive per diems in addition to reimbursement for subsistence and travel. The county commissioners who are members of the board (one from each county) are authorized to establish

the per diem, subsistence, and travel amounts. S.L. 2007-229 also amends the state's contracting laws to allow public health authorities, like many other local government units, to enter into installment contracts for the purchase of real or personal property.

### **Medical Examiners**

County medical examiners are typically physicians appointed by the Chief Medical Examiner (CME). In some jurisdictions, a physician may not be available or willing to accept an appointment. S.L. 2007-187 (S 583) amends the statute governing appointment of medical examiners (G.S. 130A-382) to revise the list of individuals eligible to serve as acting medical examiners in these instances. Under the new law, the CME may appoint as acting examiner a physician from another county, a physician assistant, a nurse, a coroner, or a person who has taken a course of training approved by the CME. Acting examiners may not perform autopsies.

S.L. 2007-187 also includes new language in G.S. 130A-381 requiring every county to provide or contract for an appropriate facility for the examination and storage of bodies that are under the CME's jurisdiction.

### **Other Public Health Issues**

- *Name changes:* The DHHS Division of Facility Services was renamed the Division of Health Services Regulation. In addition, the Commission for Health Services, which is an appointed body that promulgates regulations governing public health issues such as communicable disease control and restaurant sanitation, was renamed the Commission for Public Health. [S.L. 2007-182 (H 720)].
- *Private drinking water wells:* In 2006 legislation established a new state permitting system for private drinking water wells. S.L. 2007-495 (S 844) amends the law to provide that if a proposed well is to be situated on property that includes an onsite wastewater system, the application may include either a plat or a site plan. This change harmonizes the well application process with the onsite wastewater application process in G.S. Chapter 130A, Article 11.
- *Tort claims:* When state public health agencies, local environmental health specialists, and others are sued in connection with enforcing the state's public health laws, the claims may be filed under the State Tort Claims Act (G.S. Chapter 143, Article 31A). Until this session, the limit on claims filed under the Act was \$500,000. S.L. 2007-452 (H 22) raised the limit on claims to \$1 million. The new limit applies to torts committed on or after August 2, 2007.
- *Injury prevention:* S.L. 2007-187 enacts new G.S. 130A-224, directing DHHS to establish and administer a statewide injury prevention program. While an injury prevention program already exists within the Division of Public Health, this new law provides some guidance regarding the scope of the program's responsibilities.

## **Health Information**

### **Public Health Disclosures**

For many years, G.S. 130A-5(2) authorized the Secretary of DHHS to obtain access to confidential health information if the Secretary concluded that the information was necessary to investigate a disease or health hazard that presented a clear danger to the public health. Under that law, however, the Secretary was required to obtain a physician's or facility administrator's agreement in many circumstances. S.L. 2007-115 (H 353) removes that authority from G.S. 130A-5 and establishes a new section, G.S. 130A-15 to address this same issue, but in a slightly different way.

New G.S. 130A-15 does not change the general principle of the law—the Secretary may demand access to confidential health records in some situations. It does, however, remove the requirement that the Secretary obtain agreement from a physician or administrator. The new law directs all health care providers and persons in charge of health care facilities and laboratories to permit the Secretary to examine, review, and obtain a copy of confidential information that the Secretary considers necessary to prevent, control, or investigate a disease or health hazard that may present a clear danger to the public health. Any information collected by the Secretary under this authority is now subject to its own confidentiality protections. The information is not a public record and may be released only to public health officials, a court, or law enforcement officials in conjunction with public health activities. The new law retains language from former G.S. 130A-5(2) granting immunity to any person who permits the Secretary to access records pursuant to this law.

G.S. 130A-480 requires the State Health Director to implement a surveillance program that collects certain information from emergency departments in order to detect and investigate public health risks related to potential disease threats or terrorist incidents. The state must comply with significant restrictions on the use and disclosure of information collected pursuant to this program. S.L. 2007-8 (H 123) amends G.S. 130A-480 to allow the State Health Director to share the information with the federal public health agency, the Centers for Disease Control and Prevention (CDC). The state is required to enter into a confidentiality agreement with CDC requiring CDC to protect the confidentiality of the data it receives.

### **Disclosures to Law Enforcement and for Treatment, Payment and Health Care Operations**

S.L. 2007-115 amends G.S. 90-21.20B in an attempt to harmonize state and federal confidentiality law by allowing health care providers to disclose health information in certain situations permitted under federal law. Under the federal privacy regulation promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA Privacy Rule, 45 C.F.R. Parts 160 and 164), regulated health care providers are allowed to disclose protected health information without patient permission in a variety of circumstances. States are, however, allowed to have more protective state laws in place. Interpretation and implementation of North Carolina's confidentiality laws has been uneven and somewhat confusing over the years, primarily because it has not been clear whether the state's physician-patient privilege (G.S. 8-53) was more protective of privacy than the HIPAA Privacy Rule. Many health care providers erred on the side of caution by concluding that the privilege was more protective. Therefore, many providers refused to disclose protected health information without patient permission or a court order in circumstances in which the HIPAA Privacy Rule would have allowed disclosure.

S.L. 2007-115 addresses this ambiguity in part by adding new language to G.S. 90-21.20B authorizing health care providers to ignore the privileges and disclose information for (1) law enforcement purposes as permitted by a specific section of the HIPAA Privacy Rule, 45 C.F.R. 164.512(f) and (2) treatment, payment, and health care operations purposes as permitted by another section of the federal rule, 45 C.F.R. 164.506. Health care providers must still comply with any state law that "specifically" prohibits disclosure of particular information, such as information identifying a person who has or may have a reportable communicable disease, which is protected under G.S. 130A-143. Overall, this change in the law is rather significant in that it opens the door for health care providers to share information with each other and with law enforcement officials as permitted by the HIPAA Privacy Rule without concern regarding potential violations of the privileges recognized in state law.

## High Risk Pool

One of the most significant policy changes affecting safety net providers such as public hospitals and local health departments is the General Assembly's decision to establish a new high risk insurance pool. S.L. 2007-532 (H 265) enacts Part 6 of G.S. Chapter 58, Article 50, to establish the risk pool as a new nonprofit entity. The pool is designed to make health insurance available to and relatively affordable for individuals who are considered "high risks" by other insurers, such as individuals with certain diagnoses, medical conditions, or risk factors. The risk pool will operate much like an insurer but will be subject to unique requirements and restrictions.

The risk pool will be governed by a board of directors, to be appointed by the Governor, the General Assembly, and the Commissioner of Insurance. The risk pool will contract with an insurer to serve as the administrator for the pool. The administrator will carry out functions such as verifying eligibility, collecting premiums, and paying claims. The claims will be paid out of a Special Fund established in new G.S. 58-50-225. The Special Fund will be funded through various sources including:

- premiums,
- appropriations,
- premium taxes charged to other insurers and collected by the state pursuant to new G.S. 105-228.5B,
- a \$1.50 per member per year surcharge on the Teachers' and State Employees' Comprehensive Major Medical Plan, and
- a one-time contribution of \$5 million from the Health and Wellness Trust Fund.

The risk pool must offer at least two types of plans, including at least one preferred provider organization and one health savings account. It may charge premiums but the premiums must not be more than 150 percent to 200 percent of the standard risk rate charged by other insurers offering health insurance to individuals. The risk pool is authorized to provide premium discounts in conjunction with incentive programs and to impose a premium surcharge on smokers. Employers and insurers are not allowed to refer an individual to the pool in order to avoid that person's inclusion in an employer-sponsored group health insurance plan.

The law identifies several categories of individuals who are eligible for risk pool coverage, including a person who is denied insurance coverage for health reasons or is being charged a higher premium than that charged by the risk pool. In addition, the risk pool's board of directors is authorized to identify certain diagnoses that trigger eligibility.

## End-of-Life Decision-Making

North Carolina has several laws related to the issue of consenting to health care at the end of life. These laws were drafted at different times, are found in different chapters of the General Statutes, and address different aspects of the decision-making process. As a result, attorneys and health care providers often struggled with language differences and potential conflicts. This session, the General Assembly considered all of these laws together and made significant revisions. S.L. 2007-502 (H 634) amends and clarifies the laws governing health care agents, advance directives, and informed consent. It also enacts a comprehensive law related to organ and tissue donation.

## Health Care Agents

A person may appoint a health care agent by executing a health care power of attorney. The health care power of attorney may authorize the agent to make certain kinds of health care decisions, including end-of-life decisions, for the individual in the event of incapacity. G.S. Chapter 32A, Article 3 outlines one method for appointing a health care agent and includes a statutory health care power of attorney form. S.L. 2007-502 amends Article 3 by harmonizing the



law with the guardianship laws, making some technical changes, and replacing the statutory power of attorney form with a new form.

The law also now refers to the health care agent's authority to make decisions with respect to *life prolonging measures* rather than *life sustaining procedures*. The new term is defined as "medical procedures or interventions which in the judgment of the attending physician would serve only to postpone artificially the moment of death by sustaining, restoring, or supplanting a vital function, including mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and similar forms of treatment."

S.L. 2007-502 amends G.S. 32A-24, which extends some liability protection to health care providers that rely on health care powers of attorney. The amendments clarify that the liability protections apply to any valid health care power of attorney, not only to those using the statutory form.

### **Advance Directives and Natural Death**

Article 23 of Chapter 90 of the General Statutes recognizes an individual's right to control decisions related to the rendering of medical care at the end of life. It includes a statutory "living will" form that allows individuals to provide advance instructions about their desires related to withholding or discontinuing care at the end of life. S.L. 2007-502 amends Article 23, including the living will form, in part to harmonize it with the revisions to the health care power of attorney changes described above. For example, this law now also refers to *life prolonging measures* and specifically addresses how the directions in a living will interact with the authority granted to a health care agent.

Under the previous version of the law, a physician was permitted to honor a declaration. S.L. 2007-502 now *requires* physicians to follow the instructions in a declaration in many circumstances. A physician may refuse to honor a declaration if doing so would violate either the physician's conscience or a conscience-based policy of the facility, but the physician must cooperate with an attending physician who is willing to honor the declaration. A physician may also refuse to honor a declaration if, after a reasonable inquiry, there are reasonable grounds to question the validity of the declaration. As with health care powers of attorney, providers acting in reliance upon valid living wills are afforded some liability protection, regardless of whether the statutory form is used.

If a person does not have a living will, G.S. 90-322 provides some guidance regarding when an attending physician may decide to withhold or discontinue certain care. S.L. 2007-502 amends that law to harmonize many of the provisions with the other changes to the end-of-life laws. In general, a physician will have some discretion to withhold or discontinue life-prolonging measures if the person is permanently incapacitated and either (1) has an incurable or irreversible condition that will result in death within a relatively short period of time or (2) is unconscious and, to a high degree of medical certainty, will never regain consciousness. Prior to withholding or discontinuing life-prolonging measures, the physician must attempt to obtain agreement from one of several identified people, including a guardian, a health care agent, a spouse, parents, children, siblings, and others.

Chapter 90 of the General Statutes also allows physicians to issue "Do Not Resuscitate" (DNR) orders with the consent of the patient or the patient's representative. S.L. 2007-502 amends G.S. 90-21.17 to make the language compatible with the other end-of-life statutes and also to authorize physicians to issue a new type of order, a Medical Order for Scope of Treatment (MOST). While the term is not defined, it appears that a MOST is an order that identifies agreed-upon treatment beyond resuscitation, such as the use of antibiotics and the availability of artificial nutrition and hydration. The law directs DHHS to develop a MOST form and specifies that the form must explain that a MOST may suspend conflicting directions in other advance directives, a health care power of attorney, or another legally recognized instrument.

## **Informed Consent**

S.L. 2007-502 also takes steps to harmonize the state law governing informed consent with all of the changes made to the end-of-life statutes. The previous version of the informed consent law, G.S. 90-21.13, included a list of persons who were authorized to consent to care on behalf of another person. The revisions provide a more comprehensive and detailed list of authorized persons. This new list mirrors the list of individuals authorized to agree to a physician's decision to withhold or discontinue life-prolonging measures pursuant to G.S. 90-322. If none of these individuals is available to provide informed consent, the physician may provide care to the patient if another physician agrees or if the delay in obtaining agreement from another physician would endanger the life or seriously worsen the condition of the patient. Note that this change in the law applies to informed consent in all health care situations, not just end-of-life situations.

## **Organ and Tissue Donation**

In 2006 the National Conference of Commissioners on Uniform State Laws (Conference) adopted a Revised Uniform Anatomical Gift Act. S.L. 2007-538 (H 1372) incorporated the model into North Carolina Law by adding a new Part 3A to G.S. Chapter 130A. According to the Conference, the act is "designed to encourage the making of anatomical gifts" and also "honor and respect the autonomy interest of individuals to make or not to make an anatomical gift of their body or parts."<sup>3</sup>

The law provides several methods for allowing a person to make a gift before death, such as including the gift in a will, registering with a donor registry, authorizing a symbol to appear on a driver's license, and, in the event of a terminal illness or injury, by communicating the donor's wish to at least two adults, at least one of whom is a disinterested witness. The law also provides several options for refusing to make a gift and also amending or revoking a gift.

Separate provisions of the law address anatomical gifts from decedents. The law outlines who has the authority to make a gift of a decedent's body or body part and the process that must be followed for making such a gift. It also lists persons and entities who may receive such gifts, including hospitals, medical schools, organ procurement organizations, eye and tissue banks, and even specific individuals. If the donor does not specifically designate an intended recipient of the gift, the law specifies who is entitled to receive it.

S.L. 2007-538 also revises G.S. 20-43.2, the law requiring the Department of Transportation Division of Motor Vehicles to establish and maintain the state's organ donor registry. The amendments to the law require that organ procurement organizations and eye banks must be able to have access to the registry at all times. It also requires that personally identifiable information maintained by the registry be protected from unauthorized disclosure.

## **Health Care Professions**

### **Medicine**

S.L. 2007-346 (H 818) makes significant changes to the laws governing the practice of medicine found in Chapter 90, Article 1 of the General Statutes. First and foremost, it establishes a new definition of the practice of medicine in G.S. 90A-1A. The new definition encompasses the prescription and administration of medicine, the treatment of disease, illness, pain, or defect (including the management of pregnancy and birth), and the performance of surgery. The law still provides for a long list of exceptions, including a new temporary exception for physicians and surgeons providing health care services to a sports team visiting the state.

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3. National Conference of Commissioners on Uniform State Laws, *Prefatory Note to the Revised Uniform Anatomical Gift Act* (Oct. 13, 2006), available at <http://www.anatomicalgiftact.org/DesktopDefault.aspx?tabindex=1&tabid=63> (last visited Aug. 30, 2007).

S.L. 2007-346 completely overhauls the process for appointing members of the North Carolina Medical Board. Previously, the North Carolina Medical Society played a major role in the selection of seven of the twelve members of the board. This change in the law may have been in response to a lawsuit that was filed in early 2007 alleging that the state improperly delegated the authority to make appointments to a single private entity, the Medical Society.<sup>4</sup> Beginning in January 2008, an independent review panel will evaluate the applicants for most of the physician, physician assistant, and nurse practitioner positions on the board. The nine-member review panel will include four representatives from the Medical Society and one representative each from five other professional societies. The review panel will make recommendations to the Governor, who will then make appointments based upon those recommendations.

S.L. 2007-346 adds several new sections to G.S. Chapter 90, Article 1 regarding licensure requirements for physicians, graduates of foreign medical schools, physician assistants, and anesthesiologist assistants (*see* discussion of anesthesiologist assistants below). The law now requires that the public have access to much of a licensee's information, such as educational background and training, contact information, criminal history, final disciplinary actions that result in the suspension or revocation of privileges, and certain malpractice related information. It also empowers the N.C. Medical Board to develop and implement methods for identifying physicians who are not performing up to standards (termed "dyscompetent").

One of the Medical Board's key functions is disciplining licensees. Under current law, hearings may be conducted by hearing committees comprised of three or more board members. The act amends the hearing committee requirements to provide that the nonmembers may also be appointed as hearing officers. S.L. 2007-346 also amends G.S. 90-14.6, which governs admissibility of evidence in a disciplinary proceeding, to provide that witnesses called from other states must not only have training and experience in the same field of practice as the individual under investigation, but must also be familiar with the standard of care among members of the same profession in North Carolina. If the board receives a complaint regarding the care of a patient, it is now required to report to the complainant at the conclusion of its inquiry and explain its disposition of the inquiry. This may involve sharing a copy of the licensee's written response to the complaint.

Beginning in October 2007, the Medical Board will have the authority to regulate the retention and disposition of medical records held by individuals licensed by the board. This authority also extends to records maintained by individuals who are not licensed by the board but only if the individual is not licensed under other state law. The board does not have the authority to regulate medical records maintained in the normal course of business by a licensed health care institution. The board will likely exercise its rulemaking authority to adopt regulations governing retention and disposition.

A separate bill, S.L. 2007-418 (H 1381), also makes several amendments to G.S. Chapter 90, Article 1. The act authorizes the North Carolina Medical Board to issue four new categories of licenses. The first is a *resident's training license*, which may be granted to an otherwise unlicensed physician while he or she is participating in a graduate medical education training program (G.S. 90-12.01). The second new category is a *military limited volunteer license*, which is available to applicants who are licensed and in good standing in another state and are authorized to treat military personnel or veterans (G.S. 90-12.1A). This category of licensee is allowed to practice medicine or surgery only at clinics that specialize in the treatment of indigent patients. Under the third category, the board is authorized to issue a *special purpose license* to any applicant who holds a full and unrestricted license in another jurisdiction and does not have any disciplinary action pending against him or her (G.S. 90-12.2A). The statute does not set out any further restrictions on a person holding a special purpose license, but it authorizes the board to adopt rules to implement the law. The final new category of license is a *medical school faculty license*. The physician must hold a full-time appointment at one of the state's four medical schools

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4. *See* Sarah Ovaska, *Doctor takes on Medical Society; suit says power shields wrongdoers*, Raleigh News & Observer (Mar. 1, 2007). The lawsuit was dropped after the legislation was enacted. *Plaintiffs drop medical lawsuit: Board, society had been targets*, Raleigh News & Observer (Aug. 22, 2007).

and not be subject to a disciplinary order or other action in another state or jurisdiction. A person holding a medical school faculty license may practice medicine or surgery only within the confines of the medical school or an affiliate of the medical school.

### **Nursing**

The North Carolina Board of Nursing is charged with administering the Nursing Practice Act in Chapter 90, Article 9A of the General Statutes. S.L. 2007-148 (S 376) grants new powers to the board, including the power to acquire property and designate one or more of its employees to serve papers or subpoenas issued by the board. It also allows the board to designate committees empowered to conduct disciplinary hearings and submit recommended decisions to the full board.

### **Dentistry and Dental Hygiene**

S.L. 2007-346 (H 818) amends the laws governing the practice of dentistry to allow a dentist who is not licensed in North Carolina to provide dental services on a voluntary (i.e., uncompensated) basis. New G.S. 90-37.2 allows the North Carolina State Board of Dental Examiners to issue these temporary volunteer permits to any dentist who graduated from a dental school approved by the North Carolina State Board of Dental Examiners, passed an exam substantially similar to North Carolina's licensing exam, and holds an unrestricted license issued by another state. The temporarily permitted dentist must practice at certain types of facilities and under the supervision or direction of a dentist licensed in North Carolina. The temporary permits may be valid for up to one year but may be renewed indefinitely.

Another new law, S.L. 2007-124 (S 1337), amends the Dental Hygiene Act in G.S. Chapter 90, Article 16 to authorize dental hygienists to perform dental hygiene functions, such as cleaning teeth and taking x-rays, outside the direct supervision of a dentist. This new authority applies only if (a) the hygienist meets certain requirements related to experience, training and continuing education and (b) the dentist examined and evaluated the patient within the previous 120 days, provided a written treatment plan for the patient, and directed the hygienist to perform the functions. In addition, the new authority extends only to services provided in specific types of settings, including long-term care facilities, rural and community clinics, and certain facilities serving dental access shortage areas. Dentists who order hygienists to perform such unsupervised work must submit annual reports to the North Carolina State Board of Dental Examiners.

### **Social Work**

Licensure of social workers is addressed in G.S. Chapter 90B and is governed by the North Carolina Social Work Certification and Licensure Board. Under current law, the board is authorized to issue a two-year provisional social work license in some circumstances. S.L. 2007-379 (S 1090) amends G.S. 90B-7(f) to limit the term of the provisional license. Under the new law, a provisional licensee must pass the board's qualifying clinical examination within two years and complete all requirements for licensure within six years. The licensing law was also amended to remove two categories of individuals who were exempt from the requirements applicable to licensed clinical social workers. The exemptions applied to certain individuals who were practicing social work before 1992 and to employees engaged as clinical social workers exclusively for hospitals, adult care homes, nursing homes and facilities licensed under G.S. Chapter 122C (mental illness, developmental disabilities, and substance abuse facilities).

S.L. 2007-379 also amends the law related to record keeping. Under revised G.S. 90B-6(i), any agency employing a licensed social worker must maintain records for a minimum of three years from the date the social worker terminated service to the client and the client's record is closed.

## Other Professions

- *Anesthesiology assistants*: S.L. 2007-146 (H 1492) authorizes the North Carolina Medical Board to license anesthesiologist assistants and imposes limitations on the services that a licensed assistant may provide. While S.L. 2007-146 initially placed the licensure criteria in G.S. 90-11, section 9.1 of S.L. 2007-346 (H 818) transferred the criteria to a new G.S. 90-9.4.
- *Chiropractic*: G.S. Chapter 90, Article 8 governs the licensure of chiropractic physicians. S.L. 2007-525 (S 864) amends Article 8 to require all applicants to consent to criminal background checks and directs the North Carolina Department of Justice to facilitate requests for such requests. S.L. 2007-525 also adds new G.S. 90-154.4, which prohibits chiropractors from offering enticements to patients (i.e., incentives to enter treatment) in certain situations.
- *Laser hair practitioners*: The practice of hair removal or reduction through the use of laser technology is now subject to oversight by the Board of Electrolysis Examiners. S.L. 2007-489 (H 726) amends the Electrolysis Practice Act in G.S. Chapter 88A to require licensure for laser hair practitioners and laser hair practitioner instructors. It also increases the penalty for practicing electrolysis or laser hair removal without a license from a Class 2 misdemeanor to a Class I felony.
- *Respiratory care*: S.L. 2007-418 (H 1381) authorizes the respiratory care board to raise application, license and other related fees.
- *Recreational therapy*: S.L. 2007-389 (S 768) amends the North Carolina Recreational Therapy Licensure Act to exempt from licensure requirements any person employed in recreational therapy by DHHS as long as the therapy services are provided solely under the direction and control of DHHS. The exemption expires in June 2010.
- *Psychologists*: S.L. 2007-468 (H 1488) is addressed in Chapter 19, “Mental Health.”

## Health Care Facilities

### Hospitals

The state now has expanded statutory authority to discipline licensed hospitals. S.L. 2007-444 (H 772) amends G.S. 131E-78 to provide DHHS with new authority to suspend the admission of new patients to a hospital or suspend specific services of a hospital when the hospital has failed to comply with state law and, as a result, conditions exist that are dangerous to the health or safety of the patients. As with any adverse action on its license, a hospital has the right to contest the action in accordance with the Administrative Procedure Act (G.S. Chapter 150B).

State officials also have new authority to relax hospitals’ regulatory burdens in certain emergency situations. S.L. 2007-444 enacts new G.S. 131E-84, authorizing the DHHS Division of Health Service Regulation to temporarily waive any applicable rules for a hospital that is providing temporary shelter and temporary services requested by an emergency management agency. The new statute also authorizes DHHS to “preapprove” the waiver of rules such that the emergency management agency may automatically assume a waiver exists if a disaster or emergency has been declared in accordance with state law.

The 2005 General Assembly considered a bill (S 391) that would have required hospitals to report to the state certain information about nosocomial infections (infections acquired in the hospital). Under the proposed legislation, the data would have been available to the public. While that proposal was not enacted, the legislature did pass a law this year that lays the foundation for introducing such a reporting requirement in the future. S.L. 2007-480 (H 1738) establishes the Advisory Commission on Hospital Infection Control and Disclosure (Advisory Commission). The Advisory Commission is charged with preparing state agencies, hospitals and the public for a mandatory reporting law, which the General Assembly intends to have in place by 2010. S.L. 2007-480 directs the Advisory Commission to submit to the General Assembly by January

2009 recommendations and draft legislation related to public disclosure of the data. The act includes detailed guidance regarding the process needed for reviewing, adjusting, and validating any data disseminated to the public.

### **Other Facilities**

Under current law, a person or organization interested in providing certain types of health care services or opening certain types of health care facilities must apply to the state for a “certificate of need” or CON. S.L. 2007-473 (H 1685) directs DHHS to establish an expedited review process that would apply in limited circumstances. It would be available only when a person or organization who holds a current CON for an adult care home or a nursing home seeks to relocate from one facility or campus to another facility or campus within the same county. The expedited process would be available only if the relocation will not result in an increase in the total number of beds in the facility.

Other legislation related to adult care homes and home care agencies is addressed in Chapter 25, “Senior Citizens.”

### **Health Care Personnel Registry**

DHHS currently maintains a health care personnel registry pursuant to G.S. 131E-256. The registry is designed to track individuals who are working in a health care facility and have been found by DHHS to have mistreated a resident of the facility, misappropriated property at the facility, or diverted drugs. S.L. 2007-544 (S 56) makes three significant changes to the registry law. First, it amends the definition of *health care personnel* to include all individuals who are not licensed but who have direct access to a health care facility’s residents or clients or to their property in the course of working in the facility. Second, it expands the list of health care facilities covered to include several additional types of providers, including certain unlicensed community-based providers of services for the mentally ill, the developmentally disabled, and substance abusers. Third, it expands the list of activities that must be registered to include diversion of drugs belonging to a patient or client of the health care facility and fraud against a patient or client.

### **Miscellaneous**

- *Medical malpractice*: Many medical malpractice claims allege negligence and seek damages for personal injury or wrongful death. S.L. 2007-541 (H 1671) establishes a statutory framework governing voluntary arbitration of such claims. This new law is discussed in Chapter 6, “Courts and Civil Procedure.”
- *Pharmacy records*: S.L. 2007-248 (H 1369) makes two significant changes to the laws governing pharmacy records. It amends G.S. 90-85.26(a) and G.S. 90-412(a) to allow certain records to be retained in electronic, rather than paper, form. It also amends G.S. 90-106(h) by eliminating the requirement that a pharmacist write his or her own signature on the face of any prescription order for a controlled substance.
- *Impaired driving*: When a law enforcement officer requests a blood or urine sample in impaired driving situations, G.S. 20-139.1 requires certain health care personnel to draw the blood or collect the urine regardless of whether the suspect agrees. S.L. 2007-115 amends G.S. 20-139.1 to allow health care providers to refuse to collect urine or draw blood if it reasonably appears that the procedure cannot be performed without endangering the provider. This amendment is discussed in more detail in Chapter 21, “Motor Vehicles.”

- *Respite care*: Respite care is the provision of temporary relief to family members and others who care for the elderly or for individuals with disabilities, chronic or terminal illness, or dementia. S.L. 2007-39 (H 424) directs DHHS to study the availability and delivery of respite care and make recommendations for state action on issues such as the need for more respite care providers, whether and how such providers should be licensed, and available funding for respite care.
- *Funeral establishments*: S.L. 2007-297 (H 1400) prohibits the taking of human tissue at funeral establishments, subject to limited exceptions for embalmers, medical examiners, and autopsy technicians.

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