

# NORTH CAROLINA MEDICAL BOARD

## Expert Reviewer Manual



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The purpose of this manual is to describe the North Carolina Medical Board’s (“Board”) processes, guidelines, and expectations for medical record review. The Board greatly appreciates your willingness to serve as a case reviewer. You are an important part of the Board’s mission to protect the public.

### **The Role of the Board in Physician Discipline.<sup>1</sup>**

The Board is responsible for investigating and, when appropriate, taking regulatory actions against physicians for violations of the Medical Practice Act (North Carolina General Statutes; Chapter 90). The Board fulfills its statutory responsibility by investigating complaints, reports of malpractice payments, changes in staff privileges, actions by other state medical boards, and other reports that come to its attention. Complaints and other types of investigations, along with supporting material, including the physician’s response to the allegations and medical records, are first reviewed by Board staff to determine if further investigation or expert review is warranted. Only a relatively small portion of cases (complaints, malpractice, and other investigations) received by the Board are sent for expert review, and physicians are given the opportunity to respond to a Board inquiry and provide answers to the allegations prior to sending a case for expert review. For the purposes of this manual an expert reviewer or witness is a physician who, based on their education, training, skill, and experience, has sufficient knowledge such that Board members can rely upon the witness’s opinion about the patient care under review. The Board submits approximately 150 cases per year for such reviews.

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#### **Key Point**

*Your review is an important step in the investigative process and must be completed before the Board can make a final disposition. The timely submission of your report is vital to resolution of the case.*

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The Board uses expert reviewers in quality of care investigations to determine whether the accepted standard of care has been met. Physician reviewers for the Board should have a full and unrestricted North Carolina license, current ABMS or AOA board certification, no recent Board actions or investigations, and have been engaged in clinical practice in the same area of practice as the physician being investigated for the two years prior to reviewing the case. Reviewers must be familiar with the standards of care applicable for the date of treatment they are reviewing. It is the reviewer’s responsibility to assist the Board in determining if, and to what extent, a physician has breached the applicable standards of care. The reviewer is provided information regarding relevant details of the investigation, the physician’s explanation of their care or involvement in the case, pertinent medical records, and other documents which may include diagnostic studies, x-rays, consultative medical records from other physicians, billing records, the physician’s response, and a worksheet, to allow for determination of whether the physician provided patient care that was within the standard of care. If you believe additional information is needed to render an opinion do not hesitate to ask us and we will endeavor to obtain it.

You will be asked to provide your impartial unbiased opinion as to whether the care was within the standard. To assist you in the process of establishing an adequate foundation for your conclusions you may refer to, and include in your written report, reference materials such as peer-reviewed journal articles, recognized specialty society guidelines, textbook articles, and other relevant medical literature. Your role is to review the materials provided and determine if there was a departure from the accepted standard of care. It is important that you review the case material and medical records with sufficient care and diligence to be able to confidently defend your opinions and conclusions.

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<sup>1</sup> Although the Board may investigate any practitioner regulated by the Board, for the purposes of this manual the term “physician” will be used to refer to all licensees regulated by the Board. The Board currently regulates physicians, physician and anesthesiology assistants, perfusionists, nurse practitioners (jointly with the NC Board of Nursing), and clinical pharmacist practitioners (jointly with the NC Board of Pharmacy).

You should recognize that submitting a case for review does not necessarily imply there were departures from the standard of care, and your conclusions and opinions should be based on your knowledge of the accepted standard of care, using your education, training, experience, and knowledge. It is important to recognize that, as a reviewer for the Board you are neither an advocate for the Board nor an advocate for the physician.

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**Key Point**

*Submitting a case for review does not necessarily imply there were departures from the standard of care.*

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**Standards for Board Regulatory Action**

The Board has authority to take action against North Carolina physicians regardless of their physical practice location for violations of the laws and rules governing the practice of medicine in North Carolina. This authority extends to out of state North Carolina licensed telemedicine physicians providing care to North Carolina patients. This includes the power to place on probation with or without conditions, impose limitations and conditions on, publicly reprimand, assess monetary redress, issue public letters of concern, mandate free medical services, require satisfactory completion of treatment programs or remedial or educational training, fine, deny, annul, suspend, or revoke a license, or other authority to practice medicine.

Your determination of whether the treatment under review is within the standard of care will help the Board determine what action to take. The Board may take action for quality of care type cases for any of the following reasons:

- Unprofessional conduct including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or outside of North Carolina.
- Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients or failing to maintain acceptable standards of one or more areas of professional physician practice. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. In order to annul, suspend, deny, or revoke a license of an accused person, the Board shall find by the greater weight of the evidence that the care provided was not in accordance with the standards of practice for the procedures or treatments administered.

If you are reviewing care provided by a resident (physician in training), physician or anesthesiology assistant, nurse practitioner, or CPP you should know that failure to meet the acceptable and prevailing standard of care when delegating or supervising medical care provided by others may also be grounds for Board action against the supervising physician.

If you are reviewing a case that involves alternative or integrative medicine you should know the Board may not revoke or discipline a physician in any manner, solely because the physician's practice uses a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practice unless, by competent evidence, the Board can establish the treatment has a safety risk greater than the prevailing treatment or that the treatment is generally not effective.

A finding of substandard care does not automatically result in disciplinary action by the Board. Absent repeated or grossly negligent acts the Board ordinarily will first attempt remediation such as requiring topic specific CME or may pursue other confidential action against the physician under review.

## Reviewer Assignment

Board staff identify potential reviewers from a list maintained by the Board and contacts them to determine if they are available, have sufficient expertise or experience to review the case, and if any conflict of interest with the physician involved exists. Because medicine is an ever-changing profession, reviewers must have experience with the treatment or procedure involved during the time frame of the issues in question. If you find during your review that you do not have direct experience with the medical issues, diagnoses, or procedures you have been asked to review please contact the staff person at the Board who sent you the records for review for further instructions. Information provided to the reviewer may include the patient complaint or details of the malpractice case, relevant investigative information and material, patient medical records including x-rays and other diagnostic studies if appropriate, and a worksheet to guide the reviewer in the process. A cover letter will address any specific concerns the reviewer should consider and address in the report. If, after accepting the case for review, you find your education, experience, or background is not suited to review the case, or other commitments preclude you from meeting the completion deadline, or for any reason you need to be excused from the case (for example to avoid potential conflict of interest) immediately notify Board staff.

## Timely Review Completion and Report Submission Is Essential

Because cases referred for review are potentially serious, the Board requests completed review reports be returned within 30 days. The Board recognizes review is a time-consuming process and often reviewers are busy with their own practice. However, because a physician providing substandard care poses a potential threat to the public, the Board requests that reviews be completed promptly.

## Confidentiality

Reviewers are expected to maintain the confidentiality of all information and materials sent to them by the Board as part of the review process. Reviewers are not permitted to divulge any information about the case with anyone other than Board staff.<sup>2</sup> Reviewers must maintain the confidentiality of the identity of all persons involved, all medical records and any other information included in the review. Reviewers should not contact any Board member or any of the patients, physicians or other persons involved or under review. If additional information is needed from any of these sources, the reviewer should address questions to Board staff. Reviewers are encouraged to perform any literature research necessary to assist them in determining the applicable standard(s) of care but should not make any effort to investigate or obtain additional facts of the case further. Posting or discussion of any aspect of the case on social media, even if anonymous or disguised, is not permitted.

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### Key Point

*Reviewers must scrupulously maintain the confidentiality of persons, medical records, and all other information related to case review.*

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## Conflicts of Interest

Objectivity is vital to the integrity of the review process. It is incumbent on reviewers to conduct their reviews in an impartial manner. To ensure impartiality and the integrity of the review process, reviewers should not participate in any review in which there is the potential for conflict of interest. If you have personal knowledge of the physician or other individuals involved, you have current or former business relationships, or if you feel you cannot be objective for any reason please do not accept the case. Reviewers should not accept cases under the following circumstances.

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### Key Point

*Reviewers should not participate in any review where there is the potential for conflict of interest.*

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<sup>2</sup> Reviewers may, on occasion, consult with professional colleagues regarding aspects of a case they are reviewing; but must maintain the strict confidentiality of the identity of the physicians and patients under review.

- The reviewer has/had a close personal, professional, or business relationship with the physician or the physician’s immediate family which would bias, or appear to bias, the reviewer’s judgement.
- An arrangement exists in which the reviewer routinely refers patients or receives referrals from the physician under review.
- The reviewer has treated any of the patients whose care is under review.
- The reviewer’s practice competes with that of the physician under review.
- The reviewer has knowledge of, or information about, the physician other than that related to the current investigation, which could bias or appear to bias the reviewer’s judgment about the case under review.
- The reviewer has previously formed an opinion about the practice, skills, or character of the physician under review which might bias (positively or negatively) the reviewer’s assessment of the present case.
- The reviewer practices in the same hospital, hospital system, locality, or practice setting as the physician under review. If this is the case the prospective reviewer should contact Board staff to determine whether this presents a conflict of interest.
- The reviewer has a close professional or personal relationship with a sitting Board member.

Consider these issues carefully. Failure to disclose a conflict of interest has serious consequences. If a reviewer has a conflict of interest but accepts review of the case, the Board may be unable to continue investigation. If a conflict is not discovered until after Board action is taken, the Board’s decision may be overturned on judicial review. Reviewers should not accept a case for review if any bias, positive or negative, would affect or would have the appearance of affecting their review. Reviewers who are unsure whether a possible conflict of interest exists should contact a Board attorney to determine the propriety of a reviewer’s participation in the case.

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**Key Point**  
*Failure to disclose a conflict of interest has serious consequences.*

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### **Civil Immunity**

Reviewers for the Board are provided statutory immunity from civil liability as noted in NCGS §90-14 (f): “A person, partnership, firm, corporation, association, authority, or other entity acting in good faith without fraud or malice shall be immune from civil liability for (i) reporting, investigating, or providing an expert medical opinion to the Board regarding the acts or omissions of a licensee or applicant that violate the provisions of NCGS §90-14 (a) or any other provision of law relating to the fitness of a licensee or applicant to practice medicine and (ii) initiating or conducting proceedings against a licensee or applicant if a complaint is made or action is taken in good faith without fraud or malice. A person shall not be held liable in any civil proceeding for testifying before the Board in good faith and without fraud or malice in any proceeding involving a violation of NCGS §90-14 (a) or any other law relating to the fitness of an applicant or licensee to practice medicine, or for making a recommendation to the Board in the nature of peer review, in good faith and without fraud and malice”.

Your immunity from civil liability does not apply if you conduct the review with “fraud or malice”. Malice in this context means intentionally or recklessly committing a wrongful act in the course of your work for the Board. If you act in good faith and follow the guidelines put forward in this manual, especially those regarding confidentiality and conflicts of interest, you will be provided immunity. If you disregard these rules intentionally or are careless about following them, you may lose it. Discussing a case with any person outside the Board review process is an example of action which could result in the loss of immunity for reviewers and the denial of the confidentiality protection and due process rights provided by law to the physician under review.

## Standard of Care

Although a case submitted for expert review by the Medical Board may originate as a malpractice lawsuit it is important to understand that the law for evaluating the care in a malpractice lawsuit is different from that when you evaluate a case for the Medical Board. Specifically, the Medical Board asks that you assess whether the care is within or below the statewide standard of care for North Carolina. Do not evaluate the case on the basis of what you may consider your personal standard of care, but rather on what a reasonably prudent physician in North Carolina would do under the same or similar circumstances. In this regard it is permissible to consider or comment on the circumstances under which the care was provided. For example, care provided at a small rural hospital with limited resources might not be the same as that available at a large academic facility. If you are using national or published guidelines in your opinion, please provide reference to the source you have used.

You may find the physician's care to have been within the standard of care for North Carolina physicians. If that is the case do not hesitate to say so. However, if you believe the care was below standard you should focus on how, why, and to what degree the care provided deviated from the standard of care regardless of whether there was injury to the patient. Explain why the care provided, or not provided, to the patient was a departure from the standard of care in North Carolina. Do not simply state your opinion that the physician's care was a departure from the standard; explain why. Be specific and avoid ambiguous terms. You may also conclude that a case involves several issues or may have multiple areas to be considered. Clearly state your conclusions for each issue involved. Because the standard of practice or care is constantly evolving it is important to assess the care in terms of the standard of practice at the time the care was provided.

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### **Key Point**

*Patient injury is not essential. The focus of your review should be on whether there was a departure from accepted standard of practice not whether the patient was injured.*

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## What to Write in Your Report

You will be provided a worksheet for your case review. A sample worksheet is included at the end of this manual. Although not mandatory use of the worksheet is strongly encouraged. At a minimum your written report should include:

- Name of the physician under review, patient name, your name, and the case number (which will be provided by the Board).
- A summary or brief narrative description of each patient reviewed, including the symptoms, diagnosis, and course of treatment. Although you may develop a synopsis or outline of the medical record for help in preparing your report, a simple restatement of the details of the medical record is generally not helpful to the Board and should not be included in your final report unless you feel it is necessary to justify your opinion and conclusions.
  - It is not unusual to find conflicting, or even contradicting, information about aspects of a case from various sources of information; for example, conflicts between an operative report and a physician's later statement to the Board about their patient care. On occasion the Board may request that the physician appear before the Board to explain and resolve these discrepancies. You are encouraged to point out or mention in your report any inconsistencies or confusing information you have identified during your medical record and case review.
- A statement of whether you can form an opinion regarding the care rendered, including diagnosis, treatment, medical record keeping, and overall care; and if it departed from or failed to conform to the standards of acceptable and prevailing medical practice in North Carolina.
- If it is not possible to determine whether the standard of care was met, based on the information

provided for review, you should indicate this. If you believe additional information or material might allow you to form an opinion you should contact Board staff to determine if this additional information is available. You should not attempt to obtain any additional information about the case on your own.

- A summary of your opinion on how the standard of care applies in each case. Include your reasoning and rationale stating whether your opinion was based on education and experience, practice guidelines, published references, or national standards. The Board expects the reviewer to be familiar with relevant published guidelines and, if used, to cite those guidelines. Providing citations or reference to specific source materials, e.g., books, professional journals, published practice guidelines will assist the Board in reviewing the report, and will support your review should the case proceed to a formal hearing.
- There may be specific concerns outlined in the materials provided by the Board and you are asked to provide a response and opinion regarding these additional specific concerns.
- On occasion the Board may be interested in your review of a specific limited period of time in a patient's care. For example, the Board may want the care and prescribing reviewed for the time following a physician's recent remedial CME. You should receive specific instructions in this regard. The documents provided to you may include the patient's entire medical record however under these circumstances you may limit your review to the time period specified. If you have any questions in this regard do not hesitate to contact the Board's expert review coordinator for additional information.
- Your conclusions regarding the standard of care for diagnosis, medical records, treatment, and overall care should be based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided. You are asked to indicate if the physician departed from or failed to conform to the standards of acceptable and prevailing medical practice in North Carolina. Additionally, your conclusions regarding the standard of care should generally correspond with your narrative summary of case. For example, if you identify deficiencies in the care of the patient, but then conclude the care was, nevertheless within an acceptable standard you should provide some brief explanation of this seeming discrepancy. It is not enough that you identify deficiencies in the medical record or patient care, your specific concerns should be written in a logical, relevant, and coherent manner.
- You may also include additional comments or statements of other concerns including, if relevant, a discussion of extenuating factors or issues favorable to the physician, even if they are not the focus of the case. There also may be ethical or professionalism lapses you feel contribute to the issues of the case under review; these concerns should also be included in your report. Any issues you believe require further investigation by the Board or possibly by another reviewer should also be mentioned.
- Cultural competency. Not all cultural competency issues relate to foreign languages or cultures. Cultural competency encompasses gender, and gender orientation, socioeconomic status, faith, profession, disability, and age, as well as race and ethnicity. Expert reviewers for the Board should be sensitive to, and be respectful of, all the diverse patient communities within North Carolina. The Board will not tolerate culturally biased comments, observations, or statements in reviews submitted to the Board.
- Your opinions and observations about the case should be based on recognized objective standards of care. Poor or substandard care should be identified and discussed; however, disparaging, inflammatory, or frivolous remarks and ad hominem attacks must be avoided.

The Board will rely, to a substantial extent, on your report to determine what action, if any, to take. Based on further deliberations and a consideration of all information available, including your report, the Board



may choose to take no action, attempt remediation, or take various types of formal action ranging from a public letter of concern to license suspension. If charges are not pursued, the Board may use your report to advise the physician under review of concerns regarding the physician's practice, and changes the Board expects the physician to make to meet the standard of care. It is therefore critical that your report be thorough, detailed, and supported by a discussion of the case materials you have reviewed.

### **Process Following Board Receipt of Your Review**

Once your completed review is returned to the Board, it will be reviewed by Board staff for a determination of what route it should take to final Board consideration. Ultimately the Board determines how to proceed with the case. The Board has considerable discretion and may take one of the following actions:

- **Accept as information.** The Board may close the case without further action when it determines, based on all factors, including your review report, that no breach of the applicable standards of care occurred or that any violations found were not substantial, willful, or repeated. Even if review of the case concludes the physician breached the applicable standards of care the Board has discretion in deciding whether, and how, to proceed.
- **Private Action.** The Board frequently uses Interim or Private Letters of Concern (ILOC/PLOC) in cases where the Board has concerns about the care provided by the physician, but the concerns do not rise to the level of formal or public action. An ILOC/PLOC is a confidential communication between the Board and the physician which may request the physician obtain topic specific CME or seek other, non-disciplinary remediation. The Board may rely on the information from your review report to advise the physician of specific concerns and recommend corrective action. The informal action becomes part of the physician's permanent internal Board record. Although the Board may share this information with other state medical boards and other regulatory agencies these letters are not available to the public.
- **Formal Charges.** In the event the review report establishes grounds for initiating formal action and the Board elects to proceed, the Board will file public charges against the physician. It is possible, depending on circumstances, that a negotiated settlement may be reached prior to filing formal charges. The facts establishing any violation of the applicable standards of care will be included in legal documents when the physician is charged.

### **Reviewer's Involvement in the Hearing Process**

Part of being a Board medical expert means agreeing in advance to be available to testify at a deposition and/or a hearing if necessary. Less than 5% of all cases sent for review result in a Board medical expert testifying at a deposition and/or a hearing. While this rarely happens, the Board relies, to a substantial extent, on your expert medical opinion and reports to determine whether to resolve a case with no action, attempt remediation, or pursue formal action. If the Board takes no action or attempts private resolution or remediation, your identity and report will generally not be shared with the physician whose care you reviewed.

The majority of cases where the Board decides to pursue formal action against a physician are resolved before public charges are actually filed. In these cases, your expert report will likely be shared with the physician whose care you reviewed during the settlement negotiation process. It is unlikely that you will be contacted further about the case.

If formal public charges are filed and a hearing is scheduled, then your report will likely be shared with the physician whose care you reviewed, and you may be asked to testify at a deposition and/or a hearing. If that happens you will be contacted in advance by a Board attorney who will work with you to schedule mutually

convenient dates and times to discuss the case, conduct your deposition and, if needed, prepare your hearing testimony. If you have questions at any time about the status of the case, you may call the Board attorney assigned to the case. Although your appearance at a hearing is voluntary, for those cases which proceed to a hearing your expert testimony will be vital to the Board's deliberations.

### **Payment**

You will receive \$175 per hour for your review of case materials and completion of your report. Time spent for a pre-hearing deposition, preparing to testify at hearing, and testifying at hearing is reimbursed as outlined in the fee schedule attached to this manual. Discuss any concerns you have about compensation with Board staff before accepting the case for review.

### **Conclusion**

The Board is very appreciative of your willingness to review cases for the Board; your time and effort are highly respected and critical to the Board's mission to regulate the practice of medicine for the benefit and protection of the people of North Carolina. The Board recognizes these are challenging cases and it is often difficult to reach a balanced and unbiased assessment and then, just as importantly, efficiently articulate your concerns in a professional manner. Your review will be instrumental in the Board's decision for the case.

*\*Acknowledgement is made to the Iowa and California Medical Boards for their kind permission to use extended portions of their respective review manuals; and to Patrick Balestrieri, JD, Senior Board Attorney, and Venkata Jonnalagadda, MD, Board member, for much appreciated edits, comments, and suggestions.<sup>3</sup>*

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<sup>3</sup> SGK V6; 20 May 2019.

## Frequently Asked Questions

### **Why am I being asked to review this case?**

The Board will ask for an expert review for a variety of reasons. The Board may simply need additional information and an opinion about a case not otherwise available. As previously noted not all cases submitted for external review will result in a public action. The Board has a variety of options depending on all information available, including your case review.

### **How does the concept of standard of care apply to my case review?**

The applicable standard of care should be in accord with the standards of care or practice among members of the same or similar health care profession at the time the care being reviewed was provided.

### **How often will I be asked to complete a review for the Board?**

It depends. As you might expect some specialties, such as internal medicine and pain management come to the Board's attention more frequently than others, such as pediatrics or pathology. As a result, reviewers in some specialties or areas of practice may be asked more frequently than others to perform a review. The Board needs reviewers in all areas of practice, but the frequency you may be asked to perform reviews is variable and depends on multiple factors. In general, it would be unusual for a reviewer to be asked to perform more than two reviews per year.

### **Who will see my report, and can I remain anonymous?**

The Board maintains the confidentiality of reports submitted by reviewers to the extent allowed by law. Should the case proceed to a hearing for possible action the physician and their legal representative will be provided a copy of your report and you may be asked to testify at a deposition and/or a hearing. Be aware that once a case proceeds to a hearing your report may become a public record.

### **Will I be asked to testify?**

Less than 5% of cases sent for review result in a Board medical expert testifying at a deposition and/or a hearing. If the Board determines that public action is indicated, and no agreement with the physician regarding disposition of the case can be reached, a hearing may be scheduled, and you may be asked to provide expert testimony. The majority of cases are settled without going to a hearing.

### **What is expected if I am asked to provide expert testimony?**

- Be prepared. Review the case and your review before the hearing or deposition.
- Be consistent. If the opinions you express at a hearing are inconsistent, in any way with those you expressed in your written review or deposition, be prepared to explain how and why your opinion has changed.
- Listen to the questions and answer responsively and honestly. Don't be argumentative or nonresponsive.
- Work with the Board attorney before testifying.
- Dress neatly and maintain a professional demeanor.

### **Can I be sued for serving as a case reviewer for the Medical Board?**

North Carolina statute (NCGS §90-14 (f)) provides civil immunity for Board reviewers when their review is provided "in good faith without fraud or malice". Additionally, Board attorneys will provide you with assistance should any legal action result from your review activities with the Board.

### **What should I include in my report?**

Your review should provide the Board with a concise statement of the care provided, an outline as to the accepted standard of care, a description, if any, of the deviation, and the rationale for your conclusions. The Board generally believes a medical record should provide a clear understanding of the patient's diagnosis and course of treatment. Physicians are expected to maintain adequate legible medical records containing, at minimum,

sufficient information to support the diagnosis, justify the treatment, accurately document the care provided, indicate advice and cautionary warnings provided to the patient, and provide sufficient additional information for other practitioners to assume continuity of patient care at any point in the course of treatment. Additional information on how to prepare your report is included on the sample reviewer worksheet included at the end of this manual. You may also want to refer to the Board’s position statement on “MEDICAL RECORDS – Documentation, Electronic Health Records, Access, and Retention” at: <https://www.ncmedboard.org/resources-information/professional-resources/laws-rules-position-statements/position-statements/medical-records-documentation-electronic-health-records-access-and-retentio>.

**Can I do research while reviewing a case and preparing my report?**

Yes, you may consult peer-reviewed journal articles, medical texts, and other relevant reference materials. Please identify any references used in your review. You should not discuss the case with other physicians, Board members, or anyone else; although reviewers may, on occasion, consult with professional colleagues regarding aspects of a case they are reviewing. As always you must maintain the strict confidentiality of the identity of the physicians and patients under review and scrupulously protect the confidentiality of the physician and patients involved.

**What if additional information is needed?**

Contact the Board investigator, Board attorney or staff to request any additional information you need to complete the review. Do not contact other physicians, witnesses, patients, Board members or others without discussing it first with Board staff.

**How long do I have to review the case and complete my report?**

Because issues related to cases under investigation are potentially serious you are asked to complete your review as expeditiously as reasonably possible; usually within 30 days of receipt of case material.

**How much time should I spend on medical record review and report completion?**

Please contact Board staff if your review process will require more than 3 hours per individual medical record or patient or 10 hours total. Some cases may involve several (3-10) patients. The Board recognizes these cases are often complex and may require more time to complete. In those situations, you should request additional time from Board staff prior to proceeding.

**How much will I be paid?**

You will receive \$175 per hour for your medical record case review and completion of your report. Time spent for a pre-hearing deposition, preparing to testify at hearing, and testifying at hearing is reimbursed as outlined in the reviewer fee schedule attached to this manual.

**What should I do with the case material after I have completed my review?**

The medical records need not be returned to the Board, but due to the sensitive nature of all documents related to the case, please securely destroy all the documents.

**What should I do if medical records or other documents associated with a case are lost or stolen?**

Case material should be maintained in a secure manner as would be expected of any confidential information. If materials are stolen, lost, or misplaced please contact the Board attorney or investigator assigned to the case for instructions on how to proceed.



**NORTH CAROLINA MEDICAL BOARD**

**Review Worksheet**

(Please type or attach a separate typed report for 1 & 4)

**Licensee Name:**

**Patient Name:**

**Expert's Name:**

**Case No.**

**1. Brief description of symptom, diagnosis, and course of treatment.**

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**2. Can you form an opinion?** Based on your background and experience and review of all information provided you, and assuming that the treatment as documented was provided, can you form an opinion as to whether the care rendered by the care provider, including diagnosis, treatment or record keeping, departed from or failed to conform to the standards of acceptable and prevailing medical practice (in the medical community throughout North Carolina)?

Yes, I can form an opinion.

No, I cannot form an opinion.

I need more information (specify): \_\_\_\_\_

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**3. What is your opinion?** Please use the definitions below as “guidelines” to be used in defining standard of practice. You are not limited to these guidelines in forming your opinion, but please state your own additional criteria if applicable.

**a. Diagnosis.** Evaluation of a medical problem using means such as history, physical examination, laboratory, and radiographic studies, when applicable.

Below standard of practice/care

Within standard of practice/care

Rev. 5/2019



## Expert Review Brief Sample\*

### **Brief description of symptom, diagnosis, and course of treatment.**

The patient is a 40-year-old with past history of diabetes and hypertension who presents to her primary care physician on 5/19/2012 with a complaint of left foot pain after stepping on a toothpick one month earlier. She is diagnosed with an abscess and given a Bicillin IM injection, oral Levaquin for 10 days, and Bactroban ointment. She was also instructed to apply heat. No specific follow up plan was documented. On the summary problem sheet, Dr. Jones notes "FB [foreign body] in foot (?), abscess". This is the only documented information present for that office visit.

The patient then presents 1 month later on 6/18/2012. No specific chief complaint was documented. She was again diagnosed with an abscess to her left foot, given another Bicillin injection, Levaquin again for 21 additional days, and told to use hot soaks. The office note comments "referral to dermatology, podiatry, or orthopedics", but there are no details or other documents of a referral. No other follow-up plan was documented. There are no laboratory tests or procedure notes associated with these two visits and no assessment of the patient's comorbid conditions (blood sugar, etc.).

Of note in the appointment records there is an 11:45 AM appointment for the patient on 5/28 without a corresponding clinic visit or no-show note. The year is unclear since no year is shown on that page. "2012" is handwritten on a different page and a "2014" is handwritten on yet another page. It is uncertain if this was a 9-10 day follow up appointment from the 5/19/2012 visit, but it does correspond with Dr. Jones response referring to a follow up appointment.

Submit the completed Expert Reviewer's Worksheet with an indication of your opinion regarding whether the diagnosis, treatment, records, and overall care was within or below the standard of care.

### **Explain your opinion:**

The standard of practice in North Carolina would be to clearly document the extent of the infection or abscess at both visits and document any supplemental information to support the impression that other serious conditions, such as a retained foreign body were considered and not present. The standard of practice would also be to consider or perform an I&D of the abscess which may have identified a retained foreign body. Alternatively, a wound culture could have been considered at either visit to identify appropriate antibiotic coverage, especially since the wound was already one month old at the first visit and failed to improve at the second visit.

On Diagnosis: Dr. Jones fails to note any physical exam on either of the two visits which lead to the conclusion this is only an abscess without any secondary problems, such as the retained foreign body or antibiotic resistance. The failure for the abscess to improve over the two-month time span should have prompted him undertake further investigation to arrive at the proper diagnosis.

On Treatment: Dr. Jones treats the abscess in the first visit with oral and IM antibiotics and provided a follow up appointment. He does not document exploring, irrigating, or dressing the wound as he stated in his response to the Board. Dr. Jones fails in the second visit to investigate further with an I&D or a wound culture to uncover possible reasons for the treatment failure. He also fails to modify antibiotic coverage since the abscess failed to improve with the first round of Bicillin and Levaquin. He also fails to provide a precise referral to a specialist, only noting a very nonspecific line on "derm, podiatry or ortho".

On Records: Dr. Jones fails completely on both visits for appropriate history and physical exam of the complaint, any rationale for the treatment given or not given, discussion of possible complications, and a full documentation of medications prescribed. He also fails to record any subsequent action for the referral he mentioned in the second visit. There is no mention of the status of the patient's diabetes at either visit.

Overall: Dr. Jones fails to provide sufficient or appropriate care for an infection in an at-risk patient who was failing to respond after two visits.

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\* The form and extent of an expert review varies with its subject matter and purpose. For example, an expert review regarding a technical or complex surgical procedure or for care which occurred over a prolonged time might require substantially more detail and analysis than the simple example shown above.



## North Carolina Medical Board Medical Expert Fee Schedule

Thank you for agreeing to review this matter for the North Carolina Medical Board (“Board”) and prepare an expert report. Although unlikely, you may also be asked to testify at a deposition or a hearing to support and explain your expert opinion.

The Board appreciates your assistance and wants you to know that professional participation in the regulatory process is essential to protecting the public and preserving self-regulation of physicians and other health care professionals. The fees paid to you come from license application and renewal fees from applicants and licensees.

The Board pays the following fees/expenses for expert review and deposition and hearing testimony.

- **Medical Record Review, Document Review, Telephone Calls, and Authoring Expert Reports**
  - One Hundred and Seventy-Five Dollars (\$175) per hour for medical record review, document review, telephone calls with Board staff and your time spent authoring expert reports.
  - If it appears your review of this matter will take more than ten (10) hours of your time, please contact the person who sent you the medical records at the Board before proceeding any further with your review to discuss how much additional time you estimate it will take you to complete your review and author an expert report(s).
  
- **Deposition Testimony**
  - One Hundred and Seventy-Five Dollars (\$175) per hour for all time spent preparing for your deposition. This includes medical record review, document review, and telephone calls and in-person meetings with Board Attorneys and other staff.
  - Two Hundred and Fifty Dollars (\$250) per hour for actual time spent testifying in deposition. This shall include a minimum payment to you of Seven Hundred and Fifty Dollars (\$750) per deposition (i.e., you will be paid Seven Hundred and Fifty Dollars (\$750) if your total time spent being deposed is less than three (3) hours).
  
- **Hearing Testimony**
  - One Hundred and Seventy-Five Dollars (\$175) per hour for all time spent preparing for your hearing testimony. This includes medical record review, document review and telephone calls and in-person meetings with Board Attorneys and other staff.
  - Three Hundred Dollars (\$300) per hour for actual time spent waiting at a hearing site to be called to testify and testifying at a hearing. This shall include a minimum payment to you of One Thousand Two Hundred Dollars (\$1,200); i.e., you will be paid \$1,200 if your total time spent waiting to be called and testifying is less than four (4) hours.

- **Mileage, Travel Time, Food & Lodging**
  - The Board will pay you for all travel in your own vehicle at the current Internal Revenue Service mileage reimbursement rate in effect on the date of travel. In addition, the Board will pay you One Hundred and Twenty-Five Dollars (\$125) per hour for travel time to and from a meeting site, deposition site or hearing site (or hotel site if you are arriving the day before a hearing).
  - The Board will pay for meals associated with your deposition and hearing testimony. The cost of any single meal shall not exceed thirty Dollars (\$30). Alcoholic beverages and meals of others with whom you might dine are not reimbursable.
  - The Board will make and pay for any lodging reservations you may require. In the event you desire to make your own lodging reservations, you will need to have this approved in advance by a member of the Board staff.