

BOARD MEETING MINUTES

January 21 - 23, 2026

**3127 Smoketree Court
Raleigh, North Carolina**

General Session Minutes of the North Carolina Medical Board (NCMB) Meeting held January 21-23, 2026.

The January 21-23, 2026 meeting of the North Carolina Medical Board was held virtually. Anuradha Rao-Patel, MD, President, called the meeting to order. Board members in attendance were Robert L. Rich, Jr., MD, President-Elect; Mark A. Newell, MD, MMM; Secretary/Treasurer; Earic R. Bonner, MD, MBA; Vickie A. Harry; Shannon R. Joseph; Gregory S. McCarty, MD; Anthony R. Plunkett, MD.; Sharona Y. Johnson, PhD, FNP-BC; Board members absent: Miguel A. Pineiro, PA-C, MHPE; Devdutta G. Sangvai, MD, JD, MBA

PRESIDENTIAL REMARKS

Dr. Anuradha Rao-Patel reminded the Board members of their duty to avoid conflicts of interest with respect to any matters coming before the Board as required by the State Government Ethics Act. Reported conflicts were included within individual committee reports.

ANNOUNCEMENTS and UPDATES

Dr. Rao-Patel read the Conflict of Interest statement for newly appointed Board member, Shannon R. Joseph. Dr. Rao-Patel recognized new staff as they were introduced by their perspective manager and also called on managers to recognized staff with employment milestones.

NORTH CAROLINA PHYSICIAN HEALTH PROGRAM REPORTS (NCPHP)

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Dr. Joseph Jordan gave the NCPHP Compliance Committee report. The specifics of this report are not included because the information contained in the report is confidential and non-public.

A motion passed to return to open session.

NCMB LEGAL DEPARTMENT REPORT

Mr. Brian Blankenship, Chief Legal Officer, gave the Legal Department Report on Friday, January 23, 2026.

Open session:

Mr. Blankenship updated the Board on the schedule of the February 2026 and June 2026 hearings and hearing assignments.

A motion passed to close the session pursuant to N.C. Gen Stat. §143-318.11(a) to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and/or 90-21.22 of the North Carolina General Statutes and not considered public records within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney/client privilege.

Closed session:

Mr. Blankenship provided information within the attorney-client privilege regarding work product occurring since the last Legal Department Report was presented.

The Legal Department Report was concluded.

The Board accepted the report as information.

A motion passed to return to open session.

Andre Nicolas Gay, M.D.'s Motion for Relief

The Board heard Andre Nicolas Gay, M.D.'s Motion for Relief.

Dr. Rao-Patel reminded the Board members of their duty to avoid conflicts of interest with respect to any matter coming before the Board as required by the State Government Ethics Act.

Board Members Gregory S. McCarty, M.D. and Shannon R. Joseph were noted as recused.

The Board was represented by Robert Patchett. Dr. Gay was represented by Nicholas Dowgul.

The Board heard arguments of counsel for Dr. Gay and the Board. Following, arguments and deliberation the Board voted to deny Dr. Gay's Motion for Relief.

NCMB COMMITTEE REPORTS

Executive Committee Report

Members present were: Anuradha Rao-Patel, MD, Chair; J. Nelson Dollar, MA; Mark A. Newell, MD, MMM; Robert L. Rich, MD. Member absent: Devdutta G. Sangvai, MD, JD, MBA

Open Session.

Financial Update

a. Year-To-Date Financials

The Committee reviewed the following financial reports through November 30, 2025: Balance Sheet, Profit & Loss versus Budget, and the Profit & Loss Comparison with the accounting team.

Committee Recommendation: Accept the financial information as reported.

Board Action: Accept Committee recommendation. Accept the financial information as reported.

b. Investment Account Update

The Committee reviewed the investment statements for October and November 2025 with the accounting team.

Committee Recommendation: Accept the financial information as reported.

Board Action: Accept the Committee recommendation. Accept the investment statements as reported.

c. Report on Audit of Financial Statements

Mr. Joshua Anderson, CPA, Dean Dorton Allen Ford, PLLC, met with the Executive Committee to present the Year-End Financial Statement Audit Report for the fiscal year ending October 31, 2025.

According to the Independent Auditor's Report: "In our opinion, the accompanying financial statements referred to above present fairly, in all material respects, the financial position of the Board, as of October 31, 2025 and 2024, and the respective changes in financial position and cash flows for the years then ended in accordance with accounting principles generally accepted in the United States of America.

CLOSED SESSION

A motion passed to go into restricted closed session pursuant to Section 143-318.11(a)(1) and Section 143-748 of the North Carolina General Statutes to preserve the confidentiality of internal audit work papers.

The Committee and other Board members met privately with the auditors to give the auditors the opportunity to share any concerns regarding the audit report or process.

a. Report on Audit of Financial Statements

The Committee and other Board members met privately with the auditors to give the auditors the opportunity to share any concerns regarding the audit report or process.

A motion passed to return to open session.

OPEN SESSION

Committee Recommendation: Accept the Year-End Financial Statement Audit Report as reported.

Board Action: Accept Committee recommendation. Accept the Year-End Financial Statement Audit Report as reported.

New Business:

a. Presentation by NBOME

Dr. John Gimpel and Mr. Douglas Murray presented to the Board an update on some key

activities ongoing in 2026, most notably information regarding some changes to the COMLEX-USA exams that are taking effect starting in May 2026, as well as the C3DO initiative to offer and administer a clinical skills exam in conjunction with colleges of osteopathic medicine.

Committee Recommendation: Accept the NBOME presentation as information.

Board Action: Accept the Committee recommendation. Accept the NBOME presentation as information.

b. 2026 FSMB Annual Meeting Update

Mr. Thomas W. Mansfield, NCMB CEO, informed the Committee that the 2026 FSMB Annual Meeting will be held April 30-May 2, 2026 in Baltimore. It is time to determine which NC Medical Board members are interested in attending. All members are invited, and those who are new to the Board or have never attended are encouraged. The Annual Meeting is a special opportunity to learn from and establish relationships with members from other constituent boards and FSMB staff. If you want to serve on an FSMB committee or workgroup, attendance at the Annual Meeting is helpful.

If you would like to attend, begin by saving the dates on your calendar. Ms. Loney Johnson will send an email and would like a response regarding your attendance within 2 weeks. Ms. Johnson will assist you with both registration and hotel reservations. She can also explain our protocols and policies around reimbursement for airfare or car travel.

Committee Recommendation: Accept the 2026 FSMB Annual Meeting update as information.

Board Action: Accept Committee recommendation. Accept the 2026 FSMB Annual Meeting update as information.

c. 2026 NCMB Retreat Discussion

Mr. Mansfield stated the 2026 NCMB Retreat will be held in the western part of North Carolina. The Executive Committee needs to select dates for the retreat. Please check your schedules for holding the retreat the weekend of August 7-9. Ms. Johnson will send an email with the dates and information about the Chetola Resort in Blowing Rock.

Committee members should also be prepared to discuss goals for the retreat and potential topics.

Staff, working with the President, will bring back ideas for retreat topics as well as location options to discuss at a future meeting.

Committee Recommendation: Accept the 2026 NCMB Retreat discussion as information.

Board Action: Accept Committee recommendation. Accept the 2026 NCMB Retreat discussion as information.

Policy Committee Report

Members present were: Robert L. Rich, Jr., M.D., Chair; J. Nelson Dollar, M.A.; Shannon R. Joseph; Gregory S. McCarty, M.D.; Anthony R. Plunkett, M.D. Member absent: Devdutta G. Sangvai, M.D., J.D., MBA.

Old Business:

a. 3.2.1: Medical Records (Appendix A)

After the November 2025 meeting, staff emailed stakeholders the revised position statement for feedback. Two comments were received and reviewed by the Committee. The comments were noted to be positive and the Committee voted to adopt and publish the revised position statement.

Committee recommendation: Adopt and publish the revised position statement.

Board Action: Accept Committee recommendation. Adopt and publish the revised position statement.

New Business:

a. 5.1.1: Office-Based Procedures

Staff provided the genesis of the position statement and noted staff has received feedback from outside organizations that the position statement is regularly used as a guidance document for inspections of ambulatory surgical facilities. The Committee reviewed and discussed the edits and comments provided by Committee members prior to the meeting. The Committee directed staff to incorporate the discussed revisions, then circulate and bring back for review by the Committee at a later meeting, with an anticipated date of March 2026. After the Committee is satisfied with the changes, the proposed revisions will be circulated to stakeholders for feedback.

Committee recommendation: Incorporate discussed revisions, circulate to Committee members, and bring back for review at a later meeting, with an anticipated date of March 2026.

Board Action: Accept Committee recommendation. Incorporate discussed revisions, circulate to Committee members, and bring back for review at a later meeting, with an anticipated date of March 2026.

b. 5.1.2: Laser Surgery

The Committee reviewed the one comment received from a Committee member prior to the meeting and after discussion recommended making no changes to the current position statement.

Committee recommendation: Accept review of the position statement as information.

Board Action: Accept Committee recommendation. Accept review of the position statement as information.

c. 5.1.3: Care of the Patient Undergoing Surgical or Other Invasive Procedure (Appendix B)

The Committee reviewed the one proposed edit received from a Committee member prior to the meeting and agreed to make the revision.

Committee recommendation: Incorporate the proposed revision and publish the revised position statement.

Board Action: Accept Committee recommendation. Incorporate the proposed revision and publish the revised position statement.

d. 8.1.1: Physician Practice Drift

The Committee discussed the comment and proposed revision received by Committee members prior to the meeting. Staff explained that the position statement was specifically drafted to be aimed at physicians and not Advanced Practice Providers. The Committee agreed to make no changes to the current position statement.

Committee recommendation: Accept review of the position statement as information.

Board Action: Accept Committee recommendation. Accept review of the position statement as information.

Miscellaneous:

a. Position Statement Review Chart

The Committee reviewed the position statement review chart and determined that, in addition to bringing back the revised position statement 5.1.1: Office-Based Procedures, the Committee will review position statements 8.3.1: Advertising and Publicity and 10.1.1: Referral Fees and Fee Splitting at the March 2026 meeting. Staff will circulate those position statements to the Committee members for consideration and comment prior to the March 2026 meeting.

Committee recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

Licensing Committee Report

Members present were Earic R. Bonner, MD, MBA, Chair; Vickie A. Harry; Mark A. Newell, MD, MMM; Robert L. Rich, MD. Member absent: Miguel A. Pineiro, PA-C, MHPE

Open Session:

a. Interstate Medical License Compact (IMLC) Update

Becky Powers, Chief of Licensing and Registration, provided an update regarding IIMLC applications. As of January 1, 2026, IMLC incoming applications were 162 and outgoing

applications were at 112 with a total of 274.

- b. Final approval of Internationally Trained Physician Employees (ITPE) Temporary Rule 21 NCAC 32 B . 1362, International Trained Physician (Appendix C)

Marcus Jimison, Deputy General Counsel, provided the information explaining the proposed final temporary Rule regarding Internationally Trained Physician Employees. 21 NCAC 32B .1362 was proposed for adoption in order to create a process that would implement Part II of House Bill 67/SL 2025-37, which was signed into law July 1, 2025, but goes into effect January 1, 2026. The proposed rule establishes application process and requirements for the Internationally Trained Physician Employee License..

Committee recommendation: Approve the proposed temporary Rule.

Board Action: Accept Committee recommendation. Approve the proposed temporary Rule.

License Interview Report

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Five licensure interviews were conducted virtually. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Disciplinary (Investigative) Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, Shannon R. Joseph; PhD, FNP-BC; Robert L. Rich, MD. Members absent: Miguel A. Pineiro, PA-C, MHPE; Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Investigative) Committee reviewed 54 investigative cases. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Disciplinary (Complaints) Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, Shannon R. Joseph; PhD, FNP-BC; Robert L. Rich, MD. Members absent: Miguel A. Pineiro, PA-C, MHPE; Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Complaints) Committee reviewed 66 complaint cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public.

A motion passed to return to open session.

Disciplinary (Compliance) Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, Shannon R. Joseph; PhD, FNP-BC; Robert L. Rich, MD. Members absent: Miguel A. Pineiro, PA-C, MHPE; Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Compliance) Committee reviewed six investigative cases. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Disciplinary (Malpractice) Committee Report

Members present were: Mark A. Newell, MD, MMM, Chair; J. Nelson Dollar, MA; Vicki A. Harry; Sharona Y. Johnson, Shannon R. Joseph; PhD, FNP-BC; Robert L. Rich, MD. Members absent: Miguel A. Pineiro, PA-C, MHPE; Devdutta G. Sangvai, MD, JD, MBA

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

The Disciplinary (Malpractice) Committee reviewed 35 cases. A written report was presented for the Board's review. The Board adopted the Committee's recommendation to approve the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Investigative Interview Report

A motion passed to close the session pursuant to Section 143-318.11(a) of the North Carolina General Statutes to prevent the disclosure of information that is confidential pursuant to Sections 90-8, 90-14, 90-16, and 90-21.22 of the North Carolina General Statutes and not considered a public record within the meaning of Chapter 132 of the General Statutes and/or to preserve attorney-client privilege.

Ten investigative interviews were conducted virtually. A written report was presented for the Board's review. The Board adopted the recommendations and approved the written report. The specifics of this report are not included because these actions are not public information.

A motion passed to return to open session.

Advanced Practice Providers & Allied Health Committee Report

Members present were: Anthony R. Plunkett, MD, Vice-Chair; Earic R. Bonner, MD, MBA; Vicki A. Harry; Gregory S. McCarty, MD. Member absent: Miguel Pineiro, PA-C, MHPE

New Business:

a. Proposed Rule 21 NCAC 32U .0103 – Influenza Test and Treat by Pharmacists

Staff discussed SL 2025-37. This new law authorizes pharmacists to test for and initiate treatment for influenza. In September 2025, the State Health Director issued two standing orders implementing the new law. In December 2025, representatives from the Medical Board and the Board of Pharmacy met and approved the standing orders as written.

SL 2025-37 directs both Boards to adopt the standing orders as administrative rules. In January 2026, the Board of Pharmacy passed its rule. Proposed rule 21 NCAC 32U .0103 incorporates the Board of Pharmacy rule by reference.

Committee recommendation: Approve proposed rule 21 NCAC 32U .0103 as written.

Board Action: Accept Committee recommendation. Approve proposed rule 21 NCAC 32U .0103 as written.

b. Proposed Rule 21 NCAC 32S .0227 – Physician Assistants Team-Based Practice

Staff discussed SL 2025-37, which amended the Medical Practice Act to allow physician assistants who have obtained 4,000 clinical hours of experience and 1,000 clinical hours in a particular specialty to practice in a team-based setting without physician supervision. The new law goes into effect July 1, 2026, or when a rule is in place, whichever is earliest.

Board staff consulted with representatives and counsel from the North Carolina Academy of Physician Associates (“NCAPA”) and representatives from the North Carolina Medical Society to draft and develop a rule to implement the new law.

Representatives from the NCAPA were in attendance during the Committee meeting.

Committee recommendation: Approve proposed rule 21 NCAC 32S .0227 as written. Committee to reconsider possible changes after the end of the public comment period.

Board Action: Accept Committee recommendation. Approve proposed rule 21 NCAC 32S .0227 as written. Committee to reconsider possible changes after the end of the public comment period.

Outreach Committee Report

Members present were: Anthony R. Plunkett, MD, Chair; Vicki A. Harry; Sharona Y. Johnson, PhD, FNP-BC

Old Business:

- a. Update on Presentations
 - i. Professional and public presentations
 - ii. Regulatory Immersion Series events
 - 1. RIMS year in review

The Communications Director gave an overview of professional and public outreach efforts, including the Regulatory Immersion Series mock disciplinary course presented to medical schools and PA programs. All professional outreach presentations for 2026 are currently fully staffed with presenters. There is currently demand for licensing related presentations, particularly covering the Interstate Medical Licensure Compact, which is anticipated to be a frequently requested topic as the year progresses. Communications staff are continuing with public outreach efforts as well. Most recently, staff spoke with social workers affiliated with NC DHHS, delivering a 10-minute “NCMB 101” presentation followed by an opportunity to table and interact with attendees. The Communications Director also provided a “year- in-review” update on the RIMS program, noting that NCMB reached all five medical schools and 11 out of the 12 PA schools, the 12th PA school having opted to push their presentation date to 2026 for scheduling reasons. In 2025, the RIMS program reached more than 1,300 medical and PA students and completed 17 total presentations. The Communications Director noted that only three sitting Board Members presented a session in 2025. Surveys indicate that students and programs place great value on having a clinician Board Member as their presenter. Accordingly, the Communications Director has asked the Committee Chair to encourage Board Member participation in the RIMS program.

Committee recommendation: Accept as information.

Board Action: Accept Committee recommendation. Accept as information.

- b. Update on Board Service Awareness Efforts

The Communications Director gave an update regarding staff progress in developing Board Service Awareness resources to be shared on a year-round basis. Currently, staff have re-activated the “Five Questions with a Board member” feature in the *Forum* newsletter, aimed at highlighting the importance of NCMB’s work and the positive impact on the clinicians who serves. The first installment featuring Dr. Rao-Patel was shared in the November-December issue of the *Forum*. Communications staff will work with clinician Board members to contribute an installment of their own. Communications staff are also developing an online information kit on Board Service. This dedicated page on the website will contain all of the information that prospective Board members want to know, such as the time commitment, qualifications, application process, and include FAQs and short videos from Board members.

Committee recommendation: Accept as information and approve making general request for clinician Board Member participation in the Five Questions Forum feature.

Board Action: Accept Committee recommendation. Accept as information and approve making general request for clinician Board Member participation in the Five Questions Forum feature.

New Business:

a. Opportunities for Professional Presentations at Grand Rounds

The Committee discussed expanding professional outreach to include Grand Round presentations to medical faculty at North Carolina hospitals and health systems. The Communications Director noted that medical professionals typically prefer to have a clinician Board member present. As this is the case, the success of this initiative would be heavily reliant on Board members’ availability and willingness to present. The Communications Director suggested that we begin by having Board members help identify opportunities to present Grand Rounds at their own facilities. The Committee Chair suggested NCMB target departments in specialties that are underrepresented on the Board as a way of building Board Service Awareness into NCMB presentations. Another strategy to alleviate the travel and scheduling burden on Board members would be to emphasize virtual opportunities for presentation when coordinating with program contacts. During Committee discussion, medical staff meetings were offered as another target audience to consider. These meetings are typically held virtually and bring together a large audience of medical professionals. Communications staff might consider developing shorter, more focused presentations rather than longer form content so that it will easily fit into the meeting format.

Committee recommendation: Direct staff to develop and implement strategies for securing invitations to present Grand Rounds and report back to Outreach Committee.

Board Action: Accept Committee recommendation. Accept as information. Direct staff to develop and implement strategies for securing invitations to present Grand Rounds and report back to Outreach Committee.

Miscellaneous:

a. Podcast year in review

The Communications Director recapped NCMB's podcast statistics as of the end of 2025. MedBoard Matters celebrated its 5-year anniversary, having published 52 episodes published to date, 8 of them in 2025. While it's difficult to pinpoint the exact size of the audience, MedBoard Matters had 2,933 downloads in 2025 and 12,149 total downloads to date. and has a worldwide audience with listeners in 80 countries. MedBoard Matters is performing well and ranks in the top 25% of all podcasts as far as regular content and listeners. The most downloaded episode of 2025 was the four-part series on Hurricane Helene, followed by an episode covering the IMLC's implementation in North Carolina. Communications staff are looking forward to another great year of engaging and informative episodes!

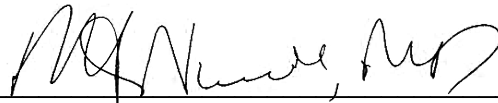
Committee Recommendation: Accept as Information.

Board Action: Accept Committee recommendation. Accept as information.

ADJOURNMENT

The Medical Board officially adjourned at 11:18 a.m. on Friday, November 21, 2025.

The next meeting of the Medical Board will be virtual, January 21-23, 2026.



Mark A. Newell, MD, MMM, Secretary/Treasurer

3.2.1: MEDICAL RECORDS – Documentation, Electronic Health Records, Access, and Retention

Documentation

An accurate, current, and complete medical record is an essential component of patient care. Licensees shall maintain a medical record for each patient to whom they provide care. The medical record should be legible. When the caregiver does not write legibly, notes should be dictated, transcribed, reviewed, and signed within a reasonable time. It is incumbent upon the licensee to ensure that the transcription of notes is accurate (particularly in those instances where medical records are generated with the assistance of dictation software or artificial intelligence).

The medical record is a chronological document that:

- Records pertinent facts about an individual’s health and wellness;
- Enables the treating care licensee to plan and evaluate treatments or interventions;
- Enhances communication between professionals, assuring the patient optimum continuity of care;
- Assists both patient and licensee in communication with third party participants;
- Allows the licensee to develop an ongoing quality assurance program;
- Provides a legal document to verify the delivery of care;
- With appropriate consent, may be used as a source of clinical data for research and education; and
- Assists with compliant billing and coding.

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

- The purpose of each patient encounter and appropriate information about the patient’s history and examination;
- The patient’s past medical history including an updated problem list, surgical history, family history, and social history;
- The licensee’s clinical decision making including the plan for any treatment and the care and treatment provided;
- Prominent notation of current medications (including all prescribed, recommended, or provided medications, and notation of medications actually taken) and other significant allergies, or a statement of their absence; and
- Clearly documented informed consent obtained from the patient when appropriate.

Licensees are also encouraged to include patient learning needs, barriers to care, and other factors as part of the medical record.

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

- Each page in the medical record contains the patient’s name or ID number.

- Include all personal, biographical information such as home address, employer, marital status, and all telephone numbers, including home, work, and mobile phone numbers.
- All entries shall contain the author's identification and the date. Author identification may be a handwritten signature, initials, or a unique electronic identifier.
- All drug therapies are listed, including dosage instructions and, when appropriate, indication of refill limits. Prescription refills should be recorded.
- Appropriate plans and specified times for follow-up care should be included.
- All consultation, laboratory, and imaging reports should be entered into the patient's record, reviewed, and the review documented by the licensee who ordered them. Abnormal reports should be noted in the record, along with corresponding follow-up plans and actions taken.
- An appropriate immunization record is evident and kept up to date.
- Appropriate preventive screening and services are offered in accordance with the accepted practice guidelines.
- When possible, licensees should retain and archive all text messages and email communications with patients within the patient's medical records so that they can be retrieved if needed.

Electronic Health Records

The Board recognizes and encourages the use of electronic health records ("EHR"). The promise and potential of information technology in health care, particularly the use of EHR, presents licensees with distinct challenges. While the Board encourages the adoption and appropriate use of various forms of EHR, there are some unique aspects and problems associated with EHR that have been repeatedly encountered by the Board, some of which are discussed below. This subsection is meant to identify issues which the Board has repeatedly found to be problematic in malpractice and complaint cases coming to the Board's attention. Basic, well-established principles of medical record documentation, as outlined above, apply to all forms of medical record documentation, including EHR.

The following guidelines are offered to assist licensees in meeting their ethical and legal obligations:

- *EHR Deficiencies.* Licensees must be aware of the idiosyncrasies and weaknesses of the EHR system they are using and adjust their practice accordingly. Licensees are ultimately responsible for the adequacy of their EHR entries and documentation.
- *Responsibility of Licensees.* Licensees remain responsible for clinical decision making. EHR are becoming increasingly sophisticated and may provide flags for follow-up care or other clinical decision-making support, such as health maintenance recommendations. While an EHR system may assist in the clinical decision-making process, it is not responsible for decision making. The licensee is. For example, it is not acceptable to blame an EHR because it failed to recommend particular testing or it failed to prompt clinical follow-up. Increasingly elaborate documentation, clinical management, and productivity tools may also result in increased opportunities for errors or omissions. These errors or omissions result from the failure of the licensee to assume appropriate responsibility for the care of the patient. In the end, decision-making responsibility rests solely with the licensee; regardless of the information or notices provided by the EHR.
- *Use of Templates.* The Board cautions against overuse of template content or reliance on EHR software which pre-populates, carries forward, or clones information from one encounter to the next, or from different licensees, without the licensee carefully reviewing and updating all information. Documentation of clinical findings for each patient encounter must accurately and contemporaneously reflect the actual care provided. The use of "copy-and-paste" should only be

employed in circumstances when the totality of copied material from prior interactions is pertinent to the current situation.

- *Availability of, or Access to, EHR.* Licensees must be able to provide patient medical records under their control in a timely¹ manner for various situations, such as consultations, transfer of care to another licensee, or practice closure. The Board has encountered situations where licensees were unable to access their patients' medical records due to either fee or other disputes with the EHR vendor. This is particularly common when the medical records are maintained off site (e.g., cloud storage). Licensees must understand provisions of their contract with the EHR vendor in this regard.
- *Breakdown of Patient-Licensee Communication.* Misunderstandings and miscommunications between patients, patient family members, licensed health care professionals, and office staff generate a substantial percentage of complaints received by the Board. Many EHR systems allow direct licensee-patient communication (i.e. via a "patient portal"). While this form of communication can facilitate communication, such as follow-up of lab or x-ray results or medication refills, it also places a responsibility on the licensee to provide timely responses to legitimate requests from patients for feedback or information.
- *Employed Licensees and Independent Contractors.* The Board recommends all employed licensees/independent contractors review their employment agreements regarding ownership of the EHR. There should be explicit provisions which set forth the rights and duties of the practice and the licensee upon termination of employment, with regards to notification of patients and access to medical records.
- *Artificial Intelligence.* Once a licensee chooses to use AI, they accept responsibility for responding appropriately to the AI's recommendations. For example, if a licensee chooses to follow the course of treatment provided by an AI-generated response, then they should be prepared to provide a rationale for why they made that decision. Simply implementing the recommendations of the AI without a corresponding rationale may not be within the standard of care. Alternatively, if the licensee uses AI and suggests a course of treatment that deviates from one delineated by AI, then they should document the rationale behind the deviation and be prepared to defend the course of action. Generally, the reason a licensee provides for disagreeing with any AI recommendation should be because following that recommendation would not be consistent with the applicable standard of care.

Access to Medical Records

A licensee's policies and practices relating to medical records under their control should be designed to benefit the health and welfare of patients, whether current or past, and should facilitate the transfer of clear and reliable information about a patient's care. Such policies and practices should conform to applicable federal and state laws governing health information. These principles of medical record access also apply to licensees practicing via telemedicine.

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

¹ In evaluating timeliness, the Board will look at the responsiveness of the licensee and the efforts undertaken to provide the requested records or information to the intended recipient.

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

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

Licensees may charge a reasonable fee for the preparation and/or the photocopying of medical records, keeping in mind that state law limits fees a licensee can charge for copies of medical records in certain cases, including liability claims for personal injury, social security disability claims, and workers' compensation claims. To assist in avoiding misunderstandings, and for a reasonable fee, the licensee should be willing to review the medical records with the patient at the patient's request. Medical records should not be withheld because payment of a patient's account is overdue (including charges for copies or summaries of medical records).

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

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

Licensees should not relinquish control over their patients' medical records to third parties unless there is an enforceable agreement that includes adequate provisions to protect patient confidentiality and to ensure access by both the licensee and patient to those medical records.*

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

Retention of Medical Records

Licensees have both a legal and ethical obligation to retain patient medical records under their control. The Board, therefore, recognizes the necessity and importance of a licensee's proper maintenance, retention, and disposition of medical records. Patient interests related to present and future healthcare needs should be a licensee's primary consideration when determining how long to retain medical records.

Other Considerations and Board Expectations:

- Patients should be notified regarding how long the licensee will retain medical records.
- In order to preserve confidentiality when discarding old medical records, all medical records should be retained and destroyed in a HIPAA compliant manner, including both paper medical

records and EHR. If it is feasible, patients should be given an opportunity to claim the medical records or have them sent to another care licensee before old medical records are discarded.

- The licensee should respond in a timely manner to requests from patients for access to, or copies of, their medical records.
- Licensees should notify patients of the amount, and under what circumstances, the licensee will charge for copies of a patient's medical record.
- Those licensees providing episodic care should attempt to provide a copy of the patient's medical record to the patient, the patient's primary care licensee, or, if applicable, the referring licensee.

It should be noted that these expectations relate solely to Board inquiries and do not preempt other legal or ethical record retention requirements. Licensees are encouraged to seek advice from private legal counsel and/or their malpractice insurance carrier, particularly when responding to a subpoena to produce records.

*NOTE: Refer also to the Board's Position Statement on "[Departures from or Closings of Medical Practices](#)."

5.1.3: Care of the Patient Undergoing Surgical or Other Invasive Procedure*

The evaluation, diagnosis, and care of the surgical patient undergoing surgery or other invasive procedure* is primarily the responsibility of the licensee performing the procedure (e.g. "proceduralist"**.). The proceduralist bears responsibility for ensuring the patient undergoes a pre-procedure assessment appropriate to the surgery/procedure. The assessment shall include a review of the patient's history, timely physical exam, and other data relevant to the procedure. The proceduralist shall have a detailed discussion with each patient regarding the diagnosis and the nature of the surgery/procedure, advising the patient fully of the risks involved. It is also the responsibility of the proceduralist to reevaluate the patient immediately prior to the procedure.

It is the responsibility of the proceduralist to assure safe and readily available postoperative care for each patient on whom he or she performs surgery or procedure. It is not improper to involve other licensed health care professionals in postoperative/post-procedure care so long as the proceduralist maintains responsibility for such care. The postoperative/postprocedure note must reflect the findings encountered in the individual patient and the surgery/procedure performed.

*Invasive procedures are medical acts performed for the purpose of structurally altering the human body by incision or destruction of tissues, including therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transportation of live human tissue. This includes endoscopies, cardiac catheterizations, interventional radiology procedures, and other procedures.

**Proceduralist refers to the licensee performing the procedure.

1 21 NCAC 32B .1362 is proposed for adoption under temporary procedures as follows:

2
3 **SECTION .1300 – GENERAL**

4
5 **21 NCAC 32B .1362 APPLICATION FOR INTERNATIONALLY TRAINED PHYSICIAN EMPLOYEE**
6 **LICENSE**

7 (a) The Internationally Trained Physician License is limited to physicians who have not attended accredited
8 medical schools or graduate medical education programs in the United States.

9 (b) In order to obtain an Internationally Trained Physician License, the Board must receive from the applicant or
10 the primary source:

11 (1) a completed application, attesting under oath or affirmation that the information on the application
12 is true and complete, and authorizing the release to the Board of all information pertaining to the
13 application;

14 (2) a completed form from (1) a hospital located and licensed in North Carolina attesting to an offer of
15 full-time employment, or (2) a NC licensed supervising physician located at a medical practice in a
16 North Carolina rural county with a population of less than 500 people per square mile attesting to
17 an offer of full-time employment where the supervising physician is physically practicing on-site;

18 (3) documentation of a legal name change, if applicable;

19 (4) a photograph, two inches by two inches, affixed to the oath or affirmation that has been attested to
20 by a notary public;

21 (5) proof of licensure in good standing from the medical licensing authority in a foreign country as
22 required by G.S. 90-12.03(a)(2);

23 (6) proof of 130 weeks of medical education from a medical school as described in G.S. 90-12.03(a)(3);

24 (7) furnish an original ECFMG certification status report;

25 (8) proof of ECFMG eligibility, which shall include furnishing an original ECFMG certification status
26 report and successful passage of USMLE Step 1 and Step 2;

27 (9) proof of either (1) two years of graduate medical education approved by applicant's country of
28 licensure or (2) active practice in country of licensure for at least 10 years after graduation. Proof
29 graduate medical education will require verification from both the graduate medical education
30 program regarding attendance and applicant's country of licensure of approval. Proof of active
31 practice will require verification from employers, with applicable dates, positions and
32 responsibilities; if the applicant was self-employed, the Board may require business documents, tax
33 records, and patient attestations for the 10-year period to confirm the active practice of medicine;

34 (10) examination transcripts from the examining body that meet of one of the requirements of G.S. 90-
35 12.03(4);

36 (A) if applying on the basis of the USMLE, the USMLE transcript must show a score on
37 USMLE Step 3 and the applicant must have passed within three attempts.

1 (B) if applying on the basis of the COMLEX, the COMLEX transcript must show a score on
2 COMLEX Level 1, Level 2 (cognitive evaluation), and Level 3 and the applicant must have
3 passed each level within three attempts.

4 (C) if applying on the basis of any other board-approved examination under G.S. 90-10.1 or 21
5 NCAC 32B .1303, the transcript must be received from the examining body and must show
6 a passing score of each part.

7 (D) if applying on the basis of a comprehensive assessment, the applicant should submit a
8 proposal to the Board prior to undergoing the assessment to ensure approval. The
9 comprehensive assessment must be performed by independent licensed physicians or
10 medical educators. The assessment must evaluate the applicant's clinical knowledge, skills
11 and judgment as well as their cognitive state and safety to practice. The assessment must
12 perform the evaluation through multiple choice examination, neuro-cognitive screen,
13 structured clinical interviews, simulated patient encounters, and procedure simulations.
14 The assessment must evaluate and specify all current strengths and weaknesses in the
15 intended area(s) of practice. The assessment must include testing and evaluation by
16 licensed physicians or medical educators. The Board must receive an assessment report
17 from the independent evaluators indicating the applicant's competence, all strengths and
18 weaknesses in practice, and the ability to practice safely.

19 (E) if the applicant does not qualify for any of the examinations listed in G.S. 90-12.03(a)(4),
20 the Board may waive the requirement as long as the applicant satisfies all other
21 requirements of G.S. 90-12.03, holds an O-1 visa, and submits the same supporting
22 documentation provided to the US Citizenship and Immigration Services indicating their
23 extraordinary ability is relevant to the practice of medicine. The applicant must
24 successfully pass the Special Purpose Examination or Post Licensure Assessment Systems
25 within one year or the temporary license is rendered inactive.

26 (11) confirmation from all jurisdictions where the applicant holds or has held a license that the applicant
27 has not had a license revoked, suspended, restricted, denied or other acted against and is not the
28 subject of any pending investigation as required by G.S. 90-12.03(a)(5);

29 (12) criminal background check translated into English and submitted by country of licensure directly to
30 the Board;

31 (13) submit two completed fingerprint record cards;

32 (14) submit a signed consent allowing a search of local, state, and national files for any criminal record;

33 (15) confirmation that the applicant has practiced medicine for at least five years. Proof of active practice
34 will require verification from employers, with applicable dates, positions and responsibilities; if the
35 applicant was self-employed, the Board may require business documents, tax records, and patient
36 attestations;

37 (16) demonstration of proficiency in English by:

- 1 (A) successfully passing an examination required under G.S. 90-10.1;
2 (B) licensure from a country where English is the primary language utilized by medical
3 education programs; or,
4 (C) completing the Occupational English Test (OET) Medicine. The transcript for OET
5 Medicine must be received from OET.
- 6 (17) supply a certified copy of applicant's birth certificate or a certified copy of a valid and unexpired
7 U.S. passport if the applicant was born in the U.S. If the applicant does not possess proof of U.S.
8 citizenship, the applicant must provide information about applicant's immigration status which the
9 Board will use to verify applicant's lawful presence in the U.S.;
- 10 (18) valid social security number;
- 11 (19) pay to the Board a non-refundable fee pursuant to G.S. 90-13.1(a) plus the costs of a United States
12 criminal background check; and,
- 13 (20) upon request, supply any additional information the Board deems necessary to evaluate the
14 applicant's competence and character.
- 15 (c) All information submitted under subsection (b) must be delivered to the Board from the primary originating
16 source in English in order to verify the accuracy and authenticity of the information.
- 17 (d) An applicant may be required to appear in person for an interview with the Board or its agent if the Board
18 determines it needs more information to evaluate the applicant based on the information provided and the Board's
19 concerns.
- 20 (e) An application must be completed within one year of the date of the applicant's oath.
- 21 (f) The holder of an internationally trained physician employee license may submit an application to convert
22 their license to a full license after four years of active practice and who meets the requirements of G.S. 90-12.03(d).
23 The Board must receive from the applicant or the primary source:
- 24 (1) a completed application, attesting under oath or affirmation that the information on the application
25 is true and complete, and authorizing the release to the Board of all information pertaining to the
26 application;
- 27 (2) submit to a criminal background check, and pay the cost of the criminal background check;
- 28 (3) submit a signed consent allowing a search of local, state, and national files for any criminal record;
- 29 (4) report their practice plans, including geographic location of practice, practice setting, and area of
30 specialty; and,
- 31 (5) pay to the Board a non-refundable fee pursuant to G.S. 90-13.1(a).

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33 History Note: Authority G.S. 90-5.1(a)(3); 90-8.1; 90-12.03; 90-13.1;