



The NCMB: Moving forward with Outreach

Over the past few months, I have had the pleasure of attending various meetings with some of my colleagues. In one recent conversation, I spoke at some length with a colleague who expressed her passionate belief that the NCMB targets licensees in some of the rural areas of the state. It was clear she viewed the Board as an adversary even though she acknowledged that her personal experiences with the NCMB have been limited to license application and annual renewal. She echoed what I have heard more than once over the past few months – “The last thing I need is to hear from the NCMB.”

Independent of geographic location, specialty mix and practice demographics, when I visit with colleagues it inevitably comes up that most licensees hope to avoid the NCMB at all costs. While I certainly understand the sentiment, and appreciate that often these comments are made in jest, I believe this represents an opportunity to do better. The NCMB views licensees and other stakeholders as important partners in its mission of patient protection and is committed to finding ways we can work together. Making meaningful progress towards this goal is a top priority for the Board and for me personally during my term as Board President.

The Board has been working steadily over the past several years to make the NCMB a fundamentally more open, inclusive and transparent organization. As far back as 2010 the Board’s first DO president, Dr.

Don Jablonski, wrote in this very space about the Board’s work to involve stakeholders in key policy decisions by convening roundtable discussions on issues such as administrative medicine, advertising Board certification and physician scope of practice. He wrote that he wished for his term as Board President to be known as a “year of transparency.” Stakeholder roundtables are still going strong, by the way, and have become an important means of gathering feedback. [CONTINUED ON PAGE 2](#)



NCMB President Cheryl Walker-McGill, MD, says Outreach is a process that can result in increased and improved communication, collaboration and strength.

Delegating medical tasks to unlicensed personnel

By Marcus Jimison, NCMB Staff Attorney

In the third year of law school students are taught the universal legal question that must be decided in all cases: “Can I do that?” In at least one respect, medicine has its own version of this universal question. It is, “Who can do what?”

NCMB staff members routinely field inquiries from physicians and others about what medical tasks may be delegated to unlicensed individuals working in medical offices or hospitals. Unfortunately, the answers to these questions are rarely easy. The simple truth is that it is impossible to catalogue everything that healthcare workers do in a vast and rapidly evolving profession. Assuming it was even possible to compile such a list, the job of keeping that list current and complete would be enormous.

There are, however, laws and principles to aid a licensee in determining what tasks may properly be delegated to unlicensed healthcare workers. This article will briefly explain these principles and provide guidance for how to apply them.

First, let’s start with the law. North Carolina General Statute §90-18(c)(13) allows physicians to delegate to a qualified person any act, task, or function that is “permitted by law” or “established by custom.” [CONTINUED ON PAGE 6](#)

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These meetings are one visible example of how the Board has been trying to break down the wall between regulator and licensee. And yet, it is clear to me that many still feel alienated and unheard.

Recently, as part of its strategic planning process, the Board agreed to devote an unprecedented amount of time and resources to outreach, in hope of changing this.

When I think of outreach, I visualize one hand reaching out to another hand. Outreach is a process that can result in increased and improved communication, collaboration and strength. Outreach increases transparency and leads to better interactions. Outreach leads to improved relationships.

Communication

Board Members see outreach as a means of improving communication among the NCMB, its licensees and other key stakeholders. Board Members value the perspectives gained through the NCMB’s interactions with licensees and other professionals. The insights and information the Board receives help ensure that its policies remain relevant.

At the same time, licensees must understand that the Board is a regulatory body, not a voluntary professional organization that advocates for the best interests of its members. This is a nuanced message for the Board to deliver. We want licensees to know that the NCMB offers many resources to support them and that the Board truly wants licensees to thrive. Its mission, however, is to protect patients. We are ready and willing to hear ideas, questions, comments, concerns and even criticisms from licensees and others representing the profession. In return, I ask licensees to accept that the Board’s actions in response to their comments and suggestions must always be balanced against the mission and the best interest of patients and the public.

Licensee comments can drive and, indeed have driven, positive changes to Board processes and policies. The license application process is one example. For years, hospitals, medical practices, physician recruiting firms and licensees themselves have voiced frustrations about the amount of time it takes the NCMB to process license applications. Applicants are typically advised that it may take approximately four months (longer if the applicant has adverse history) for a license to be issued upon receipt of the application. But we have listened to the complaints and concerns, and we have changed this. Sensible modifications to the application process, such as accepting

emailed electronic copies of certain documents and forms in lieu of paper copies, are speeding things up. In the last quarter of 2014 the average time for a license to be issued was just three months. (And this includes applicants who are taking a “casual” approach to the process.)

Collaboration

Outreach provides opportunity for collaboration. With more than 43,000 licensees (nearly 75 percent of whom practice in state), the NCMB’s vision is indeed a shared vision. I believe expanding and strengthening relationships through collaboration will magnify the Board’s ability to fulfill its mission.

As the Board becomes a more active participant in professional meetings and policy discussions statewide, we have found opportunities to partner with organizations that share common goals. For example, last year the NCMB successfully applied for grant funding that it provided to the NC Academy of Family Physicians to help defray the cost of a CME course in opioid prescribing presented at the group’s annual meeting in December. From the NCMB’s perspective, increasing the number of prescribers who are informed about current standards of care can improve quality, which protects patients and prevents situations that might result in regulatory problems.

Another example of collaboration is the Board’s ongoing partnership with the state-run NC Controlled Substances Reporting System (NCCSRS), which tracks all controlled substances dispensed in outpatient settings in North Carolina. New administrative rules will soon allow the NCCSRS to provide the Board with data about the highest volume prescribers, as well as information on prescribers who have had two or more patient deaths from opioid overdose during the previous 12 months. The Board will use this data to identify potentially problematic prescribing and take action, as appropriate, to stop it. This represents a true advance in the NCMB’s ability to protect patients, potentially enabling the Board to address prescribing issues before licensees come to attention due to a patient death or adverse incident.

Strength

The NCMB has been and will continue to be a leader among state medical boards. We could not do this without the support and input from our constituents. Communication and collaboration lead to improved relationships and improved relationships leads to strength.

Obviously, for this to work, the Board needs licensees

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Forum staff

Publisher

NC Medical Board

Editor

Jean Fisher Brinkley

Editor Emeritus

Dale G. Breaden

Contact Us

Street Address

1203 Front Street
Raleigh, NC 27609

Mailing Address

PO Box 20007
Raleigh, NC 27619

Telephone / Fax

(800) 253-9653
Fax (919) 326-1130

Website:

www.ncmedboard.org

E-Mail:

info@ncmedboard.org

Have something for the editor?

forum@ncmedboard.org

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

Schedule a visit with the NCMB

The North Carolina Medical Board is pleased to provide Board Members and/or Board staff to speak to professional groups and other audiences: medical students, residents, professional meetings and conferences, hospital grand rounds, and practice meetings or retreats.

Most programs provide a general overview of the Board's structure, mission and responsibilities as well as in depth discussion around important issues in medical regulation. The Board is also able to develop programs tailored to specific audiences and events upon request.

If you are interested in scheduling a speaker, please contact the Board's Public Affairs Director: Jean Fisher Brinkley, Director at 919-326-1109 x230 or jean.brinkley@ncmedboard.org

to be actively engaged. The Board must continue talking with licensees, not just talking to them.

If you are active in a local or state professional society, serve on a hospital staff, or work in a group practice and would like to invite a Board speaker to an upcoming meeting, I encourage you to contact us. The Board has visited with a number of organizations across the state and we look forward to continuing these discussions. Instructions for scheduling a Board speaker are provided in a box accompanying this article. As we move forward

this year, Board Members and NCMB senior staff will attend and, where possible, present to as many licensee groups and professional meetings as possible. Outreach is one of the top priorities identified in the 2015-2018 Strategic Plan the Board developed and adopted late last year (see below to read all of the NCMB's goals). I am proud to have participated in this process, as I believe that periodically engaging in thoughtful review of challenges and opportunities leads to stronger, more effective organizations.

I and my colleagues on the Board look forward to hearing from all of you, meeting with you and working together for the benefit of the people of North Carolina.

Best Regards,



Cheryl L. Walker-McGill, MD, MBA

NCMB Strategic Plan: 2015- 2018

At its September 2014 Retreat, the Board reached consensus around being more proactive in its mission of protecting the public and more relevant to the constantly changing marketplace, health care practice models, and licensee, stakeholder, and public expectations. The Board also recognizes the uncertainties and complexities inherent in its Current State (2014) and seeks to clarify for those it serves and to lead in its policies - as much as practicable - toward a shared vision of its Future State, by 2018.

BOARD GOVERNANCE

- Vigorous oversight of the NC Physicians Health Program ensures that PHP affords due process; complies with state laws, operating agreements and best practices; and regularly monitors and evaluates treatment centers (2015)
- Ongoing education on Board roles to accrue organizational knowledge and consistency in decision-making (2016)
- NC Medical Practice Act is modernized (2017)
- Board Members view NCMB's effectiveness by Strategic Goals achieved while also continuing to act decisively in licensing and disciplinary duties (2018)

POLICY

- Telemedicine and retail medicine policies balance changes to the delivery of medical care with patient protection (2016)
- Innovative licensure initiatives, including multi-state compacts, as feasible, gain legislative approval and are implemented (2018)

OUTREACH AND TRANSPARENCY

- Policies, protocols and outcomes are widely communicated to all constituencies (2015+)
- Licensee education initiatives for medical schools/students, training programs/residents, and health care systems receive priority (2015+)
- Convenor role engages constituents and informs policy development (2015+)
- NCMB is a trusted resource for policy makers and the public, providing data and analytics to enhance mission (2017)
- NCMB is known for active constituency engagement and collaboration as judged by a stakeholder survey (2018)

ORGANIZATIONAL CAPACITY & OUTCOMES

- Staff reorganization facilitates role of Executive Director in Outreach and Policy, and strengthens internal capacities (2015)
- Data and uses of analytics focus regulatory attention and improve outcomes (2016)
- Cross-training, succession planning and professional development plans exist throughout NCMB organization (2016)
- Performance measures ensure mission efficiencies and regulatory quality (2016)
- Synchronous leadership of Board and senior staff drives organizational effectiveness (2018)

FINANCIAL STRENGTH

- Legislative approval for a fee increase is enacted and investment policy is recalibrated (2015)
- New revenues, ongoing cost controls and optimal use of technology bolster finances (2017)
- NCMB operates with appropriate office and public hearing space (2018)
- Balanced budgets, reserves at 50%, and investments earn three-year rolling average of > 5% ROI, using financial modeling (2018)

The NCMB's approach to regulating telemedicine

Pascal Udekwu, MD

As you know, the NCMB adopted revised position statements related to the practice of telemedicine last fall. The Board's primary goal at the time was to provide important clarifications to telemedicine companies and the licensees they employ while maintaining a strong stance on patient protection.

I believe the revised versions of the Board's positions on Telemedicine and Contact with patients before prescribing do just that.

Changes to the position statements, adopted in November 2014, include the following:

- The expectation that telemedicine practitioners will engage in practice improvement and outcomes monitoring
- Clarification that telemedicine practitioners are held to the "standard of care" governing their practice specialty and there is no separate (or lower) standard of care for telemedicine practice
- Clarification that the physician-patient relationship need not be established through an in-person encounter so long as a physician may acquire the same or superior information through the use of technology and peripherals
- Additional burdens are placed on the practitioner to ensure he or she verifies identity and location of the patient and provides his or her identity, location and professional credentials to the patient
- A new section clarifies constraints on prescribing
- Telemedicine practitioners are held to the same professional standards concerning communication and transfer of health care records to the primary care physician or medical home
- Contact with patients prior to prescribing need not occur through an in-person encounter, so long as a practitioner has access to the same or superior information through telemedicine technology

So far, the response to the revised position statements has been generally positive. Individuals representing telemedicine companies or the telemedicine industry have indicated that the changes clear up questions raised by the previous versions of these statements, removing apparent obstacles.

For example, prior to the revisions it was widely believed that the NCMB's positions on telemedicine and prescribing did not support the issuance of prescriptions to patients following a telemedicine consult. Now, it should be clear that prescribing may be appropriate as part of such an encounter, with the important caveat that the prescriber must have sufficient information

to make a diagnosis. This is a critical point to resolve, especially as telemedicine steadily expands into primary care. It's worth noting that the Board's recent review of telemedicine has largely been focused on this emerging market for telemedicine.

One comment I have heard is that the NCMB could have done more to ease the concerns of telemedicine providers by including lists of treatments or procedures the Board believes can or cannot be handled appropriately via telemedicine. I do not believe this would have been wise, or even possible. New technologies and applications for telemedicine emerge almost daily and it simply not feasible for the Board to maintain a current catalogue of approved or disapproved uses. Such a list would almost certainly be out of date the moment the gavel banged to approve it.

A few licensees have expressed their belief that the NCMB, in developing any policy regarding telemedicine, is needlessly interfering in how medical professionals practice. I suspect anyone who would argue this point lacks a full understanding of the NCMB's mission. The Board has no desire to control how telemedicine is practiced in the state of North Carolina. This should evolve naturally as patient demand, technological capabilities and provider interests allow.

The NCMB's interest in telemedicine is the same as its interest in all care provided to North Carolinians: ensuring that medical treatments provided to patients meet at least minimum accepted and prevailing standards established in North Carolina. The recent revisions to the NCMB's positions on Telemedicine and Contact with patients before prescribing put licensees and the many interests fueling telemedicine's growth across North Carolina on notice that this is so.

It is my hope, and the Board's expectation, that any licensee who practices telemedicine will ensure that he or she is able to provide quality care, and meet all related professional obligations to their patients. At the same time, the Board will remain vigilant and will continue to uphold prevailing standards of care in telemedicine as well as face to face care.



Pascal Udekwu, MD

Dr. Udekwu is a trauma surgeon who practices at WakeMed Health & Hospitals in Raleigh, and the President-Elect of the NCMB. He chaired the Policy Committee that led the recent review and revision of the Board's position statement on telemedicine.

Telemedicine Position Statement

(Adopted July 2010) (Revised November 2014)

"Telemedicine" is the practice of medicine using electronic communication, information technology or other means between a licensee in one location and a patient in another location with or without an intervening health care provider.

The Board recognizes that technological advances have made it possible for licensees to provide medical care to

patients who are separated by some geographical distance. As a result, telemedicine is a potentially useful tool that, if employed appropriately, can provide important benefits to patients, including: increased access to health care, expanded utilization of specialty expertise, rapid availability of patient records, and the reduced cost of patient care.

TELEMEDICINE POSITION STATEMENT

The Board cautions, however, that licensees practicing via telemedicine will be held to the same standard of care as licensees employing more traditional in-person medical care. A failure to conform to the appropriate standard of care, whether that care is rendered in-person or via telemedicine, may subject the licensee to potential discipline by this Board. It is the Board's position that there is not a separate standard of care applicable to telemedicine. Telemedicine providers will be evaluated according to the standard of care applicable to their area of specialty. Additionally, telemedicine providers are expected to adhere to current standards for practice improvement and monitoring of outcomes

The Board provides the following considerations to its licensees as guidance in providing medical services via telemedicine:

Training of Staff

Staff involved in the telemedicine visit should be trained in the use of the telemedicine equipment and competent in its operation.

Evaluations and Examinations

Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate evaluation prior to diagnosing and/or treating the patient. This evaluation need not be in-person if the licensee employs technology sufficient to accurately diagnose and treat the patient in conformity with the applicable standard of care.

Other evaluations may also be considered appropriate if the licensee is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the licensee needs to complete an adequate assessment. On the other hand, a simple questionnaire without an appropriate evaluation may be a violation of law and/or subject the licensee to discipline by the Board.¹

Licensee-Patient Relationship

The Board stresses the importance of proper patient identification in the context of the telemedicine encounter. Failure to verify the patient's identity may lead to fraudulent activity or the improper disclosure of confidential patient information. The licensee using telemedicine should verify the identity and location of the patient and should be prepared to inform the patient of the licensee's name, location and professional credentials. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status evaluation, physical examination and appropriate diagnostic and laboratory testing. Licensees using telemedicine should also ensure the availability for appropriate follow-up care and maintain a complete medical record that is available to the patient and other treating health care providers.

Prescribing

Licensees are expected to practice in accordance with the Board's Position Statement "Contact with patients before prescribing." It is the position of the Board that prescribing controlled substances for the treatment of pain by means of telemedicine is not consistent with the stand of care. Licensees prescribing controlled substances by means of telemedicine for other conditions should obey all relevant federal and state laws and are expected to participate in the



Controlled Substances Reporting System.

Medical Records

The licensee treating a patient via telemedicine must maintain a complete record of the telemedicine patient's care according to prevailing medical record standards. The medical record serves to document the analysis and plan of an episode of care for future reference. It must reflect an appropriate evaluation of the patient's presenting symptoms, and relevant components of the electronic professional interaction must be documented as with any other encounter.

The licensee must maintain the record's confidentiality and disclose the records to the patient consistent with state and federal law. If the patient has a primary care provider and a telemedicine provider for the same ailment, then the primary care provider's medical record and the telemedicine provider's record constitute one complete patient record. Licensees practicing via telemedicine will be held to the same standards of professionalism concerning medical records transfer and communication with the primary care provider and medical home as those licensees practicing via traditional means.

Licensure

The practice of medicine is deemed to occur in the state in which the patient is located. Therefore, any licensee using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina.³ Licensees need not reside in North Carolina, as long as they have a valid, current North Carolina license.

North Carolina licensees intending to practice medicine via telemedicine technology to treat or diagnose patients outside of North Carolina should check with other state licensing boards. Most states require physicians to be licensed, and some have enacted limitations to telemedicine practice or require or offer a special registration. A directory of all U.S. medical boards may be accessed at the Federation of State Medical Boards Web site: http://www.fsmb.org/directory_smb.html.

Breaking this law down, tasks may be delegated to others so long as the following criteria are met:

1. The individual is trained and qualified to do the task. Training may be formal (courses, certificate programs) or informal (demonstrated by the licensee or another qualified individual in the practice setting).
2. The task is “established by custom” or otherwise “permitted by law.”
3. The task is supervised by the physician. Supervision may mean direct supervision or be fulfilled through the licensee’s acknowledgment of his or her responsibility for the actions of the other healthcare worker, depending on the circumstances.

In most instances, the key question in deciding whether it is permissible to delegate a particular task turns on whether delegation is “established by custom.”

The Board has not adopted a precise interpretation for what is meant by “established by custom.” However, the following principles should be taken into account when determining whether delegation of a particular task is “established by custom.”

1. What do other physicians within the specialty do?
2. Is it generally considered acceptable to other physicians within that specialty to delegate the task?
3. Is the task invasive or does it involve a level of risk to the patient?
4. Does the task require licensure if done by someone not working under a physician’s supervision?
5. Is the activity in question regulated by another Board or agency?

If the answer to Questions 1 or 2 is “no,” meaning that physicians within the specialty do not typically delegate such tasks to others or believe it is unacceptable to do so, then the Board would likely determine that delegation is not “established by custom.” In addition, the more invasive a procedure is (Question 3), the more unlikely it is to be customarily delegated to an unlicensed healthcare worker to perform.

If a procedure requires separate licensure or is regulated

by another Board or agency (Questions 4 and 5), then it should not be delegated to an unlicensed worker to perform.

A good example of applying Questions 4 and 5 to a real world situation is the practice of acupuncture. A physician may perform acupuncture if properly trained to do so. However, acupuncture is a regulated profession in its own right and licensed acupuncturists may practice it without physician supervision or involvement. Thus, a physician must not allow a worker who is not a licensed acupuncturist to perform acupuncture even if that person is supervised by the physician and the physician believes the unlicensed individual is qualified to perform acupuncture. To be perfectly clear, a physician cannot delegate an acupuncture procedure to a person who is not a currently licensed North Carolina acupuncturist.

To sum up, a physician should delegate medical tasks only if the physician is satisfied that:

1. The unlicensed worker is qualified to do the task
2. The task can be performed safely by the worker
3. Other physicians within the relevant specialty find it acceptable to allow an unlicensed worker to perform the task
4. The task does not require another healthcare license and
5. The physician provides appropriate supervision

This article may spark even more questions as to when delegation of certain tasks is appropriate. Hopefully, it has provided licensees with a basic framework to come up with the answers. The next time the question of whether to delegate arises, apply the principles outlined in this article to the situation at hand; consult with other physicians in the same specialty and ask what they do; consider what you have learned and, hopefully, the answer will be clear. If you are still at a loss, the Board’s staff is always available to consult.

¹ For purposes of this article, an unlicensed individual is anyone other than a physician, physician assistant, nurse practitioner, registered nurse or licensed practical nurse.
² G.S. § 90-18. Practicing without license (c) The following shall not constitute practicing medicine or surgery as defined in this Article: (13) The performance of any medical acts, tasks, and functions by a licensed physician assistant at the direction or under the supervision of a physician in accordance with rules adopted by the Board. This subdivision shall not limit or prevent any physician from delegating to a qualified person any acts, tasks, and functions that are otherwise permitted by law or established by custom.

The table below lists examples of procedures and task where delegation is appropriate and some where it is not:

Task	Appropriate to Delegate?	Comments
Taking blood pressure	Yes	Minimally invasive, clearly established by custom
Administering flu vaccines	Yes	Minimally invasive, and can be performed safely by a well-trained staff person
Taking an initial or preliminary patient history or assessment	Yes	Requires proper training and supervision
Taking x-rays	Yes	Requires formalized training but not licensure. Completion of a training course and certification would be good indicators of proper training
Laser hair and tattoo removal	Yes	Requires proper training and supervision. Also, requires a pre-treatment history and focused physical by a physician, PA or NP. See Board position statement on Laser Surgery
Laser Eye Surgery	No	Requires specialized training by an ophthalmologist. Risk of serious injury if performed by a non-ophthalmologist is significant
Acupuncture	No	Requires separate healthcare licensure
Physical Therapy	No	Requires separate healthcare licensure
Cosmetic injections, Botox and fillers	No for anyone other than a licensed nurse	Within the specialty of dermatologists and plastic surgeons and others who do cosmetic procedures, injections are customarily delegated to an LPN or RN but not unlicensed individuals.
Surgical assist, closing wounds and suturing	No for anyone other than a specialized nurse	Not customarily delegated to unlicensed individuals and risk of serious injury if performed by an unlicensed individual is significant
Supervision of an RN or LPN	No	Unlicensed personnel may not supervise nursing functions of an RN or LPN

Free Continuing Education program on illegal Online Drug Sales

The Federation of State Medical Boards (FSMB) and the Alliance for Safe Online Pharmacies (ASOP) have teamed up to offer online continuing education (CME/CPE) for physicians and other prescribers, as well as pharmacists. The free program is focused on the growing problem of illegal online drug sales.

This program, entitled “Internet Drug Sellers: What Providers Need to Know,” is a learning activity that encourages participants to discuss the risks and patient safety issues involved with purchasing medications from a rogue Internet pharmacy. The program is available at www.fsmb.org/free-online-cme-cpe-activity.

The course will guide participants through understanding the common characteristics of illegal online drug sellers while raising awareness about the issue. After completing the program physicians and pharmacists will have a proficient understanding of this issue and be armed with the current tools and resources

to identify fraudulent online pharmacies.

Recent studies found that nearly 97% of online drug sellers are operating illegally, and that half of websites selling medicine online deal in counterfeit drugs. Consumers, lured by the cheap prices promised on rogue websites, may end up paying a higher price than anticipated, as medications may be counterfeit, ineffective, or adulterated with other ingredients, including potentially toxic chemicals. The problem is significant, with an estimated one in six Americans purchasing drugs online without a valid prescription at some point.

Experts agree that education is the key to combating the problem effectively. As trusted health care professionals, physicians, physician assistants and other prescribers, along with pharmacists, play a key role in educating consumers about the risks associated with purchasing medications online from an unverified source. This program offers medical professionals the information necessary to help patients protect themselves from illegal online drug sales. Input for this activity was provided by the U. S. Food and Drug Administration and from faculty from the University of California at San Diego, LegitScript and the Federation of State Medical Boards.

FREE CME

www.fsmb.org/free-online-cme-cpe-activity

Call for applicants: Serve on the NCMB

The terms of four sitting Medical Board members expire October 31, so now is the time to apply if you have ever considered serving the state of North Carolina and the medical profession in this capacity.

Applicants are needed for two physician seats on the Board and for one seat that is reserved for a physician assistant or nurse practitioner. In addition, one seat is available for a member of the public, to be directly appointed by the Governor. The three remaining seats (two physicians, one PA or NP) must be filled by the process set down in statute (N.C. Gen. Stat. § 90-2 and 90-3), which requires interested parties to apply via the Review Panel, an independent body that nominates candidates for consideration by the Governor. By law, the Review Panel must nominate two candidates for each open seat for the Governor’s consideration. All Board Member terms are three years, beginning Nov. 1 and ending October 31, 2017. Instructions for applying via either pathway (Review Panel or direct gubernatorial) are below.

Review Panel-nominated openings

Under North Carolina law, interested parties must apply through the Review Panel. This independent body screens applicants, conducts interviews and makes recommendations to the Governor, who then appoints physicians to the Medical Board. The Review Panel will only consider physicians (MDs or DOs) who hold active, unrestricted NC medical licenses. Applicants must be actively practicing clinical medicine at least part time and must have no history of disciplinary action within the past five years. Applications are due by July 1.

The Review Panel will interview all qualified applicants in Raleigh in August. All three of the positions for which applicants are sought currently are held by Board members who are eligible for reappointment; however, these Board Members must go through the application and interview process. For more information, contact Jerel Noel, the Review Panel Administrator, at (919) 861-4545.

Direct gubernatorial appointments

Applicants are needed for one public member seat. The individual currently occupying the public member seat is eligible for reappointment, but must reapply. The public member position is open to anyone except a licensed health care professional, or the spouse of one. Public members are appointed directly by Governor Pat McCrory. For instructions on how to apply, visit <http://www.governor.state.nc.us/administration/boards-and-commissions2>

LEARN MORE

Review Panel: <http://ncmedboardreviewpanel.com/>

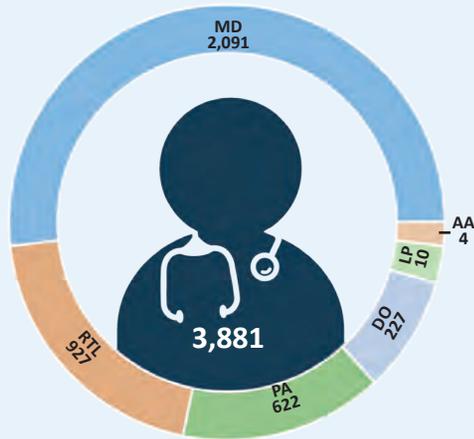
Gubernatorial: <http://www.governor.state.nc.us/administration/boards-and-commissions2>

Year in Review: A look back at data from 2014

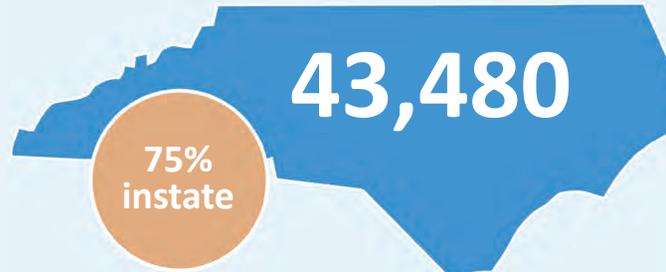
Data reflects information for the calendar year beginning Jan. 1, 2014 and ending Dec. 31, 2014

MD: Physicians, DO: Osteopathic Physician, RTL: Resident Training Licensee, PA: Physician Assistants, LP: Licensed Perfusionist, AA: Anesthesiology Assistant

TOTAL LICENSES ISSUED

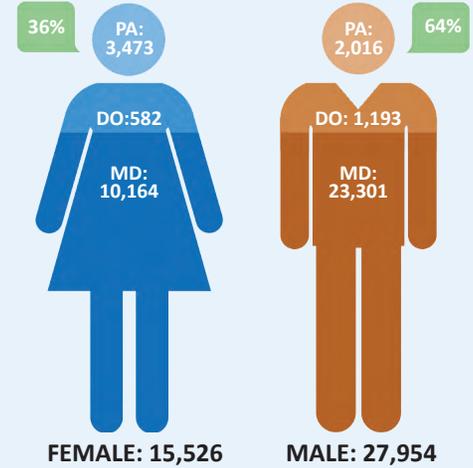


TOTAL LICENSEE POPULATION



MD: 33,465 | DO: 1,775 | RTL: 2,597
PA: 5,489 | LP: 138 | AA: 16

TOTAL BY SEX



PHYSICIAN ASSISTANT POPULATION BY COUNTY

Age Group	County	Count
0 - 4	Alleghany	3
	Anson	4
	Ashe	4
	Avery	1
	Bertie	4
	Camden	0
	Caswell	4
	Chowan	3
	Clay	1
	Gates	1
	Graham	1
	Greene	3
	Hyde	1
	Jones	1
	Madison	3
	Northampton	1
	Pamlico	3
	Perquimans	4
	Tyrell	0
	Warren	3
Washington	3	
Yancey	3	
5 - 9	Alexander	6
	Bladen	6
	Caldwell	9
	Cherokee	8
	Currituck	5
	Franklin	7
	Hertford	8
	Macon	7
	Martin	5
	Mitchell	7
	Montgomery	8
	Pender	9
Person	9	
Polk	6	
Richmond	6	
Stanly	9	
Stokes	9	
Yadkin	6	
10 - 20	Beaufort	15
	Chatham	15
	Dare	18
	Davie	16
	Duplin	13
	Edgecombe	15
	Halifax	12
	Haywood	14
	Hoke	11
	Jackson	19
	Lenoir	15
	Lincoln	12
McDowell	17	
Rutherford	17	
Sampson	12	
Scotland	16	
Swain	13	
Transylvania	10	
Wilkes	14	
21 - 49	Alamance	44
	Brunswick	49
	Burke	34
	Carteret	34
	Cleveland	27
	Columbus	25
	Davidson	22
	Granville	22
	Lee	27
	Nash	41
	Onslow	48
	Pasquotank	23
Randolph	36	
Rockingham	21	
Surry	32	
Union	41	
Vance	27	
Watauga	23	
Wilson	35	
50 - 615	Buncombe	212
	Cabarrus	72
	Catawba	81
	Craven	51
	Cumberland	262
	Durham	369
	Forsyth	412
	Gaston	78
	Guilford	272
	Harnett	51
	Henderson	50
	Iredell	65
Johnston	61	
Mecklenburg	615	
Moore	93	
New Hanover	202	
Orange	78	
Pitt	136	
Robeson	61	
Rowan	59	
Wake	563	
Wayne	53	
TOTAL	In State	4,962
	Out of State	526
	Grand Total	5,488

PHYSICIAN ASSISTANT POPULATION GROWTH



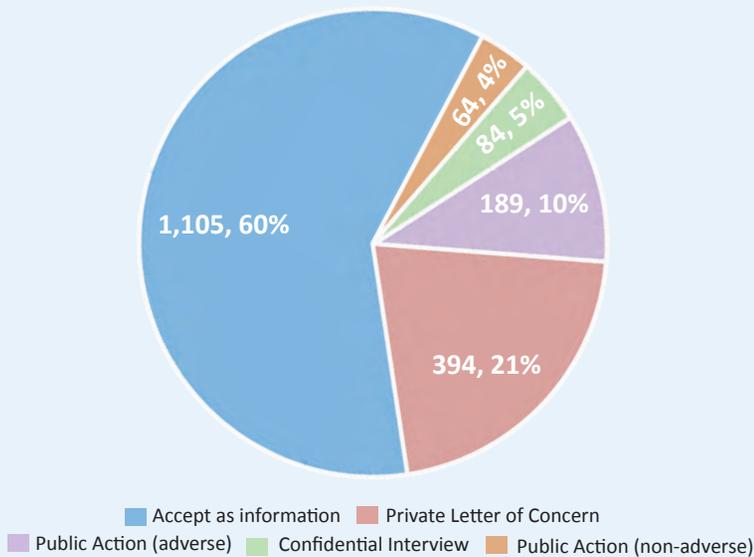
Physician assistants are the fastest growing licensee group regulated by the NCMB. In each of the past three years, the annual growth in the PA licensee population has exceeded 7 percent, and the PA population has increased by nearly 25 percent since 2010. By comparison, the number of licensed physicians has increased by about 4.5 percent since 2010. Current physician population data is available in the NCMB's 2014 Annual Report, available online at www.ncmedboard.org

FINES RECEIVED

Fines collected benefit the NC Department of Education.



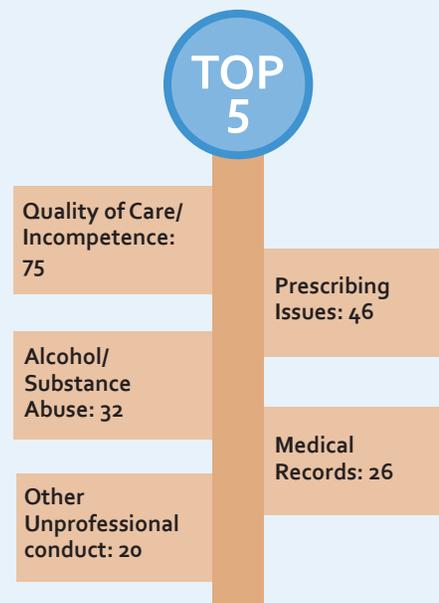
PUBLIC & PRIVATE ENFORCEMENT ACTIVITIES**



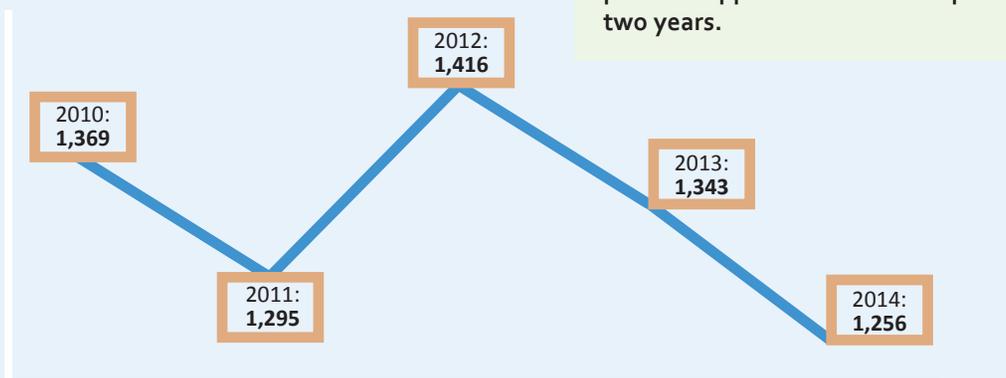
ADVERSE ACTIONS



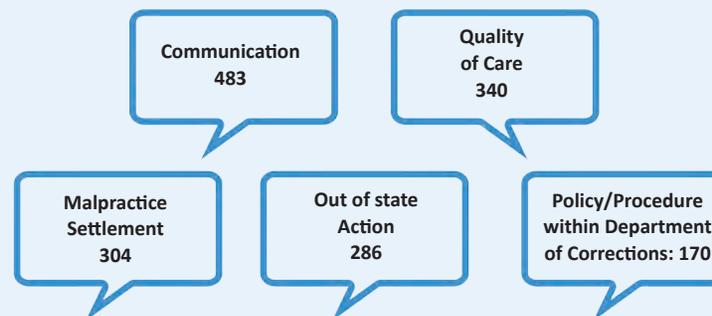
CAUSES OF PUBLIC ACTION



COMPLAINTS BY YEAR



TOP FIVE DISCIPLINARY CASE ALLEGATIONS



Total complaints received in 2014: 1,304

It's time to get your licensee information page ready for visitors

The NCMB maintains the state's largest and most comprehensive database of information about licensed physicians and physician assistants. This information, accessed via the Board's website, is the most used resource on the NCMB's website, with about 3,000 "hits" each business day. In a given year, the Board's Licensee Information pages, which provide comprehensive information about every physician and physician assistant licensed by the Board, receive more than three-quarters of a million visits. Soon, that number may be even larger.

Over the next few months, the NCMB will launch an online public outreach campaign promoting the Board's Look Up a Licensee tool. This goal of this campaign is to raise awareness of the Board and its mission, and position the NCMB as the state's definitive source of information about licensed physicians and PAs.

For licensees, that means now is the time to make sure their licensee information is accurate and complete. This article will briefly review all types of licensee required to be reported to the Board under NCGS 90-5.2-5.3, as well as the numerous categories of optional information that provide additional useful information to patients and other users.

VISIT US ONLINE FOR MORE

For tips on managing your online reputation visit the online version of the Forum <http://www.ncmedboard.org/newsletter>

Non-Adverse Required Information

There are 12 types of required information, including non-adverse and adverse categories, required under NCGS 90-5.2, 5.3. All licensed physicians and PAs must report information in these categories, if any exists

1 Address and telephone number of the primary practice setting: Licensees have the opportunity to review and, if needed, update this information as part of the online annual license renewal process. Even so, keeping addresses and phone numbers up to date is a constant challenge (as evidenced by the volume of returned mail received by the Board). Licensees may update their address and phone information at any time by logging in to the Licensee Information portal on the NCMB's website.

2 Area(s) of practice: This information is meant to describe the licensee's current primary clinical activities. Often, though not always, area of practice matches the licensee's area of specialty training. Licensees should make sure to designate a primary area of practice. Failure to designate a primary area of practice may result in the licensee's exclusion from certain searches and reports, making it difficult or impossible for Web visitors to access their information. Tip: Be discriminating when selecting areas of practice. This category is intended to capture the licensee's main areas of clinical interest, not to list every possible area in which he or she is competent to practice. Example: Primary area of practice: Anesthesiology; All areas of practice: Anesthesiology, Pain medicine

3 Hospital privileges (within NC): If held, privileges should be noted by facility name. Don't forget to promptly remove facilities if hospitals are relinquished or lost.

4 Medical, osteopathic or physician assistant schools/programs attended and graduation dates: The Board pulls this from license application information on file. A brief check to verify the accuracy

of the educational institution and graduation date is all that is required of the licensee.

5 Graduate medical or osteopathic training (residency) programs attended and completion dates: When the Board initially launched expanded licensee information pages in December 2009, the scope of information captured about postgraduate training did not include area of training, though it was later added. Look over your training information and make sure each institution attended, area of training completed and training completion dates is accurate.

6 Board certifications: Initially, the NCMB recognized and posted only certifications conferred by boards approved by the American Board of Medical Specialties, Bureau of Osteopathic Specialists of the American Osteopathic Association or the Royal College of Physicians and Surgeons of Canada. The Board's current policy allows for boards not affiliated with these organizations to be posted provided they meet certain criteria. These criteria are listed in the Board's Position Statement on

7 Medical licenses, active or inactive, granted by another state or country: The Board does not currently distinguish between active or inactive out of state or out of country licenses. As with all other types of required information, it is the responsibility of the licensee to ensure that this information is updated as new licensees are obtained. According to the most recent national physician census data, more than 20 percent of doctors are licensed in more than one state, and the number is growing as practice patterns change with the advent of new technologies and telemedicine models.



Adverse Required Information

The vast majority of licensees do not have any information to report in any of the following adverse categories. The NCMB estimates that approximately 6 percent of licensees have reportable information in one or more of the following categories.

- 1 Final suspensions or revocations of hospital privileges** Only final actions are posted; matters that are pending appeal, or actions that have been reversed are not public. Hospital actions are posted for a period of 7 years.
- 2 Final disciplinary orders or actions of any regulatory board or agency:** This includes actions taken by other state medical boards, the U.S. Food and Drug Administration, the U.S. Drug Enforcement Administration, Medicare or the N.C. Medicaid program, among others. Just like NCMB public actions, orders or actions of other regulatory boards and agencies are posted indefinitely.
- 3 Felony convictions:** All felony convictions are posted. They remain part of the licensee's posted information indefinitely.
- 4 Certain misdemeanor convictions:** State law specifies that convictions involving offenses against

a person, offenses of moral turpitude, offenses involving the use of drugs or alcohol and violations of public health and safety codes are public information. Additional information about the specific types of misdemeanor convictions posted to a licensee's public information page can be found in administrative rule 21 NCAC 32X .0104 and in the Licensee Information Reporting Guide posted on the Board's website (found under Licensee Info Pages in the Professional Resources section). Misdemeanors are posted for 10 years.

- 5 Certain malpractice payment information:** Posting criteria for malpractice payments are set by statute. In accordance with state law and related administrative rules the following information is posted: 1. All judgments or awards that occurred on or after Dec. 1, 2002, and 2. Settlements or other payments of \$75,000 or more that occurred on or after May 1, 2008. No dollar amounts or information that might identify a patient are published. Malpractice information is posted for seven years.



Optional Information

The Board provides licensees with the opportunity to supplement required information with information in several optional categories that may be of interests to patients and the public. The Board highly recommends reporting information in these optional categories. An accurate, complete licensee information page provides useful, objective information to visitors. Optional information that may be reported includes:

- 1 Licensee photo:** The NCMB added the option of uploading a photo, subject to NCMB guidelines, last year. Photos are uploaded via the licensee information portal on the NCMB website
- 2 Practice Web address:** Gives patients and others to access your practice website directly from your NCMB licensee information page.
- 3 Days licensee sees patients:** At the primary practice setting This information may be especially useful to licensees who practice academic medicine, or who divide time between multiple professional obligations
- 4 Number of years in clinical practice** (since completing residency): Gives visitors a rough idea of how long you have practiced clinical medicine. If you provide this information, be sure to update it every year at renewal to avoid being "frozen" in time.
- 5 Participation in Medicare and Medicaid and whether you are accepting new patients in these insurance programs:** This information is

valuable to patients on these public insurance programs and can save them the time and frustration of seeking appointments from licensees that do not accept their insurance, or who have capped their Medicare and/or Medicaid patient populations.

- 6 Description of practice philosophy:** A favorite optional category among patients. Practice philosophy provides the licensee with an opportunity to communicate how he or she approaches patient care.
- 7 Whether you use electronic medical records in the office setting**
- 8 Non-English languages spoken in the office and by the licensee:** Very helpful patients who are not fluent in English, or who are seeking a provider who speaks a particular language
- 9 Things that set you apart** Honors and awards, professional volunteer service (work in indigent clinics, etc.), current faculty appointments, professional publications (peer-reviewed), memberships in professional organizations

North Carolina Medical Board

Quarterly Board Actions Report | November 2014 - January 2015

The Board actions listed below are published in an abbreviated format. The report does not include non-prejudicial actions such as reentry agreements and non-disciplinary consent orders. Recent Board actions are also available at www.ncmedboard.org. Go to "Professional Resources" to view current disciplinary data or to sign up to receive notification when new actions are posted via the RSS Feed subscription service.

Name/license #/location	Date of action	Cause of action	Board action
ANNULMENTS			
NONE			
SUMMARY SUSPENSIONS			
LEWIS, Randall Eugene, PA (001001908) Monroe, NC	11/26/2014	Between 2011 and May 2014, PA committed a series of sexual assaults on a minor female who is related to him.	Order of Summary Suspension of PA license
REVOCATIONS			
NONE			
SUSPENSIONS			
FAKHRI, Mouhamed Iyad, MD (200301225) Clinton, NC	12/10/2014	History of substance abuse, felony arrest in August 2013 on six counts of violating the NC Controlled Substances Act. MD inappropriately diverted Methadone and Tramadol to self-treat his back pain, while under the care of a treating physician, who prescribed Fentanyl and Neurontin for the pain. The treating MD was unaware that MD self-treated with the other drugs.	Indefinite suspension
FONDINKA, Godfrey Sama-Nyuvaga, MD (200301461) Fayetteville, NC	12/18/2014	Inappropriate prescribing of controlled substances; MD failed to appropriately respond to signs, including positive urine drug screen tests, that patients may have been abusing medications.	Indefinite suspension, immediately stayed; MD is limited and restricted from prescribing Schedule II or III medications. Within six months, MD must complete CME in medical records documentation.
HAMATY, Daniel, MD (000022732)	01/22/2015	Action by another state medical board (Tennessee) related to MD's misrepresenting himself as the owner of a Tennessee pain clinic. In fact the pain clinic was owned by an unlicensed layperson.	Indefinite suspension
MCCARTHY, James Andrew, MD (000031173) Oxford, NC	12/04/2014	While attending a delivery, MD struck a nurse midwife assisting with the delivery. The nurse midwife was not injured; MD has apologized to the nurse midwife for his conduct.	MD's license is suspended for 60 days, applied retroactively to the period starting on Aug. 14, 2014, and ending on Oct. 12, 2014. MD shall maintain NCPHP contract and abide by all terms.
PENROSE, John Frederick, MD (200400569) Lumberton, NC	01/14/2015	History of alcohol abuse	MD is suspended for six months, immediately stayed; MD must maintain NCPHP contract and abide by all terms.
VISCARDI, Jeffrey Joseph, MD (000039346) Greenville, NC	11/21/2014	Between 2005 and 2010, MD engaged in a romantic relationship with a patient, to whom MD provided ophthalmological care. In addition, MD prescribed and administered Botox injections to this patient and also prescribed antibiotics.	MD's license is suspended for six months, stayed except for a period of 60 days to run from Nov. 27, 2014, until Jan. 25, 2015. MD shall maintain NCPHP contract and abide by all terms.

BOARD ACTIONS REPORT

Name/license#/location	Date of action	Cause of action	Board action
PROBATIONS			
NONE			
REPRIMANDS			
ANDREWS, Thomas John, MD (201001012) Chocowinity, NC	12/30/2014	History of substance abuse	Reprimand; MD is placed on probation; MD must maintain NCPHP contract and abide by all terms.
BAILOR, Fred Ralph Waring, DO (000027890) Easton, MD	01/21/2015	Action by another state medical board (Maryland) related to DO's failure to provide care that met accepted standards in an outpatient surgery facility and failure to maintain adequate patient medical records.	Reprimand
CASE, Steven Lee, MD (201300342) Eden, NC	01/20/2015	While practicing in Florida, MD failed to timely provide X-rays requested by the patient. It was later determined that MD destroyed the X-rays, even though they were less than five years old (it is the standard to retain X-ray films for at least five years before destroying them). Later, MD relocated to NC without first appropriately notifying his patients in Florida that he was leaving the state.	Reprimand
CHAMPION, Lawrence Andrew, MD (000019912) Durham, NC	12/10/2014	In 1978, MD had an intimate encounter in his office, with a patient who presented to him for psychiatric care. Shortly after the encounter, MD and patient agreed to terminate the physician-patient relationship, and the relationship continued until 2004. The Board believes, consistent with the American Psychiatric Association's Principles of Ethics with Annotations Especially Applicable to Psychiatry, that sexual activity with a current or former patient is unethical.	Reprimand
DIAZ, Gustavo Adolfo, MD (200802055) Huntersville, NC	12/11/2014	Concerns about the quality of care provided to patients MD performed facelifts on; Concerns about prescribing	Reprimand; MD agrees to use the NC Controlled Substances Reporting System
KWIATKOWSKI, Timothy Carl, MD (009701443) Durham, NC	12/01/2014	History of substance abuse (specifically Adderall, a Schedule II controlled substance), arrest for DWI. A Board investigation determined that MD was engaged in a reciprocal arrangement with another physician wherein each would prescribe Ambien, a Schedule IV controlled substance, to the other without maintaining appropriate medical records.	Reprimand; MD must maintain NCPHP contract and abide by all terms
TAMBA, Ismael, MD (201001565) Wake Forest, NC	12/11/2014	MD prescribed controlled substances to a patient while engaged in an unduly familiar relationship with the patient that including sending texts not related to MD's care of the patient. On three occasions, MD did not appropriately document prescriptions.	Reprimand
DENIALS OF LICENSE/APPROVAL			
FARRELL, Julie Ann, MD (NA)Augusta, KY	12/18/2014	Errors and omissions on NC medical license application, including failure to note an action by the State Medical Board of Ohio. MD made the errors and omissions after being specifically advised, during a 2013 licensing interview with NC Board Members, to list the Ohio action on her application.	Denial of application for NC medical license

BOARD ACTIONS REPORT

Name/license#/location	Date of action	Cause of action	Board action
SURRENDERS			
KESSEL, John Woodruff, MD (000036206) Hickory, NC	11/01/2014		Voluntary surrender of physician license
WATT, Alan Henderson, PA (001000395) Greensboro, NC	12/17/14		Voluntary surrender of physician assistant license
PUBLIC LETTER OF CONCERN			
BELL, William Lee, MD (000023828) Robbins, NC	01/29/2015	MD prescribed controlled substances to an immediate family member who was experiencing severe pain, in conflict with administrative rules that prohibit prescribing to close family.	Public Letter of Concern; MD must complete 10 hours of CME in controlled substances prescribing
DALLAS, (Jr), Anthony Vernon, MD (201100465) Hendersonville, TN	01/14/2015	Action taken by Mississippi medical board	Public letter of concern
DAUS, Patrick Glenn, DO (009501216) Sulphur Springs, TX	01/07/2015	The Board is concerned that DO's care of a patient who presented to DO in the emergency room complaining of discomfort and bleeding associated with a catheter placed following radical prostatectomy surgery may have been below accepted standards. An independent expert review obtained by the Board was of the opinion that DO should have consulted with a urologist before ordering that a larger diameter catheter be placed. A day after the new catheter was placed, the patient returned to the ED for evaluation and was found to have urethral disruption and catheter misplacement. This required surgery to correct and the patient reports postoperative incontinence and pain. A different treatment plan might have been developed and the second surgery might have been avoided had DO consulted with a urologist.	Public letter of concern
GILLILAND, J. David, MD (201300198) Lakewood, CO	11/17/2014	Quality of care; While practicing in Colorado, MD failed to diagnose a lucent bony lesion in the tibial metaphysis of a patient MD misdiagnosed with knee sprain.	Public letter of concern
LEPORE, Henry, MD (009601376) Sunset Beach, NC	12/18/2014	Concerns about some aspects of MD's opioid prescribing; MD has completed CME in prescribing controlled substances and made improvements, which independent expert reviews verified have improved prescribing.	Public letter of concern
MAHAN, Dennis Michael, MD (000025053) Oxford, NC	12/10/2014	The Board is concerned that some aspects of OB care MD provided to a high risk patient who delivered a stillborn baby may have been below standard. An independent expert reviewer expressed concern that MD may not have recognized and appropriately acted upon signs of ongoing and increased fetal distress during labor. MD no longer practices obstetrics.	Public letter of concern
NORMANN, Sandra, MD (201300804) Fayetteville, NC	11/04/2014	MD failed to appropriately notify patients that she planned to leave the country and would not be returning.	Public letter of concern
OTUSESO, Eniola Oluyemisi, MD (200501662) Atlanta, GA	11/04/2014	The Board is concerned that MD's treatment of a patient admitted to the hospital with upper respiratory infection and severe hyponatremia failed to conform to accepted and prevailing standards.	Public Letter of Concern; MD must complete CME course on managing hyponatremia and electrolyte disorders within six months of the date of the letter.

BOARD ACTIONS REPORT

Name/license#/location	Date of action	Cause of action	Board action
SHERRILL, Kimberly Ann, MD (000028695) Little Rock, AR	11/12/2014	The Board is concerned that MD had an action taken against her AK medical license related to failure to comply with that state's CME requirements.	Public letter of concern
THAKKAR, Pradip Chimanlal, MD (000036440) Wilkesboro, NC	01/13/2015	The Board is concerned about the quality of care MD provided to a patient with diabetes, hypertension and dyslipidemia who presented with complaints of difficulty swallowing and oral lesions. MD diagnosed the patient with oral and possible esophageal candidiasis and prescribed Mycelex and Diflucan. The patient returned a week later with continued complaints of throat and mouth soreness and again the following week with poor appetite and weight loss. Blood work obtained at the third visit was not reviewed until two days after the visit and found the patient's BUN, creatinine and potassium levels elevated and her TSH low; all were significantly changed from prior levels. MD advised the patient to go to the hospital; the hospital emergency department arranged for a transfer to a different hospital for treatment. En route, the patient coded. The patient remained on life support for nine days before succumbing to renal failure and thyroid storm.	Public letter of concern
MISCELLANEOUS ACTIONS			
MITCHELL, James Alistair, MD (200400921) Hope Mills, NC	12/04/2014	History of alcohol abuse; Arrests for DWI in Nov. 2013 and March 2014; MD has completed residential treatment.	MD shall maintain NCPHP contract and abide by all terms; MD shall abstain from possession and/or use of alcohol.
CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			

FINES

The NCMB issues non-disciplinary administrative fines in certain cases where incorrect and/or incomplete information on a medical licensing application causes Board staff to spend an inordinate amount of time resolving the issue(s).		
Date	Reason	Amount
1/29/2015	Error/omission on license application or annual renewal	\$2,500.00

North Carolina Medical Board
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BOARD MEETING DATES

May 13-14, 2015 (Full Board)
June 18-19, 2015 (Hearings)
July 15-16, 2015 (Full Board)
August 20-21, 2015 (Hearings)

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

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

2014 Annual Report now available

The NCMB recently published its agency annual report, reflecting the Board's work during calendar year 2014. The Board has published a limited number of paper copies, which are available upon request. To request a hard copy, email your name and mailing address to public.affairs@ncmedboard.org

The NCMB has a long history of publishing annual data regarding the public actions taken by the Board each year. The annual report continues this tradition, while substantially increasing the scope of data released about the Board's activities.

The Annual Report features data on complaints and other investigative information received by the Board, data on malpractice reports received by specialty area of practice and information on the number of private actions taken by the Board. The report also includes information about policy initiatives and licensing program activity, as well as demographic information about the Board's licensees.

To view online, visit www.ncmedboard.org/disciplinary_reports and select the tab labeled "Annual Reports."

