FORUM
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FOR THE BENEFIT AND PROTECTION OF THE PEOPLE OF NORTH CAROLINA
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Moving forward in an era of emerging technologies

Every once in a while there comes a moment in one's career that inspires reflection. For me, as I begin my year as NCMB President, this is one of those rare moments. I started my career many years ago at Duke University sitting on the steps of what was then a brand new hospital overwhelmed with the possibilities and, at the same time, excited about the future of medicine and my life as a physician. I was humbled when I realized I was one of the first students to enter the doors of the magnificent new building. The emotions I felt then, I feel now as I rise to lead the Board during a challenging and transformative time in medicine.

NCMB President Cheryl Walker-McGill, MD, says organizations must have "the ability to identify emerging issues and act swiftly to find solutions."

Medicine is entering a new frontier of healthcare delivery. We are transitioning from volume-based to value-based healthcare, spurred by the expansion of telemedicine, the rise of innovations such as 3-D printing and robotics and consumer technologies including smartphones and other mobile devices. It is difficult to conceive how dramatically medicine has changed since 1859, when the North Carolina Medical Board was established. Yet amid all of the changes, the mission of the Medical Board has remained the same: to regulate medicine and surgery for the benefit and protection of the people of North Carolina. Patient safety is and will remain at the center of every important policy decision.

A new era requires new and innovative strategies, and the NCMB is committed to developing them. In September 2014, the NCMB took its first step by participating in a strategic planning retreat. Board Members and staff, with the help of an independent moderator, reviewed the NCMB's organizational structure and Board governance to help ensure that we are optimally positioned to meet future challenges. Fortunately, we have a strong foundation upon which to build. For their prior contributions, I wish to thank the many leaders in North Carolina who have guided the NCMB with vision, dedication and strength, including recent past Board presidents, Drs. Janice Huff, Ralph Loomis, Will Walker and Paul Camnitz.

Dr. Camnitz, the Board's immediate Past President, devoted his final President's Message (*A Medical Board of action: How the NCMB works to anticipate and address challenges in medicine, Forum*, Fall 2014) to discussion of the many ways the Board has become a more proactive organization. The ability to identify emerging issues and act swiftly to find solutions is essential to any organization that hopes to remain relevant. The Board's recent policy work on telemedicine is a prime example – one that, I believe, demonstrates the NCMB's ability to successfully navigate the challenges of the changing healthcare marketplace.

The NCMB and telemedicine

The ways in which medical care is delivered has evolved over time. In the mid-19th century, when the NCMB was established, it was customary for patients to receive medical care at home. By the early 20th century, during the post-industrial era, the pendulum swung away from house calls and patients began seeking services outside of their homes as access to medical care and the types of medical care services expanded. This model has remained in place, with few exceptions, for the better part of the last one hundred years.

In the 21st century, patients are seeking immediate and convenient access to care. This trend can be seen in the rapid rise of retail medical clinics set in superstores and

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pharmacy chains over the past decade, and it is evident today in the momentum driving expansions in telemedicine and wearable technologies. The Board has an inherent interest in telemedicine, as it does in any process change in health care that directly impacts the delivery of patient care. The NCMB has a responsibility to patients to take steps to ensure that telemedicine practiced in our state, meets accepted standards of care and patient safety.

The most direct way the Board has influenced telemedicine in North Carolina is through its position statements on *Telemedicine* and on *Contact with Patients Before Prescribing*. After a comprehensive review, the Board adopted revised versions of both position statements at its November meeting. The review process included months of consultation with stakeholders including our licensees, professional groups and telemedicine industry representatives. The latest versions maintain the Board expectation that any care provided to patients in North Carolina must conform to the accepted and prevailing standards of the applicable specialty area of practice, regardless of how care is delivered. In other words, there is no separate standard of care for telemedicine. Revisions to the prescribing position statement address the important question of whether "contact" with the patient must always occur via an in-person encounter. The new version of the position statement makes clear that it need not, as long as sufficient clinical information upon which to base diagnostic and treatment decisions is obtained. Read the full texts of both of these position statements starting on p. 7.

The relationship between medical regulators and the telemedicine industry has never been comfortable. Some industry groups see medical boards, at best, as old fashioned in their attitudes towards telemedicine and, at worst, as outright obstructionists. However, this is simply not the case in North Carolina. The Board has never spoken out against telemedicine. Its priority has always been, as a 2011 Forum article by my colleague Janice Huff, MD, pointed out, to keep the emphasis on medicine in telemedicine. I respectfully submit that it is not old-fashioned to remain faithful to the NCMB's mission – it is principled.

The NCMB is primarily concerned with the recent trend towards using telemedicine as a delivery system for primary care, which is without question the most active segment of the industry. This broader use of telemedicine represents a significant change to our current healthcare delivery system. As with any change, it is prudent to proceed carefully. I am proud of the open, inclusive process the Board used to consider changes to its policies regarding telemedicine and believe the resulting revisions provide meaningful guidance to licensees.

At the end of the day, the NCMB is committed to ensuring the people of North Carolina have access to quality healthcare. We will continually review our processes to ensure transparency and opportunity for North Carolinians to have a voice in the formulation of policies that enable the Board to fulfill its obligation to protect patients.

The tasks that lie ahead may at times seem overwhelming, but I and my colleagues on the Board are excited about the possibilities and look forward to this new era in healthcare delivery.

Best Regards,

Cheryl L. Walker-McGill, M.D.

North Carolina Medical Board Forum Credits

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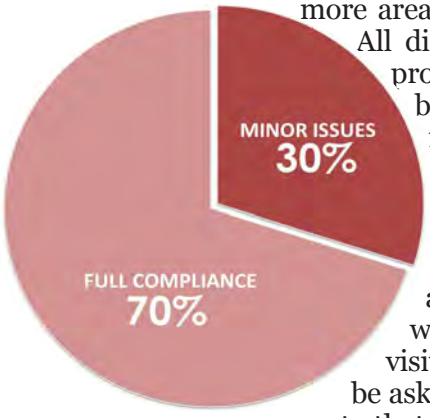
2014 PA compliance checks find most in compliance

PA site visits conducted in 2014 resulted in no public or private actions for the first time since the NCMB began conducting these compliance reviews in 2005. Congratulations to the licensees involved.

About 70 percent of physician assistants selected for compliance review visits in 2014 were in full compliance with applicable Board rules and regulations. The remaining 30 percent of PAs reviewed had one or more areas of minor noncompliance. All discrepancies were corrected promptly and no further action by the Board was deemed necessary.



The Board has already selected PAs for site visits to be conducted in 2015. PAs will be contacted by a Board field investigator, who will schedule the site visit. During the visit, PAs will be asked to produce certain documents that are required to be kept on file at each of the PA's practice locations.

PAs selected for review are notified in advance by a Board investigator, who schedules a face-to-face meeting. The PA is asked to produce certain documents that must be kept on file at the PA's practice location. The Board investigator also asks the PA a series of questions regarding his or her practice arrangement, such as how frequently he or she has one-on-one direct contact with the supervising physician.

PAs may be asked to produce the following information:

• **Written Supervisory Arrangement Statement:** Rule NCAC 32S .0213 (c) requires a signed written Supervisory Arrangement statement to be kept on file at all practice sites and be available upon request by the Board.

• **Intent to Practice Form:** Rule NCAC 32S .0203 mandates that a notification of intent to practice form be submitted to the Board prior to the performance of any medical acts, tasks, or functions under the supervision of a primary supervising physician. Such form is located on the Board's website. The rule further reads that the physician assistant shall not commence practice until he/she receives acknowledgment from the Board that the Board has received and processed the Intent to Practice Form.

• **Quality Improvement Meetings:** Rule NCAC 32S .0213 (d) requires the primary supervising physician and physician assistant in a new practice arrangement to meet monthly for the first six months to discuss practice relevant clinical issues and quality improvement measures and thereafter, meet at least once every six months. A written record of these meetings shall be signed and dated by both the supervising physician and physician assistant and shall be available for inspection upon request by the Board agent.

• **Prescriptive authority:** Rule NCAC 32S .0212 requires that each prescription issued by the physician assistant contains the physician assistant's name, practice address, and telephone number; the physician assistant's license number and, if applicable, the physician assistant's DEA number; and the responsible supervising physician's (primary or back-up) name and telephone number. Be aware that when using an electronic prescription, this same information is required to be on that prescription format as well.

• **Instructions for Prescribing, Ordering, and Administering Drugs and Medical Devices and a Policy for Periodic Review by the Physician of These Instructions and Policy:** Rule NCAC 32S .0212 (2) requires each supervising physician and physician assistant team to incorporate within his or her written supervisory arrangements instructions for prescribing, ordering, and administering drugs and medical devices and a policy for periodic review by the physician of these instructions/policy. The periodic review should occur at least annually between the physician and physician assistant.

• **Back-up Supervising Physicians:** Each physician assistant needs to maintain an ongoing list of back-up supervising physicians, if any are used. This document must be signed and dated by all involved and retained as part of the Supervisory Arrangement. At a minimum, it should be updated yearly; more often if a new physician agrees to serve as the physician assistant's back-up.

Are you in compliance?

Don't wait to be selected for a site review to make sure you are in full compliance with supervisory rules. A complete description of the information PAs should expect to provide during a compliance review is available on the PA Site Visit Checklist, which is available online in the Professional Resources section of the Board's website under "Physician Assistant Forms". The Board publishes this information on its website in an effort to encourage compliance.

North Carolina Medical Board welcomes new physician, public members; Two Board Members reappointed

In November, the North Carolina Medical Board welcomed two new members – Dr. Bryant A. Murphy, a Chapel Hill anesthesiologist and Ralph A. Walker, of Greensboro, a retired judge. Gov. Pat McCrory appointed both men to three year terms on the Board, beginning Nov. 1.

The Governor also reappointed Dr. Cheryl Walker-McGill, a Charlotte internist and preventive medicine specialist, who currently serves as Board President, and Dr. Pascal O. Udekwu, a Raleigh trauma surgeon, who serves as President-Elect of the NCMB.

All terms run from Nov. 1, 2014, until October 31, 2017.

Bryant A. Murphy, MD, MBA

Dr. Murphy practices medicine in at UNC Health Care in Chapel Hill in the Department of Anesthesiology, where he serves as Vice Chairman for Clinical Operations. Dr. Murphy is also an Associate Professor at the UNC School of Medicine in the Department of Anesthesiology.

Dr. Murphy

Dr. Murphy earned his BS degree from Duke University and his MD from the former Bowman Gray School of Medicine at Wake Forest University. He completed postgraduate training in anesthesiology at Wake Forest University Baptist Medical Center, and also completed a fellowship there in cardiothoracic and vascular anesthesiology. He is certified by the American Board of Anesthesiology, completing recertification in 2012. The same year, Dr. Murphy earned his MBA from George Washington University.

In 2012, Dr. Murphy chaired the Anesthesiology section of the National Medical Association. In addition, he is an NC delegate to the American Society of Anesthesiologists.

Ralph A. Walker, JD, LLB

Judge Walker

Judge Walker is the former director of the N.C. Administrative Office of the Courts. A former trial lawyer, prosecutor, and county attorney, Judge Walker served as a Guilford County Superior Court judge and as a judge on the North Carolina Court of Appeals. In addition, he has served as chair of the North Carolina Dispute Resolution Commission and currently is a member of the Rules Review Commission.

Judge Walker received his BBA degree from Wake Forest University and his LLB and JD degree from Wake Forest School of Law, and attended the National Judicial College.

Judge Walker serves on the governing board of Carolina Dispute Settlement Services, and is a member of the Wake County and Guilford County Bar Associations.

Cheryl Lynn Walker-McGill, MD, MBA

Dr. Walker-McGill, MD, is a medical director for Daimler Trucks, NC, Gastonia and Mt. Holly facilities. Previously on faculty at the Northwestern University School of Medicine and the University of North Carolina School of Medicine, Dr. Walker-McGill is currently an adjunct professor at the Wingate Graduate School of Business in Charlotte, North Carolina. Her current activities include corporate health and wellness, developing strategies for improving quality of healthcare delivery in targeted populations and healthcare provider education.

Dr. Walker-McGill

Dr. Walker-McGill serves on the board of the Mecklenburg County Medical Society and the Old North State Medical Society. Dr. Walker-McGill is a Fellow of the American Academy of Allergy, Asthma and Immunology and the American College of Physician Executives.

Dr. Walker-McGill earned her undergraduate and medical degrees from Duke University. She completed her residency and subspecialty training at Northwestern University and she received her MBA from the University of Chicago. Dr. Walker-McGill resides in Charlotte, NC and she is married to Dr. Paul A. McGill.

Pascal Osita Udekwu, MD

Dr. Udekwu has practiced at WakeMed Health & Hospitals in Raleigh since 1991. He completed residency training in pediatrics and in general surgery at the University of Chicago, a fellowship in trauma and surgical critical care at the University of Pittsburgh, and earned


Dr. Udekwu

a master's degree in business administration and health administration from Pfeiffer University in Misenheimer, NC.

Dr. Udekwu holds multiple leadership roles including Director of Trauma, Vice Chairman of Medical Staff Quality Improvement and Director of Surgical Critical Care, all at WakeMed Health & Hospitals. He is also Associate Director of the Surgical Residency Program at the University of North Carolina, Chapel Hill. Dr. Udekwu currently serves as an adjunct professor at UNC-Chapel Hill and is an adjunct professor at Campbell University's College of Pharmacy and Health Sciences. He is triple-board certified with certifications from the American Board of Pediatrics, the American Board of Surgery and the American Board of Surgery—Surgical Critical Care.

Dr. Udekwu has authored numerous papers and abstracts for scholarly journals and is a member of several professional organizations. He is a fellow of both the American College of Surgeons and of the American College of Chest Physicians and is actively interested in regional and national health policy.

In addition, Dr. Udekwu served in the United States Army Reserve from 1988-2005 deploying to Bagram Afghanistan as Chief of Surgery in 2003. He currently serves as a Colonel in the United States Air Force Reserve at Joint Base Andrews, Maryland.

Pending Rule Changes

NC CSRS data sharing

The NCMB has proposed an administrative rule that would allow the NC Controlled Substances Reporting system, the statewide database of all controlled substances dispensed in outpatient pharmacies, to report information about outlier prescribers to the Board for possible investigation. This change would expand the Board's ability to address potentially unsafe prescribing.

Currently the NCMB relies on complaints received from pharmacies, or from patients and their loved ones and other sources to learn about prescribing issues. The new rule, 21 NCAC 32Y .0101, would allow the NCCSRS to provide the Board with information about the highest volume prescribers of certain controlled substances, as well as information about prescribers who have had two or more patient deaths from opioid poisoning in the preceding 12 months.

The NCMB has submitted the proposed rule to the NC Rules Review Commission.

Physician Assistant CME rule

The National Commission on Certification of Physician Assistants (NCCPA) has changed the required amount of Category 1 CME for PAs from 40 to 50 hours every two years. To be consistent with the NCCPA requirements, the NCMB has proposed changing the Board's PA Rules to also require 50 hours of American Academy of Physician Assistants Category 1 CME hours every two years. The North Carolina Academy of Physician Assistants (NCAPA) Board of Directors unanimously supports the proposed rule change.

The Board has filed proposed changes to 21 NCAC 32S.0216 (a) and 21 NCAC 32S.0202 (14) to require 50 hours of accredited Category 1 CME hours every two years with the NC Rules Review Commission. CME must be recognized by the NCCPA.

In addition, the Board has proposed several revisions to clarify the purpose of rules related to physician supervision of PAs.

Public Hearing

The Board will hold a public hearing on the proposed rules at the Board's offices at 1203 Front Street in Raleigh on March 16 at 10 a.m.

Read the full text of all proposed rule changes at *http://www.ncmedboard.org/about_the_board/rule_changes*

Email comments to *rules@ncmedboard.org*

NC Medical Board Position Statements

What changed in 2014?

Each year, in the Winter issue of the Forum, the NCMB features the official position statements of the Board. The position statements are an important resource for licensees that provide guidance on a range of subjects, including direct clinical practice, professional ethics, legal and policy matters and other practice related topics. Historically, the Board has published the full text of each position statement, while identifying those that are either newly adopted, revised or reviewed during the previous year, to ensure that all licensees have the opportunity to review them at least annually.

This year, we break with that tradition. Last year the NCMB adopted a comprehensive new position statement on treating chronic pain with prescription opioid medications. With references, this position statement is more than 50 pages long – It's simply no longer practical for the Board to publish hard copies. A downloadable pdf copy of the complete position statements is available online. Individual statements are also posted online. We are in the process of reorganizing the position statements by category to make them easier to browse.

In this issue, you will find:

- A listing of all position statements that were reviewed, but not amended, in 2014
- The text of the supplementary position statement explains the Board's intent in adopting position statements and guidance on how they should be used by licensees.
- The full text of position statements that were either revised or newly adopted in 2014, with the exception of the "Policy for the use of opiates for the treatment of pain." This position statement is available at www.ncmedboard.org We are currently in the process of reformatting the policy to make it easier to read and use and expect to post a quick reference version online later this year. The titles of new position statements are green; Titles of revised position statements are purple.

What are the position statements of the Board and to whom do they apply?

The North Carolina Medical Board's Position Statements are interpretive statements that attempt to define or explain the meaning of laws or rules that govern the practice of physicians,* physician assistants, and nurse practitioners in North Carolina, usually those relating to discipline. They also set forth criteria or guidelines used by the Board's staff in investigations and in the prosecution or settlement of cases.

When considering the Board's Position Statements, the following four points should be kept in mind:

- In its Position Statements, the Board attempts to articulate some of the standards it believes applicable to the medical profession and to the other health care professions it regulates. However, a Position Statement should not be seen as the promulgation of a new standard as of the date of issuance or amendment. Some Position Statements are reminders of traditional, even millennia old, professional standards, or show how the Board might apply such standards today.
- The Position Statements are not intended to be comprehensive or to set out exhaustively every standard that might apply in every circumstance. Therefore, the absence of a Position Statement or a Position Statement's silence on certain matters should not be construed as the lack of an enforceable standard.
- The existence of a Position Statement should not necessarily be taken as an indication of the Board's enforcement priorities.
- A lack of disciplinary actions to enforce a particular standard mentioned in a Position Statement should not be taken as an abandonment of the principles set forth therein.

The Board will continue to decide each case before it on all the facts and circumstances presented in the hearing, whether or not the issues have been the subject of a Position Statement. The Board intends that the Position Statements will reflect its philosophy on certain subjects and give licensees some guidance for avoiding Board scrutiny. The principles of professionalism and performance expressed in the Position Statements apply to all persons licensed and/or approved by the Board to render medical care at any level.

*The words "physician" and "doctor" as used in the Position Statements refer to persons who are MDs or DOs licensed by the Board to practice medicine and surgery in North Carolina.

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CONTACT WITH PATIENTS BEFORE PRESCRIBING

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

Prescribing for a patient whom the licensee has not personally examined may be suitable under certain circumstances. These may include admission orders for a newly hospitalized patient, medication orders or prescriptions, including pain management, from a hospice physician for a patient admitted to a certified hospice program, prescribing for a patient of another licensee for whom the prescriber is taking call, continuing medication on a short-term basis for a new patient prior to the patient's first appointment, an appropriate prescription in a telemedicine encounter where the threshold information to make an accurate diagnosis has been obtained, or prescribing an opiate antagonist to someone in a position to assist a person at risk of an opiate-related overdose. Established patients may not require a new history and physical examination for each new prescription, depending on good medical practice.

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

- Signed prescriptions of oral antibiotics of the appropriate quantity and strength sufficient to provide curative treatment for each partner named by the infected patient. Notation on the prescription should include the statement: "Expedited partner therapy."
- Signed prescriptions to named partners should be accompanied by written material that states that clinical evaluation is desirable; that prescriptions for medication or related compounds to which the partner is allergic should not be accepted; and that lists common medication side effects and the appropriate response to them.
- Prescriptions and accompanying written material should be given to the licensee's patient for distribution to named partners.
- The licensee should keep appropriate documentation of partner management. Documentation should include the names of partners and a copy of the prescriptions issued or an equivalent statement.

It is the position of the Board that prescribing drugs to individuals the licensee has never met based solely on answers to a set of questions, as is common in Internet or toll-free telephone prescribing, is inappropriate and unprofessional.
(Created: Nov 1, 1999) (Modified: February 2001; November 2009, May 2013, November 2014)

THE TREATMENT OF OBESITY

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

The treatment of obesity should be based on sound scientific evidence and principles. Treatment modalities and prescription medications that have not been proven to have beneficial effects should not be used.

Adequate medical documentation must be kept so that progress as well as the success or failure of any modality is easily ascertained.
(Adopted [as The Use of Anorectics in Treatment of Obesityy] October 1987) (Amended March 1996, January 2005, [retitled], May 2013, March 2014)

POLICY FOR THE USE OF OPIATES FOR THE TREATMENT OF PAIN

In May 2014, the NCMB adopted a new comprehensive position statement on using controlled substances for the treatment of pain. The Policy for the use of opiates for the treatment of pain replaced the position statement that had been in use since 2008. The new policy provides detailed clinical guidance and information about Board expectations for patient management. It is by far the Board's most detailed and heavily referenced position statement.

Due to the new position statement's length, it must be accessed online, where it is available as a pdf download. The Board is in the process of developing a quick reference version of the position statement, which will be posted later this year. Access the Policy for the use of opiates for the treatment of pain at www.ncmedboard.org/position_statements/detail/Policy_for_the_use_of_opiates_for_the_treatment_of_pain
(Adopted May 2014)

END-OF-LIFE RESPONSIBILITIES AND PALLIATIVE CARE

End-of-life responsibilities and palliative care

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

It is the position of the North Carolina Medical Board that patients and their families should be assured of competent, timely, comprehensive palliative care at the end of their lives. Licensees should be knowledgeable regarding effective and compassionate pain relief, and patients and their families should be assured such relief will be provided. The Board recognizes there are times when a hospice patient needsmedications to manage pain or other symptoms in an urgent situation. Under these circumstances a hospice physician who is an employee of, under contract with, or a volunteer with a Medicare-certified hospice may prescribe medications to a patient admitted to the hospice program who he has not seen when the needs of the patient dictate.

Palliative Care

Palliative care is specialized medical care for people with serious illnesses. It is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness—whatever the diagnosis. The goal is to improve quality of life for both the patient and the family.

Palliative care is provided by healthcare providers who work together with a patient's other caregivers to provide an extra layer of support. It is appropriate at any age and at any stage in a serious

illness and can be provided along with curative treatment.**

Palliative care:

- provides relief from pain and other distressing symptoms;
- affirms life and regards dying as a normal process;
- intends neither to hasten nor postpone death;
- integrates the psychological and spiritual aspects of patient care;
- offers a support system to help patients live as actively as possible until death;
- offers a support system to help the family cope during the patient's illness and in their own bereavement;
- uses a team approach to address the needs of patients and their families, including bereavement counseling, if indicated;
- will enhance quality of life, and may also positively influence the course of illness;
- [may be] applicable early in the course of illness, in conjunction with other therapies that are intended to prolong life, such as chemotherapy or radiation therapy, and includes those investigations needed to better understand and manage distressing clinical complications.***

Opioid Use

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

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

** Taken from the Center to Advance Palliative Care (2012) http://www.capc.org/building-a-hospital-based-palliative-care-program/case/definingpc

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

(Adopted October 1999) (Amended May 2007; March 2008; January 2013; November 2014)

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

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

Through dialogue with members of the healthcare community and consumers, a number of perceived regulatory barriers to adequate pain management in end-of-life care have been expressed to the Boards of Medicine, Nursing, and Pharmacy. The following statement attempts to address these misperceptions by outlining practice expectations for physicians and other health care professionals authorized to prescribe medications, as well as nurses and pharmacists involved in this aspect of end-of-life care. The statement is based on:

- the legal scope of practice for each of these licensed health professionals;
- professional collaboration and communication among health professionals providing palliative care; and
- a standard of care that assures on-going pain assessment, a therapeutic plan for pain management interventions; and evidence of adequate symptom management for the dying patient.

It is the position of all three Boards that patients and their families should be assured of competent, comprehensive palliative care at the end of their lives. Physicians, nurses and pharmacists should be knowledgeable regarding effective and compassionate pain relief, and patients and their families should be assured such relief will be provided.

Because of the overwhelming concern of patients about pain relief, the physician needs to give special attention to the effective assessment of pain. It is particularly important that the physician frankly but sensitively discuss with the patient and the family their concerns and choices at the end of life. As part of this discussion, the physician should make clear that, in some end of life care situations, there are inherent risks associated with effective pain relief. The Medical Board will assume opioid use in such patients is appropriate if the responsible physician is familiar with and abides by acceptable medical guidelines regarding such use, is knowledgeable about effective and compassionate pain relief, and maintains an appropriate medical record that details a pain management plan. Because the Board is aware of the inherent risks associated with effective pain relief in such situations, it will not interpret their occurrence as subject to discipline by the Board.

With regard to pharmacy practice, North Carolina has no quantity restrictions on dispensing controlled substances including those in Schedule II. This is significant when utilizing the federal rule that allows the partial filling of Schedule II prescriptions for up to 60 days. In these situations it would minimize expenses and unnecessary waste of drugs if the prescriber would note on the prescription that the patient is terminally ill and specify the largest anticipated quantity that could be needed for the next two months. The pharmacist could then dispense smaller quantities of the prescription to meet the patient's needs up to the total quantity authorized. Government-approved labeling for dosage level and frequency can be useful as guidance for patient care. Health professionals may, on occasion, determine that higher levels are justified in specific cases. However, these occasions would be exceptions to general practice and would need to be properly documented to establish informed consent of the patient and family.

Federal and state rules also allow the fax transmittal of an original prescription for Schedule II drugs for hospice patients. If the prescriber notes the hospice status of the patient on the faxed document, it serves as the original. Pharmacy rules also allow the emergency refilling of prescriptions in Schedules III, IV, and V. While this does not apply to Schedule II drugs, it can be useful in situations where the patient is using drugs such as Vicodin for pain or Xanax for anxiety.

The nurse is often the health professional most involved in ongoing pain assessment, implementing the prescribed pain management plan, evaluating the patient's response to such interventions and adjusting medication levels based on patient status. In order to achieve adequate pain management, the prescription must provide dosage ranges and frequency parameters within which the nurse may adjust (titrate) medication in order to achieve adequate pain control. Consistent with the licensee's scope of practice, the RN or LPN is accountable for implementing the pain management plan utilizing his/her knowledge base and documented assessment of the patient's needs. The nurse has the authority to

adjust medication levels within the dosage and frequency ranges stipulated by the prescriber and according to the agency's established protocols. However, the nurse does not have the authority to change the medical pain management plan. When adequate pain management is not achieved under the currently prescribed treatment plan, the nurse is responsible for reporting such findings to the prescriber and documenting this communication. Only the physician or other health professional with authority to prescribe may change the medical pain management plan.

Communication and collaboration between members of the healthcare team, and the patient and family are essential in achieving adequate pain management in end-of-life care. Within this interdisciplinary framework for end of life care, effective pain management should include:

- thorough documentation of all aspects of the patient's assessment and care;
- a working diagnosis and therapeutic treatment plan including pharmacologic and non-pharmacologic interventions;
- regular and documented evaluation of response to the interventions and, as appropriate, revisions to the treatment plan;
- evidence of communication among care providers;
- education of the patient and family; and
- a clear understanding by the patient, the family and healthcare team of the treatment goals.

It is important to remind health professionals that licensing boards hold each licensee accountable for providing safe, effective care. Exercising this standard of care requires the application of knowledge, skills, as well as ethical principles focused on optimum patient care while taking all appropriate measures to relieve suffering. The healthcare team should give primary importance to the expressed desires of the patient tempered by the judgment and legal responsibilities of each licensed health professional as to what is in the patient's best interest.

(Adopted October 1999) (Amended January 2011; November 2014)

TELEMEDICINE

"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.

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.2

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.
(Adopted July 2010) (Revised November 2014)

CHILD MALTREATMENT

It is the position of the North Carolina Medical Board that child maltreatment (abuse and neglect) presents a significant risk to the health and well-being of North Carolinians. The Board's licensees have a legal responsibility to report as soon as practicable "cases involving recurrent illness or serious physical injury to any child under the age of 18 years where the illness or injury appears, in the physician's professional judgment, to be the result of non-accidental trauma." N.C.G.S. § 90-21.20(c1).4 This legal and ethical obligation requires a licensee to recognize the signs, symptoms, and etiology of child maltreatment.5 Licensees are also encouraged to learn how to refer children for expert medical evaluations of possible maltreatment.
(Adopted September 2014)

THE FOLLOWING POSITION STATEMENTS WERE REVIEWED WITH NO CHANGES MADE:

ACCESS TO MEDICAL RECORDS: (Adopted November 1993) (Amended May 1996, September 1997, March 2002, August 2003, September 2010) (Reviewed May 2014)

GUIDELINES FOR AVOIDING MISUNDERSTANDINGS DURING PHYSICAL EXAMINATIONS: (Adopted May 1991) (Amended May 1993, May 1996, January 2001, February 2001, October 2002, July 2010) (Reviewed January 2014)

ADVERTISING AND PUBLICITY: (Adopted November 1999) (Amended March 2001, November 2010, March 2012)(Reviewed September 2014)

THE MEDICAL SUPERVISOR-TRAINEE RELATIONSHIP: (Adopted April 2004) (Reviewed July 2014)

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

If you would like more information about the workload or other aspects of serving on the Medical Board, contact *nancy.hemphill@ncmedboard.org*

North Carolina Medical Board

Quarterly Board Actions Report | August - October 2014

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			
COOPER, William Levi, PA (000102775) Texas	10/28/2014	Action against PA's Texas license; PA was disciplined based on findings that PA engaged in sexual relations with three inmates who were patients under his care	Order of Summary Suspension of License
ROGERS, Rayna Larain, MD (200801709) Fayetteville, NC	10/02/2014	History of mental health issues and substance abuse/alcohol use issues; MD failed to participate in a monitoring contract with NCPHP as required by a prior Board order.	Order of Summary Suspension of License
REVOCATIONS			
NONE			
SUSPENSIONS			
FLEURY, Robert Andre, MD (000025998) Pinehurst, NC	9/23/2014	MD, a psychiatrist, initiated a social/dating relationship with a patient whom he had treated for moderate depression. It goes against the ethics of the psychiatric profession to enter into romantic relationships with current or former patients.	License is suspended indefinitely, immediately stayed except for a period of three months that shall begin on Dec. 1, 2014, and end on March 1, 2015, after which time MD's license shall be automatically reinstated. MD shall pay a fine of $10,000.
HAN, Timothy Mark, MD (200401066) Wilmington, NC	09/23/2014	History of substance abuse; history of arrest for domestic violence in December 2012; inappropriate prescribing of controlled substances.	Indefinite suspension on medical license; MD may not apply for reinstatement for one year after the date of the order; MD must pay a fine of $5,000 and provide evidence of treatment for psychiatric and substance abuse disorders before applying for reinstatement.
OENBRINK, Raymond Joseph, DO (200901584) Wilkesboro, NC	09/12/2014	History of inappropriate conduct, including unwanted touching, inappropriate comments and sexualized jokes, with patients and staff. A Board-ordered assessment resulted in DO's diagnosis with Asperger's Disorder which, left untreated, renders DO unable to practice safely.	Indefinite suspension of medical license, immediately stayed upon the following conditions: DO must maintain NCPHP contract and abide by all its terms; DO must follow treatment recommendations made by Acumen. DO must restrict weekly work hours to 40 hours.
SHEN, John, MD (000036429) Albemarle, NC	10/16/2014	While MD was out of town, one of MD's obstetric patients presented to the hospital in labor. MD was about five hours from the hospital; MD consulted with the nursing staff by telephone to discuss concerns about signs of fetal distress. Fetal monitoring was conducted but MD did not have mobile access to the results. Although a local physician was on call for MD, the on call physician was not consulted. The situation deteriorated for more than three hours before the on call physician was contacted. When the on call physician examined the patient, no fetal heart rate could be detected and it was concluded that the patient's baby died in utero.	MD's license is suspended for 30 days, immediately stayed except for a period of seven days, beginning Dec. 12, 2014, and ending Dec. 19, 2014, during which MD shall serve an active suspension. MD must provide the hospital where he practices with a detailed call schedule that will ensure MD's patients are managed by an on-call physician when MD is unable to report to the hospital within 30 minutes of the medical need to do so.

Name/license#/location	Date of action	Cause of action	Board action
WALKER, Orrin Abraham, MD (200000656) China Grove, NC	08/08/2014	MD inappropriately and excessively prescribed controlled substances, specifically hydrocodone-acetaminophen, to his wife and several of her co-workers and friends.	Indefinite suspension
PROBATIONS			
SHUCK, Linda Michele, DO (200500550) Dobson, NC	09/09/2014	Inappropriate and excessive prescribing of controlled substances.	DO is placed on probation for 12 months; Within 6 months of the date of the order, DO must complete an assessment by the Center for Personalized Education for Physicians or similar assessment for pain management approved by the Board.
REPRIMANDS			
ANDERSON, Jeffery Stuart, MD (000039759) Greensboro, NC	10/23/2014	Substandard practice of pain management care, inappropriate prescribing of controlled substances and inadequate medical records documentation.	Reprimand; MD shall have the medical director of the practice where he is employed review every patient chart where a Schedule II controlled substance is prescribed.
BAKER, John Harrison, MD (000019308) Durham, NC	10/20/2014	History of alcohol abuse; MD consumed alcohol in violation of his NCPHP contract.	Reprimand; MD's private non practice agreement is converted to a public non practice agreement effective the date of this order
FISHER, Michael Lawrence, MD (009800047) Hickory, NC	10/16/2014	Inappropriate prescribing of controlled substances.	Reprimand; MD has implemented practices to increase his vigilance against the possibility that patients may be abusing or diverting medications prescribed to them.
FREDERICK, Maximus Eziudo, MD (009400118) Raleigh, NC	08/21/2014	MD prescribed methadone to a patient for methadone maintenance treatment in a manner that was not lawful. MD was not registered with DEA as a narcotic treatment program as required by law and failed to meet other requirements.	Reprimand; MD must complete CME in prescribing controlled substances. MD must obtain and read, "Responsible Opioid Prescribing – A Physician's Guide".
HAMEL, John David, MD (009300141) Nebo, NC	08/21/2014	Substandard practice of cosmetic surgery.	Reprimand; MD is restricted from performing any elective surgical procedure that requires more than topical anesthesia EXCEPT for the following, which MD may continue to perform: Liposuction; Fat transfer; and Follicular unit extraction with implantation.
HOLMES, Joseph Nathan, MD (000037854) Salisbury, NC	9/30/2014	Quality of care; MD inappropriately treated multiple patients who presented seeking weight loss treatments. In some instances, MD prescribed phentermine to patients who presented with a normal or low-normal BMI. Medical records for patients whose care was reviewed was inadequate.	MD's license is suspended one year, immediately stayed; MD is reprimanded and fined $5,000. MD must complete CME in prescribing controlled substances and in the treatment of obesity.
LEWIS, Marvin, MD (000033542) Spring Lake, NC	10/06/2014	Quality of care; inappropriate prescribing of controlled substances; MD's supervision of mid-level practitioners failed to conform to accepted standards.	Reprimand; MD is limited and restricted from prescribing controlled substances in Schedules II, III, and IV; MD may not supervise mid-level practitioners.

Name/license#/location	Date of action	Cause of action	Board action
NAVARRO-MCGUINESS, Cheryl Tan, DO (200601750) Mooresville, NC	08/04/2014	Inappropriate and excessive prescribing of controlled substances.	Reprimand; $1,000 fine
RUSSAKOV, Alan David, MD (200501767) New Bern, NC	09/24/2014	MD prescribed opioids and other controlled substances without proper justification; MD failed to take proper precautions to limit patients' potential abuse and diversion of medications and complications from medications; Inadequate medical records documentation; Failure to document that patients were monitored with appropriate physical examinations and diagnostic tests.	Reprimand; MD shall complete CME courses in medical records documentation and in prescribing medications; MD shall obtain a practice monitor and provide a monthly list of all patients to whom MD has prescribed a controlled substance. The monitor shall review 5 patient charts per month.
WEFALD, Franklin Charles, MD (000031685) Smithfield, NC	08/21/2014	MD used profanity and made other inappropriate comments via his Twitter account; MD inappropriately prescribed medications, including controlled substances, to a family member and attempted to conceal the controlled substances prescribing by prescribing using another physician S DEA number and signing the other physician's name. MD has been assessed by NCPHP and consulted with a private therapist. He has also completed and assessment and treatment program.	Reprimand
DENIALS OF LICENSE/APPROVAL			
REECE, (II), Donald Brooks, MD (000018559) Morehead City, NC	10/03/2014	Prior history of Board discipline related to lengthy history of prescribing issues; MD has been out of active clinical practice for more than two years and has not demonstrated continued competency.	Application for reinstatement of NC medical license denied.
SURRENDERS			
NONE			
PUBLIC LETTERS OF CONCERN			
BLACKBURN, Brian Bruce, MD (000029531) Mooresville, NC	10/15/2014	The Board is concerned that care provided to a patient MD treated for recurrent sinusitis, erectile dysfunction and low testosterone may have been below accepted standards of care. A review of the patient's records found that, among other problems, evidence of polycythemia and hyperlipidemia were not addressed, signs of sleep apnea were not evaluated and use of antibiotics to address recurrent sinusitis may have been excessive. A review of other patient records found evidence of substandard care, and suggested that medical record documentation may have been inadequate.	Public Letter of Concern; MD has completed a course in medical recordkeeping and a five day internal medicine review course.
BOLANOS, Rodrigo Antonio, MD (200300224) Pinehurst, NC	08/13/2014	Professional boundary issues. In January 2014, MD's coworker filed a complaint alleging that MD made inappropriate comments. MD acknowledges making inappropriate comments to this coworker on two occasions on one day. The Board is concerned about this incident as well as MD's prior history of complaints (from co-workers) regarding inappropriate comments and touching. MD has completed a course in maintaining proper boundaries.	Public Letter of Concern

Name/license#/location	Date of action	Cause of action	Board action
ERRANTE, Natalie Ann, NP (950013) Salisbury, NC	08/04/2014	Inappropriate diagnosis and treatment of obesity.	Public letter of concern; NP must complete CME course in medical record documentation.
KING, Joseph David, MD (200900659) Plano, TX	10/14/2014	Disciplinary action by the Texas Medical Board; Quality of anesthesia care provided to a seven-year-old male undergoing a restorative dental procedure failed to meet accepted and prevailing standards.	Public letter of concern
HOLCOMBE, Kevin Westray, MD (200700145) Sebastia, FL	08/04/2014	MD failed to properly evaluate a patient who presented to the ER with fever, chills, cough, nausea, vomiting and diarrhea. MD diagnosed the patient with gastroenteritis; the patient returned to the ER three days later when she was diagnosed with pneumonia. The Board is concerned that MD failed to adequately evaluate the patient's cough and fever, failed to address the patient's low blood pressure and failed to explain his decision not to admit her.	Public letter of concern
HOUSTON, Thaddeus Drexel, MD (200902068) Charlotte, NC	09/29/2014	The Board is concerned that MD may have failed to appropriately interpret a patient's CT scan. This may have contributed to a delay in the proper management of the patient's condition and allowed for a progressive deterioration in the patient's condition.	Public letter of concern
MCCORISON, Andrew Buckbee, PA (000101095) Butner, NC	08/13/2014	The Board is concerned that PA failed to recognize that a patient's symptoms and abnormal EKG suggested that the patient suffered from ischemic heart disease. The patient died 11 days after presenting to PA in the emergency room; autopsy attributed the patient's death to ischemic heart disease secondary to hypertensive heart disease.	Public letter of concern
PERKINS, Brent Lee, PA (000100328) Calabash, NC	09/18/2014	The Board is concerned that care PA provided to patients presenting with upper respiratory illness failed to conform to accepted and prevailing standards.	Public letter of concern; PA is required to take CME in treatment of upper respiratory illness and pulmonary embolism.
RITCHIE, John Edward, MD (000039071) Winston-Salem, NC	10/29/2014	The Board is concerned that MD performed a wrong site surgery. The error occurred despite a "Time Out" in the operating room to confirm the correct surgery site, during which a nurse indicated the procedure was to be on the patient's right knee when, in fact, it should have been performed on the left knee. MD informed the patient of the error and did not bill for the procedure or followup care.	Public letter of concern
WEBB, Bruce Jonathan, MD (200201326) Portsmouth, VA	10/14/2014	History of alcoholism and post-traumatic stress disorder (PTSD); MD surrendered his NC medical license in August 2013. MD has completed a military inpatient treatment program for alcoholism and PTSD.	Public Letter of Concern; MD is urged to follow all military and NCPHP recommendations.
MISCELLANEOUS ACTIONS			
LAIZURE, Clancy Conde, PA (000100970) Asheboro, NC	10/16/2014	Concerns about quality of care/medical knowledge. An examination of patient medical records found that PA failed to obtain appropriate laboratory and radiographic studies, failed to obtain or document a complete patient history and physical examination, failed to refer patients to appropriate specialists for evaluation or treatment and failed to establish and document an appropriate differential diagnosis.	PA must obtain a comprehensive assessment from CPEP and comply with all recommendations
LOBITZ, Bruce Harlan, MD (200200137) Hendersonville, NC	08/21/2014	MD failed to respond to a Board inquiry in a reasonable time and in a reasonable manner.	MD's license is placed on inactive status
MCKNIGHT, Kevin Michael, MD (000038137) Morehead City, NC	08/04/2014	Prior history of chemical dependence; MD has completed three months of inpatient treatment	MD's license is reinstated; MD must maintain NCPHP contract

Name/license#/location	Date of action	Cause of action	Board action
WEBSTER, Laurence Seaton, MD (009500269) Winston Salem, NC	09/24/2014	Inappropriate contact and conversations with patients and staff; inappropriate self-treatment with testosterone; Concerns about quality of care.	Consent Order with reentry provisions; MD shall have a chaperone present when seeing female patients; MD shall not provide any form of hormonal treatment; MD shall not provide self-treatment. MD shall maintain a contract with NCPHP and comply with all terms.
CONSENT ORDERS AMENDED			
BOGGOLA, Vijaya Prakash, MD (RTL) Greensboro, NC	08/05/2014	History of soliciting sex from a minor online; MD has completed treatment and has been judged by the treatment center and the NCPHP to be safe to practice.	MD is issued a resident training license; MD must enter into a monitoring contract with NCPHP and abide by all terms; MD must also continue treatment.
EVANS, Michael Allen, MD (200001370) Smithfield, NC	10/24/2014	Restrictions no longer needed.	Consent order dated August 2, 2013, is amended; restrictions on controlled substance prescribing lifted. MD may administer and prescribe controlled substances in any practice setting.
TEMPORARY/DATED LICENSES: ISSUED,EXTENDED,EXPIRED OR REPLACE 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
08/15/2014	Error/omission on license application or annual renewal	$1,000.00
09/12/2014	Error/omission on license application or annual renewal	$500.00
10/29/2014	Error/omission on license application or annual renewal	$1,000.00

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BOARD MEETING DATES
Febuary 19-20, 2015 (Hearings)
March 18-19, 2015 (Full Board)
April 16-17, 2015 (Hearings)
May 13-14, 2015 (Full Board)

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.

Call for comments: Board considers position statement on physician compounding

At its meeting in January, the NCMB adopted for consideration a proposed position statement to provide guidance to licensees who may be engaged in the practice of compounding and dispensing prescription medications to patients from their medical practices.

Email comments and supporting materials, if any, to compounding@ncmedboard.org by 5 p.m. on Friday, Feb. 27. The Board will consider all feedback and make adjustments, if needed, before finally approving the position statement.

The position statement defines compounding and sets out expectations for licensees who compound for their patients, including:

- Compounding must be done for a specific individual patient
- The patient must have a prescription order that states the medical necessity of the compounded drug
- Patients must be adequately informed that they are receiving a compounded drug and be made aware of risks associated with that particular compound
- If the licensee collects a fee or charge from the patient for the compounded drug, the licensee must register with the NC Board of Pharmacy and obtain a dispensing permit
- Licensees engaged in compounding must comply with all applicable U.S. Food and Drug Administration requirements

Read the full text of the proposed position statement online at
http://www.ncmedboard.org/notices/detail/proposed-physician-compounding-positionstatement