North Carolina Medical Board
Policy Committee Meeting
Wednesday, September 17, 2014

Committee Members: Dr. Udekwu, Chairperson; Mr. Arnold, Dr. Walker-McGill, Dr. Bolick and Ms. Lennon
Staff: Todd Brosius and Wanda Long

1. Old Business:
    a. Position Statement Review
        i. Telemedicine
            Contact With Patients Before Prescribing

    b. Prevent Child Abuse North Carolina
        Issue: Request that the NC Medical Board consider issuing a position statement encouraging physicians to access training in recognizing and responding to child maltreatment.

2. New Business:

    a. Position Statement Review
        i. Advertising and Publicity

3. Position Statement Review tracking chart

North Carolina Medical Board
Policy Committee Meeting
Wednesday, May 14, 2014

Committee Members: Dr. Udekwu, Chairperson: Dr. Walker-McGill; Dr. Bolick; Ms. Lennon and Mr. Arnold.
Staff: Todd Brosius and Wanda Long

1. Old Business
    a. Position Statement Review
        i. Telemedicine
            Contact With Patients Before Prescribing

11/2013 Committee Discussion: Mr. Arnold reported on the developments by FSMB's SMART group regarding a telemedicine policy statement. The SMART group is seeking comments from licensing boards by December 6 and are hoping to have an approved version prior to the FSMB's annual meeting in April 2014. Dr. Udekwu discussed the need for the Board to give the FSMB direction regarding topics such as scope of practice and the need to have studies that demonstrate the effectiveness of telemedicine in particular instances. Dr. Udekwu commented on the pending legislation, the focuses on easing the licensing burden, reducing the need for face to face encounters. It was also noted that federal legislation is beginning to blur the jurisdictional boundaries regarding licensure requirements as they apply to telemedicine.

11/2013 Committee Recommendation: Request full Board to review the FSMB's draft of policy on telemedicine so that the Board can give targeted input by the December 6 deadline. Table consideration of Board's Position Statement until January meeting.

11/2013 Board Action: Approve the Committee Recommendation.

01/2014 Committee Discussion: Mr. Arnold updated the Committee regarding the upcoming steps and timeline for the FSMB's SMART group developing telemedicine guidelines. It was estimated that the FSMB may have guidelines in place sometime in April. The Committee agreed that it would be prudent to have the benefit of the FSMB's efforts before the Board took additional steps regarding its own position statement.

01/2014 Committee Recommendation: Table matter until FSMB guidelines have been approved.

01/2014 Board Action: Approve the Committee Recommendation.

03/2014 Committee Discussion: Mr. Arnold updated the Committee on the progress of the FSMB guidelines. They have received initial approval and will be up for final approval at the FSMB Annual meeting. It was also discussed that representatives of Blue Cross Blue Shield will present information to the Committee at its July 2014 meeting. Dr. Udekwu also indicated that two Board members would be attending the CTEL meeting.

03/2014 Committee Recommendation: Table issue until the July 2014 meeting.

03/2014 Board Action: Approve the Committee Recommendation.

05/2014 Committee Discussion: Ms. Apperson reported on the Telemedicine guidelines that were recently adopted by the FSMB.

05/2014 Committee Recommendation: Dr. Udekwu, Mr. Arnold and Ms. Apperson to begin reviewing the Board's current Telemedicine Position Statement and provide the Policy Committee their recommendations at the July Committee meeting.

05/2014 Board Action: Approve the Committee Recommendation.

07/2014 Committee Discussion: Representatives from Blue Cross Blue Shield (BCBS) presented information on two pilot studies they had completed, one potential study involving a large established group with quality metrics already in place and one potential research driven study in an urgent care setting. The BCBS representatives agreed to provide the Committee members with the 21 quality metrics used in the potential pilot program and 25 diagnoses that could be handled in an e-visit protocol. Ms. Apperson reported that the Board will host a roundtable on August 20, 2014, for approximately a dozen invited participants. Additionally, there will be time allotted at the end of the meeting for the general public to provide comments.

07/2014 Committee Recommendation: Table this issue until the September 2014 Committee meeting to allow information from the August 20th roundtable to be presented.

07/2014 Board Action: Approve the Committee Recommendation.

CURRENT POSITION STATEMENT

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.

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.

Examinations -- Licensees using telemedicine technologies to provide care to patients located in North Carolina must provide an appropriate examination prior to diagnosing and/or treating the patient. However, this examination need not be in-person if the technology is sufficient to provide the same information to the licensee as if the exam had been performed face-to-face.

Other examinations 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 examination may be a violation of law and/or subject the licensee to discipline by the Board.[1]

Licensee-Patient Relationship – The licensee using telemedicine should have some means of verifying that the person seeking treatment is in fact who he or she claims to be. A diagnosis should be established through the use of accepted medical practices, i.e., a patient history, mental status examination, 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.

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.

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.[2] 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)

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[1] See also the Board's Position Statement entitled "Contact with Patients before Prescribing."

[2] N.C. Gen. Stat. § 90-18(c)(11) exempts from the requirement for licensure: "The practice of medicine or surgery by any nonregistered reputable physician or surgeon who comes into this State, either in person or by use of any electronic or other mediums, on an irregular basis, to consult with a resident registered physician or to consult with personnel at a medical school about educational or medical training. This proviso shall not apply to physicians resident in a neighboring state and regularly practicing in this State."

The Board also notes that the North Carolina General Statutes define the practice of medicine as including, "The performance of any act, within or without this State, described in this subdivision by use of any electronic or other means, including the Internet or telephone." N.C. Gen. Stat. § 90-1.1(5)f

CURRENT POSITION STATEMENT

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 personally examined 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 personally 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, 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, 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

(Adopted November 1999) (Amended February 2001, November 2009, May 2013) (Reviewed July 2010)

STAFF EXPECTS TO E-MAIL PROPOSED REVISIONS TO THE TELEMEDICINE AND CONTACTS WITH PATIENTS BEFORE PRESCRIBING POSITIONS STATEMENTS TO BOARD MEMBERS PRIOR TO THE BOARD MEETING.

1. Old Business:

b. Prevent Child Abuse North Carolina

Issue: Request that the NC Medical Board consider issuing a position statement encouraging physicians to access training in recognizing and responding to child maltreatment.

05/2014 Committee Discussion: Elaine Cabinum-Foeller, MD, Associate Professor of Pediatrics, Brody School of Medicine and Medical Director of TEDI Bear Children's Advocacy Center addressed the Committee requesting that the Board issue a Position Statement regarding encouraging physicians to access training in recognizing and responding to child maltreatment. Although the Board has published an article in the past regarding this issue which is available on its website, they believe that a Position Statement would carry more weight.

05/2014 Committee Recommendation: Table until July to allow adequate time to obtain feedback from key stake holders.

05/2014 Board Action: Approve the Committee Recommendation.

07/2014 Committee Discussion: Mr. Brosius reported that he had received one comment from the Executive Director of the NC Academy of Family Physicians approving of the draft of the position statement and suggesting that the position statement recommend CME instead of requiring it.

07/2014 Committee Recommendation: Approve the proposed position statement. Submit for full Board approval.

07/2014 Board Action: Refer back to the Policy Committee for future consideration.

Draft Language for Position Statement

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. Physicians have both a legal and ethical responsibility to report child maltreatment when suspected. Physicians are strongly encouraged to access training to better prepare them to:

- recognize the signs, symptoms, and etiology of child maltreatment
- understand North Carolina definitions and laws regarding child maltreatment
- respond appropriately when child maltreatment is suspected
- understand the role of the North Carolina child protection system in supporting families and protecting children
- understand what to expect following a report of child maltreatment to Child Protective Services
- understand how to refer children for expert medical evaluations for possible maltreatment

2. New Business:
    a. Position Statement Review
        i. Advertising and Publicity

CURRENT POSITION STATEMENT:

Advertising and publicity*

It is the position of the North Carolina Medical Board that advertising or publicity that is deceptive, false, or misleading constitutes unprofessional conduct under the Medical Practice Act.*

The term "advertising" includes oral, written and other types of communication disseminated by or at the direction of a licensee for the purpose of encouraging or soliciting the use of the licensee's services. At issue is whether a member of the general public would be confused or deceived by the advertising in question. The following general principles are intended to assist licensees in meeting the Board's expectations: (1) advertisements should not contain false claims or misrepresentations of fact, either expressly or by implication; (2) advertisements should not omit material facts; and (3) licensees should be prepared to substantiate claims made in advertisements.

Licensees should avoid advertising and publicity that creates unjustified medical expectations, that are accompanied by deceptive claims, or that imply exclusive or unique skills or remedies. Similarly, a statement that a licensee has cured or successfully treated a large number of patients suffering a particular ailment is deceptive if it implies a certainty of results and/or creates unjustified or misleading expectations. When using patient photographs, they should be of the licensee's own patients and demonstrate realistic outcomes. Likewise, when a change of circumstances renders advertising inaccurate or misleading, the licensee is expected to make reasonable efforts to correct the advertising within a reasonable time frame.

The advent of the Internet and the proliferation of websites purporting to "rate" healthcare providers mean that licensees cannot always control information about themselves in the public domain. However, a licensee is expected to exercise reasonable efforts to bring about the correction or elimination of false or misleading information when he or she becomes aware of it.

Physicians Advertising Board Certification
The term "board certified" is publicly regarded as evidence of the skill and training of a physician carrying this designation. Accordingly, in order to avoid misleading or deceptive advertising concerning board certification, physicians are expected to meet the following guidelines.

No physician should advertise or otherwise hold himself or herself out to the public as being "board certified" without proof of current certification by a specialty board approved by the (1) American Board of Medical Specialties (ABMS); (2) the Bureau of Osteopathic Specialists of the American Osteopathic Association (AOA-BOS); (3) the Royal College of Physicians and Surgeons of Canada (RCPSC); or (4) a board that meets the following requirements:

1. the organization requires satisfactory completion of a training program with training, documentation and clinical requirements similar in scope and complexity to ACGME- or AOA-approved programs, in the specialty or subspecialty field of medicine in which the physician seeks certification. Solely experiential or on-the-job training is not sufficient;
2. the organization requires all physicians seeking certification to successfully pass a written or oral examination or both, which tests the applicant's knowledge and skill in the specialty or subspecialty area of medicine. All examinations require a psychometric evaluation for validation;

3. the organization requires diplomates to recertify every ten years or less, and the recertification requires, at a minimum, passage of a written examination;
4. the organization prohibits all certification and recertification candidates from attempting more than three times in three years to pass the examination;
5. the organization has written by-laws and a code of ethics to guide the practice of its members and an internal review and control process including budgetary practices to ensure effective utilization of resources;
6. the organization has written proof of a determination by the Internal Revenue Service that the certifying organization is tax-exempt under Section 501(c) of the Internal Revenue Code; and
7. the organization has a permanent headquarters and staff sufficient to respond to consumer and regulatory inquiries.

The Board expects any physician advertising or otherwise holding himself or herself out to the public as "board certified" to disclose in the advertisement the specialty board by which the physician was certified. A physician is expected to maintain and provide to the Board upon request evidence of current board certification. In the case of physicians who have been certified by non-ABMS, non-AOA and non-RCPSC boards, the physician is expected to maintain and provide to the Board upon request evidence that the certifying board meets the criteria listed above.

The above limitations are only intended to apply to physicians who advertise or otherwise hold themselves out to the public as being "board certified." The above criteria are not applicable in other instances, such as employment determinations, privileging or credentialing decisions, membership on insurance panels, or setting reimbursement rates.

*Business letterheads, envelopes, cards, and similar materials are understood to be forms of advertising and publicity for the purpose of this Position Statement.

(Adopted November 1999) (Amended March 2001, November 2010, March 2012) (Reviewed September 2005)

3. Position Statement Review tracking chart:

1/2010 Committee Recommendation: (Loomis/Camnitz) Adopt a 4 year review schedule as presented. All reviews will be offered to the full Board for input. Additionally all reviews will be documented and will be reported to the full Board, even if no changes are made.

1/2010 Board Action: Adopt the recommendation of the Policy Committee.

POSITION STATEMENT	ADOPTED	SCHEDULED FOR REVIEW	LAST REVISED/ REVIEWED/ ADOPTED	REVISED/ REVIEWED	REVISED/ REVIEWED	REVISED/ REVIEWED	REVISED/ REVIEWED
Telemedicine	May-10	Nov-13	May-10				
Advertising and Publicity	Nov-99	Aug-14	Nov-10	Sep-05	Mar-01		
Medical, Nursing, Pharmacy Boards: Joint Statement on Pain Management in End-of-Life Care	Oct-99		Jan-11	Oct-99			
HIV/HBV Infected Health Care Workers	Nov-92		Jan-11	Jan-05	May-96		
Writing of Prescriptions	May-91		Mar-11	Mar-05	Jul-02	Mar-02	May-96
Laser Surgery	Jul-99		Mar-11	Jul-05	Aug-02	Mar-02	Jan-00
Office-Based Procedures	Sep-00		May-11	Jan-03			
Sale of Goods From Physician Offices	Mar-01		May-11	Mar-06			
Competence and Reentry to the Active Practice of Medicine	Jul-06		Jul-11	Jul-06			
Prescribing Controlled Substances for Other Than Valid Medical or Therapeutic Purposes, with Particular Reference to Substances or Preparations with Anabolic Properties	May-98		Sept-11	Nov-05	Jan-01	Jul-98	
Referral Fees and Fee Splitting	Nov-93		Jan-12	Jul-06	May-96		
Self- Treatment and Treatment of Family Members and Others With Whom Significant Emotional Relationships Exist	May-91		Mar-12	Sep-05	Mar-02	May-00	May 96
Availability of Physicians to Their Patients	Jul-93		May-12	Nov-11	Jul-06	Oct-03	Jan-01
Sexual Exploitation of Patients	May-91		May-12	Sep-06	Jan-01	Apr-96	
Care of the Patient Undergoing Surgery or Other Invasive Procedure	Sep-91		Jul-12	Sep-06	Mar-01		
The Physician-Patient Relationship	Jul-95		Jul-12	Sep-06	Aug-03	Mar-02	Jan-00
The Retired Physician	Jan-97		Jul-12	Sep-06			
Physician Supervision of Other Licensed Health Care Practitioners	Jul-07		Sep-12	Jul-07			
Medical Testimony	Mar-08		Sep-12	Mar-08			
Advance Directives and Patient Autonomy	Jul-93		Nov-12	Mar-08	May-96		
End-of-Life Responsibilities and Palliative Care	Oct-99		Jan-13	Mar-08	May-07		
Drug Overdose Prevention	Sep-08		Mar-13	Sep-08			

Professional Use of Social Media	Mar-13		Mar-13				
The Treatment of Obesity	Oct-87		May-13	Nov-10	Jan-05	Mar-96	
Contact With Patients Before Prescribing	Nov-99		May-13	Jul-10	Feb-01		
Medical Record Documentation	May-94		May-13	May-09	May-96		
Retention of Medical Records	May-98		Jul-13	May-09			
Capital Punishment	Jan-07		Jul-13	Jul-09			
Professional Obligations pertaining to incompetence, impairment, and unethical conduct of healthcare providers	Nov-98		Sept-13	Mar-10	Nov-98		
Unethical Agreements in Complaint Settlements	Nov-93		Sept-13	Mar-10	May-96		
Guidelines for Avoiding Misunderstandings During Physical Examinations	May-91		Jan-14	Jul-10	Oct-02	Feb-01	Jan-01
Departures from or Closings of Medical	Jan-00		May-13	Jul-09	Aug-03		
Policy for the Use of Controlled Substances for the Treatment of Pain	Sep-96		May-14	Jan-13	Sep-08	Jul-05	
Access to Physician Records	Nov-93		May-14	Sep-10	Aug-03	Mar-02	Sep-97
Medical Supervisor-Trainee Relationship	Apr-04		Jul-14	Nov-10	Apr-04		