

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 Obesity] 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.ncmed-board.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 needs medications 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

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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 on-going 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

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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

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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)