

North Carolina Medical Board
Policy Committee Meeting
Thursday, July 19, 2012

Committee Members: Dr. Camnitz, Chairman; Dr. Greene; Mrs. Blizzard and Judge Lewis

1. Old Business:

a. Position Statement Review

Issue: In November 2009, the Board approved the Policy Committee's recommendation to review Position Statements at least once every four years. A review schedule has been formulated for the Committee's consideration.

Position Statements for continued review:

- i. Care of the Patient Undergoing Surgery or Other Invasive Procedure
- ii. Writing of Prescriptions

2. New Business:

a. Position Statement Review

Issue: In November 2009, the Board approved the Policy Committee's recommendation to review Position Statements at least once every four years. A review schedule has been formulated for the Committee's consideration.

Position Statements for review:

- i. The physician-patient relationship
- ii. The retired physician

b. Position Statement Review – request from Board

Issue: Request Policy Committee to amend position statement as it relates to social networking offers.

- i. Referral fees and fee splitting

c. Request for consideration for disclose in writing of monetary considerations from a pharmaceutical company.

Issue: Mr. Herbert is requesting that the Board consider requiring physicians to disclose in writing to their patients receipt of monetary considerations from a pharmaceutical company when prescribing a medicine made by that company.

Committee Members: Dr. Camnitz, Chairman; Dr. Greene; Mrs. Blizzard and Judge Lewis

1. Old Business

- a. Position Statement Review continued
 - i. Care of the Patient Undergoing Surgical or Other Invasive Procedure

05/2012 Committee discussion: The Committee discussed the implications of language indicating that the surgeon bore sole responsibility during surgery. It was suggested that removing the word "alone" from the second sentence may be sufficient. Mrs. Apperson suggested the possibility of using a liability standard in the position statement.

05/2012 Committee Recommendation: Tabled until July meeting.

05/2012 Board Action: Accept Committee recommendation.

CURRENT POSITION STATEMENT:

Care of the patient undergoing surgical or other invasive procedure*

- 1 The evaluation, diagnosis, and care of the surgical patient is primarily the responsibility of the
- 2 surgeon. He or she alone bears responsibility for ensuring the patient undergoes a preoperative
- 3 assessment appropriate to the procedure. The assessment shall include a review of the
- 4 patient's data and an independent diagnosis by the operating surgeon of the condition requiring
- 5 surgery. The operating surgeon shall have a detailed discussion with each patient regarding the
- 6 diagnosis and the nature of the surgery, advising the patient fully of the risks involved. It is also
- 7 the responsibility of the operating surgeon to reevaluate the patient immediately prior to the
- 8 procedure.
- 9
- 10 It is the responsibility of the operating surgeon to assure safe and readily available
- 11 postoperative care for each patient on whom he or she performs surgery. It is not improper to
- 12 involve other licensed health care practitioners in postoperative care so long as the operating
- 13 surgeon maintains responsibility for such care. The postoperative note must reflect the findings
- 14 encountered in the individual patient and the procedure performed.
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- 16 When identical procedures are done on a number of patients, individual notes should be done
- 17 for each patient that reflect the specific findings and procedures of that operation.

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19 (Invasive procedures includes, but is not limited to, endoscopies, cardiac catheterizations,
20 interventional radiology procedures, etc. Surgeon refers to the provider performing the
21 procedure)

22 **This position statement was formerly titled, "Care of the Surgical Patient."*

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24 (Adopted September 1991) (Amended March 2001, September 2006)

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1. Old Business:

- a. Position Statement Review continued
- ii. Writing of prescriptions

Issue: David Henderson requested that this position statement be reviewed by the Policy Committee. Comments were solicited from the Medical Society.

05/2012 Committee discussion: Current DEA regulations along with the practical limitations of electronic prescribing of controlled substances was discussed. The Committee considered both the NCMS's suggested changes to the Position Statement along with additional language that would help clarify the landscape of electronic prescribing of controlled substances.

05/2012 Committee Recommendation: Tabled until July meeting. Mr. Brosius will provide advance draft to the Committee members.

05/2012 Board Action: Accept Committee recommendation.

CURRENT POSITION STATEMENT:

1 **Writing of prescriptions**

2 It is the position of the North Carolina Medical Board that prescriptions should be written in ink
3 or indelible pencil or typewritten or electronically printed and should be signed by the
4 practitioner at the time of issuance. Prescription that are handwritten should indicate the
5 quantity in both numbers AND words, e.g., 30 (thirty). Such prescriptions must not be written on
6 pre-signed prescription blanks.

7 Each prescription for a DEA controlled substance (2, 2N, 3, 3N, 4, and 5) should be written on a
8 separate prescription blank. Multiple medications may appear on a single prescription blank only
9 when none are DEA-controlled.

10 No prescriptions should be issued for a patient in the absence of a documented physician-
11 patient relationship.

12 No prescription should be issued by a practitioner for his or her personal use. (See Position
13 Statement entitled "Self-Treatment and Treatment of Family Members and Others with Whom
14 Significant Emotional Relationships Exist.")

15 The practice of pre-signing prescriptions is unacceptable to the Board.

16 It is the responsibility of those who prescribe controlled substances to fully comply with
17 applicable federal and state laws and regulations. Links to these laws and regulations may be
18 found on the Board's website, www.ncmedboard.org

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20 (Adopted May 1991, September 1992) (Amended May 1996; March 2002; July 2002; March
21 2011) (Reviewed March 2005)

PROPOSED CHANGES TO POSITION STATEMENT:

Writing of prescriptions

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It is the position of the North Carolina Medical Board that prescriptions should be written in ink or indelible pencil or typewritten or electronically ~~printed~~ issued and should be signed by the practitioner at time of issuance. Prescriptions that are handwritten should indicate the quantity in both numbers AND words, e.g., 30 (thirty). Such prescriptions must not be written on pre-signed prescription blanks.

Each handwritten prescription for a DEA controlled substance (2, 2N, 3, 3N, 4 and 5) should be written on a separate prescription blank. Each electronic prescription for a DEA controlled substance (2, 2N, 3, 3N, 4 and 5) should be issued separately and comply with DEA regulations. Multiple medications may appear on a single prescription blank only when none are DEA-controlled.

No prescriptions should be issued for a patient in the absence of a documented physician-patient relationship.

No prescription should be issued by a practitioner for his or her personal use. (See Position Statement entitled “Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist.”)

The practice of pre-signing prescriptions is unacceptable to the Board.

It is the responsibility of those who prescribe controlled substances to fully comply with applicable federal and state laws and regulations. Links to these laws and regulations may be found on the Board’s website, www.ncmedboard.org.

2. New Business:

a. Position Statement Review

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
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	Jul-98
The Retired Physician	Jan-97	Jul-12	Sep-06				
Physician Supervision of Other Licensed Health Care Practitioners	Jul-07		Jul-07				
Medical Testimony	Mar-08		Mar-08				
Advance Directives and Patient Autonomy	Jul-93		Mar-08	May-96			
End-of-Life Responsibilities and Palliative Care	Oct-99		Mar-08	May-07			
Drug Overdose Prevention	Sep-08		Sep-08				
Policy for the Use of Controlled Substances for the Treatment of Pain	Sep-96		Sep-08	Jul-05			
Medical Record Documentation	May-94		May-09	May-96			
Retention of Medical Records	May-98		May-09				
Capital Punishment	Jan-07		Jul-09				
Departures from or Closings of Medical	Jan-00		Jul-09	Aug-03			
Professional Obligations pertaining to incompetence, impairment, and unethical conduct of healthcare providers	Nov-98		Mar-10	Nov-98			
Unethical Agreements in Complaint Settlements	Nov-93		Mar-10	May-96			
What Are the Position Statements of the Board and To Whom Do They Apply?	Nov-99		May-10	Nov-99			
Telemedicine	May-10		May-10				

Contact With Patients Before Prescribing	Nov-99		Jul-10	Feb-01			
Guidelines for Avoiding Misunderstandings During Physical Examinations	May-91		Jul-10	Oct-02	Feb-01	Jan-01	May-96
Access to Physician Records	Nov-93		Sep-10	Aug-03	Mar-02	Sep-97	May-96
Medical Supervisor-Trainee Relationship	Apr-04		Nov-10	Apr-04			
The Treatment of Obesity	Oct-87		Nov-10	Jan-05	Mar-96		
Advertising and Publicity	Nov-99		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 Legend or 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	

- 2. New Business:
 - a. Position Statement Review
 - i. The physician-patient relationship

CURRENT POSITION STATEMENT:

The physician-patient relationship

The duty of the physician is to provide competent, compassionate, and economically prudent care to all his or her patients. Having assumed care of a patient, the physician may not neglect that patient nor fail for any reason to prescribe the full care that patient requires in accord with the standards of acceptable medical practice. Further, it is the Board's position that it is unethical for a physician to allow financial incentives or contractual ties of any kind to adversely affect his or her medical judgment or patient care.

Therefore, it is the position of the North Carolina Medical Board that any act by a physician that violates or may violate the trust a patient places in the physician places the relationship between physician and patient at risk. This is true whether such an act is entirely self-determined or the result of the physician's contractual relationship with a health care entity. The Board believes the interests and health of the people of North Carolina are best served when the physician-patient relationship remains inviolate. The physician who puts the physician-patient relationship at risk also puts his or her relationship with the Board in jeopardy.

Elements of the Physician-Patient Relationship

The North Carolina Medical Board licenses physicians as a part of regulating the practice of medicine in this state. Receiving a license to practice medicine grants the physician privileges and imposes great responsibilities. The people of North Carolina expect a licensed physician to be competent and worthy of their trust. As patients, they come to the physician in a vulnerable condition, believing the physician has knowledge and skill that will be used for their benefit.

Patient trust is fundamental to the relationship thus established. It requires that:

- there be adequate communication between the physician and the patient;
- the physician report all significant findings to the patient or the patient's legally designated surrogate/guardian/personal representative;
- there be no conflict of interest between the patient and the physician or third parties;
- personal details of the patient's life shared with the physician be held in confidence;
- the physician maintain professional knowledge and skills;
- there be respect for the patient's autonomy;

- 1 • the physician be compassionate;
- 2 • the physician respect the patient's right to request further restrictions on medical
- 3 information disclosure and to request alternative communications;
- 4 • the physician be an advocate for needed medical care, even at the expense of the
- 5 physician's personal interests; and
- 6 • the physician provide neither more nor less than the medical problem requires.

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8 The Board believes the interests and health of the people of North Carolina are best served

9 when the physician-patient relationship, founded on patient trust, is considered sacred, and

10 when the elements crucial to that relationship and to that trust—communication, patient

11 primacy, confidentiality, competence, patient autonomy, compassion, selflessness, appropriate

12 care—are foremost in the hearts, minds, and actions of the physicians licensed by the Board.

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14 This same fundamental physician-patient relationship also applies to mid-level health care

15 providers such as physician assistants and nurse practitioners in all practice settings.

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17 **Termination of the Physician-Patient Relationship**

18 The Board recognizes the physician's right to choose patients and to terminate the

19 professional relationship with them when he or she believes it is best to do so. That being

20 understood, the Board maintains that termination of the physician-patient relationship must be

21 done in compliance with the physician's obligation to support continuity of care for the patient.

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23 The decision to terminate the relationship must be made by the physician personally. Further,

24 termination must be accompanied by appropriate written notice given by the physician to the

25 patient or the patient's representative sufficiently far in advance (at least 30 days) to allow other

26 medical care to be secured. A copy of such notification is to be included in the medical record.

27 Should the physician be a member of a group, the notice of termination must state clearly

28 whether the termination involves only the individual physician or includes other members of the

29 group. In the latter case, those members of the group joining in the termination must be

30 designated. It is advisable that the notice of termination also include instructions for transfer of

31 or access to the patient's medical records.

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33 (Adopted July 1995) (Amended July 1998, January 2000, March 2002, August 2003, September

34 2006)

2. New Business:
a. Position Statement Review
i.. The physician-patient relationship

CURRENT POSITION STATEMENT:

The retired physician

The retirement of a physician is defined by the North Carolina Medical Board as the total and complete cessation of the practice of medicine and/or surgery by the physician in any form or setting. According to the Board's definition, the retired physician is not required to maintain a currently registered license and SHALL NOT:

- provide patient services;
- order tests or therapies;
- prescribe, dispense, or administer drugs;
- perform any other medical and/or surgical acts; or
- receive income from the provision of medical and/or surgical services performed following retirement.

The North Carolina Medical Board is aware that a number of physicians consider themselves "retired," but still hold a currently registered medical license (full, volunteer, or limited) and provide professional medical and/or surgical services to patients on a regular or occasional basis. Such physicians customarily serve the needs of previous patients, friends, nursing home residents, free clinics, emergency rooms, community health programs, etc. The Board commends those physicians for their willingness to continue service following "retirement," but it recognizes such service is not the "complete cessation of the practice of medicine" and therefore must be joined with an undiminished awareness of professional responsibility. That responsibility means that such physicians SHOULD:

- practice within their areas of professional competence;
- prepare and keep medical records in accord with good professional practice; and
- meet the Board's continuing medical education requirement.

The Board also reminds "retired" physicians with currently registered licenses that all federal and state laws and rules relating to the practice of medicine and/or surgery apply to them, that the position

- 1 statements of the Board are as relevant to them as to physicians in full and regular practice, and that
- 2 they continue to be subject to the risks of liability for any medical and/or surgical acts they perform.
- 3 (Adopted January 1997) (Amended September 2006)

b. Position Statement Review – Request from Board

Issue: NCGS Chapter 90; Article 27, entitled “Referral Fees and Payment for Certain Solicitations Prohibited” states, in part, “A health care provider shall not financially compensate in any manner a person, firm, or corporation for recommending or securing the health care provider's employment by a patient”. MD pays a fee to Groupon for pre-paid vouchers issued by Groupon to Groupon subscribers who purchase the vouchers. Groupon “facilitates” the purchase of MD’s pre-paid vouchers which offer promotional discounts for MD’s services. A patient purchasing a voucher from Groupon pays for the price of MD’s discounted service plus additional promotional, advertising, administrative, and “offer facilitation” fees to Groupon.

Board Action: Request Policy Committee to amend Referral fees and fee splitting position statement as it relates to social networking offers.

CURRENT POSITION STATEMENT:

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Referral fees and fee splitting

Payment by or to a physician solely for the referral of a patient is unethical. A physician may not accept payment of any kind, in any form, from any source, such as a pharmaceutical company or pharmacist, an optical company, or the manufacturer of medical appliances and devices, for prescribing or referring a patient to said source. In each case, the payment violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

It is unethical for physicians to offer financial incentives or other valuable considerations to patients in exchange for recruitment of other patients. Such incentives can distort the information that patients provide to potential patients, thus distorting the expectations of potential patients and compromising the trust that is the foundation of the patient-physician relationship.

Furthermore, referral fees are prohibited by state law pursuant to N.C. Gen. Stat. Section 90-401. Violation of this law may result in disciplinary action by the Board.

Except in instances permitted by law (NC Gen Stat §55B-14(c)), it is the position of the Board that a physician cannot share revenue on a percentage basis with a non-physician. To do so is fee splitting and is grounds for disciplinary action.

(Adopted November 1993) (Amended May 1996, July 2006)

2. New Business

c. Request for consideration for disclose in writing of monetary considerations from a pharmaceutical company.

March 19, 2012

Dr. Ralph C. Loomis, Chairperson, North Carolina Medical Board

Raleigh, NC

Dear Dr. Loomis,

This is a request that you facilitate an opportunity for the NC Medical Board to consider requiring a NC licensed physician to disclose in writing to his/her patient his receipt of monetary considerations from a pharmaceutical company when prescribing a medicine made by that company; and/or hold that practice to be unethical or unacceptable.

In your Board's Ethics statement it is noted that the people of North Carolina expect a licensed physician to be competent and worthy of their trust and this trust is fundamental to the patient-physician relationship. It states further that this trust requires that, "there be no conflict of interest between the patient and the physician or third parties". I believe this practice of prescribing a drug in the shadow of monetary considerations has the clear perception of a corrupting influence which can skew and/or impair a medical judgment which should otherwise be made impartially and without bias.

At age 81, this Tar Heel native is grateful to the dozens of honorable medical practitioners who have given me wise counsel and skilled treatment through the years and have likely made it possible for me to reach this age in as healthy condition as I was at 21. I fully understand that times have changed in the delivery of health services and many of these changes have put great stress on the patient-physician relationship. However, allowing physicians, with no disclosure or disclaimer to his patient to receive tens of thousands of dollars annually to explain, promote or tout a drug or drugs among his peers is a practice which I find repulsive and not worthy of the trust of the citizens of my State.

As transparency of this practice increases, such as the website which informed me that two of my family physician specialists had received well over \$150,000 last year from several of the major drug companies whose drugs they were prescribing, the public will become more aware of the activity and will likely become similarly outraged. We are not talking about plumbers or used car dealers who are being persuaded into selling their particular brand of goods through gifts of liquor or beach vacations from their wholesalers. We are talking about a personal, fragile, perhaps sacred, bond forged over decades, being threatened by a comparatively few dollars.

I hope that our State medical leadership will take the lead by first acknowledging the perception and reality of the practice and then taking a clear, unequivocal position to protect the patient trust. To do otherwise is to put its own position of responsibility to the citizen patient of North Carolina in jeopardy.

Thank you for your consideration of this matter. Please acknowledge receipt of this letter and inform me of any subsequent action.

Sincerely,

David F. Herbert