

**North Carolina Medical Board
Policy Committee Meeting
Wednesday, January 20, 2010**

Committee Members: Dr. Walker, Judge Lewis, Dr. Camnitz and Dr. Loomis

I. Old Business:

A. Telemedicine

Issue: The Board to consider recent adoptions of telemedicine policies and statements by the Federation, Blue Cross Blue Shield and the AMA.

B. Board Certification Distinction

Issue: Rule hearing held on November 30, 2009 to receive comments.

C. Position Statement - Disruptive Physicians

Issue: The Continued Competence Committee has asked that the Policy Committee consider a Position Statement on Disruptive Physicians.

D. 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.

OLD BUSINESS:

I.A. TELEMEDICINE

Issue: The Board to consider recent adoptions of telemedicine policies and statements by the Federation, Blue Cross Blue Shield and the AMA.

5/2009 COMMITTEE DISCUSSION: Dr. Rhyne reported that the Federation recently adopted a statement regarding telemedicine. It was also reported that BCBS would be implementing a new e-medicine policy.

5/2009 BOARD ACTION: Mr. Brosius to use information from AMA, Federation, Medical Society and BCBS, to begin working on a comprehensive policy. This policy should include the telepsychiatry issue the Committee addressed last year.

7/2009 COMMITTEE DISCUSSION: Dr. Rhyne reported that the AMA recently passed a policy regarding telemedicine and that Blue Cross Blue Shield may have also taken a position regarding this issue.

7/2009 COMMITTEE RECOMMENDATION: Mr. Brosius is to continue to research this issue. The Committee will report its findings at the September meeting.

7/2009 BOARD ACTION: No action required.

9/2009 COMMITTEE DISCUSSION: Mr. Brosius presented the following proposed Position Statement. Comments were solicited from DHHS and their recommendations were considered and incorporated where the Policy Committee deemed appropriate.

9/2009 COMMITTEE RECOMMENDATION: Present proposed Position Statement to the full Board for consideration. This issue will be revisited at the November 2009 meeting.

9/2009 BOARD ACTION: Have proposed Position Statement published in Forum for comments before final adoption by Board.

11/2009 COMMITTEE RECOMMENDATION: Continue to collect comments. Position Statement and comments will be considered at the January 2010 meeting.

11/2009 BOARD ACTION: Continue to collect comments. Position Statement and comments will be considered at the January 2010 meeting.

1/2010 COMMITTEE DISCUSSION: Comments received are provided for the Committee's review.

Telemedicine

“Telemedicine” is the practice of medicine using electronic communication, information technology or other means between a physician 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 physicians 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 physicians practicing via telemedicine will be held to the same standard of care as physicians 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 physician 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 -- Physicians 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 physician as if the exam had been performed face-to-face.

Other examinations may also be considered appropriate if the physician is at a distance from the patient, but a licensed health care professional is able to provide various physical findings that the physician 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 physician to discipline by the Board.¹

Informed Consent -- The physician using telemedicine should obtain the patient’s informed consent before providing care via telemedicine services. In addition to information relative to treatment, the patient should be informed of the risks and benefits of being treated via telemedicine, including how to receive follow-up care or assistance in the event of an adverse reaction to the treatment or in the event of an inability to communicate as a result of a technological or equipment failure. The patient retains the right to withdraw his or her consent at any time.

Physician-Patient Relationship – The physician 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. Physicians 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.

¹ See also the Board’s Position Statement entitled “Contact with Patients before Prescribing.”

Medical Records -- The physician 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 physician 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 physician and a telemedicine physician for the same ailment, then the primary physician's medical record and the telemedicine physician'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 physician using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina.² Physicians need not reside in North Carolina, as long as they have a valid, current North Carolina license.

North Carolina physicians 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.

Fees – The Board's licensees should be aware that third-party payors may have differing requirements and definitions of telemedicine for the purpose of reimbursement.

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.

Todd,

Below is the language that might be better in the first paragraph of your document (it comes directly from the Medicaid policy document)...with the word electronic only, I am afraid it will confuse folks and you will get questions about use of telephones, etc as adequate treatment.

There is also a section in “informed consent” that seems to exclude the fact that informed consent is not necessary in the process of completing an involuntary commitment review (under our MH 122C); and that will be a use of telemedicine for us.....I have asked Rich to provide a specific sentence that may directly address that issue.....thanks for your help with this, and for letting us take look prior to prime time...take care, Mike

Telemedicine is the use of two-way real-time interactive audio and video technology to provide and support health care when distance separates participants who are in different geographical locations..

Michael Lancaster, MD
Chief, Clinical Policy
DMH/DD/SAS

From: Mike Lenker [mailto:milenker27@aol.com]
Sent: Sunday, November 15, 2009 12:34 AM
To: Info
Subject: telemedicine position statement

To Whom It May Concern,

I am a licensee of the NCMB and would like to comment on the position statement on telemedicine published in the Fall 2009 Forum.

Physicians occasionally will telephone or email an expert or other colleague physician to pick his or her brain about a case. I gather that this is not considered telemedicine, since it has gone unregulated since the invention of the telephone, but it seems to me that this practice would be included in the proposed definition of telemedicine as "the practice of medicine using electronic communication . . . between a physician in one location and a patient in another location with or without an intervening health provider." In such telephone consults, the patient's identity is not provided, but it seems to me that what the consultant is doing is still a form of "the practice of medicine." If the position is not intended to apply to this practice, please say so, or change the definition.

I am a radiologist, and about half of my practice consists of reporting imaging studies performed at other North Carolina hospitals than the one at which I am physically located. This is common practice, and I gather that it is also common practice for such services to be rendered by radiologists located outside the state, but licensed here.

Teleradiology, as this is known, is generally considered a subset of telemedicine. I am not sure whether the position statement is supposed to apply to teleradiology. If not, that should be stated, because it implies a narrower definition of telemedicine than commonly understood.

For the purpose of the following comments, I assume that the position statement IS intended to apply to teleradiology.

In the context of teleradiology, the Informed Consent section of the statement is nonsensical, since there is no difference (except for a minuscule delay) between sending the images down the hall to be interpreted and sending them around the world. Requiring informed consent for this would be, at least, an unnecessary burden. In the near future, some interventional procedures, angiography and fluoroscopy, could also be performed remotely, but most of these are already subject to informed consent.

Under the Physician-Patient Relationship section, as applied to radiology, the provision about verifying the person is who they claim to be is problematic. Already, the radiologist is relying on the physician ordering the test, and the technologist performing it, to identify the patient, whether for teleradiology or in-house interpretation. Actually, I think the wording is too strong in any context, since patients commonly present themselves in the emergency department and lie about their identity. Are we supposed to fingerprint them? Or deny treatment if they don't present identity documents? The position could simply be that the standards of patient identification (whatever they may be) are not changed by the use of telemedicine.

Under Licensure, the statement says “ . . . any physician using telemedicine to regularly provide medical services to patients located in North Carolina should be licensed to practice medicine in North Carolina.” “Regularly?” I thought the current standard was that NO medical services could be provided without a license to practice in the state where the patient is located. If this statement is intended to weaken that standard, then some definition of “regularly” should be included. Or perhaps there could be an exception only in case of emergency?

The issue of location inside or outside the U.S. has been an issue for teleradiology. I understand that Medicare and most insurers will not pay for radiology interpretations rendered by physicians located outside the U.S., regardless of their licensure. I think this is a bad thing, because it prevents the use of radiologists working on the other side of the world, who are awake during their local daytime, providing services to U.S. patients at night. I am one of the radiologists who stays up all night to provide that service, now. I would like the opportunity to do it from one of several foreign countries during the day. If the NCMB does not have an issue with a duly licensed telemedicine physician being located outside the U.S., it might be helpful to say so.

Thank you for your consideration.

Michael Lenker, MD, DABR, NC lic.# 9701032

Here's what I came up with re the informed consent issue:

At the end of the informed consent paragraph, add:

It is noted that telemedicine examinations performed in the course of involuntary commitment procedures, in accordance with the provisions of G.S. 122C-263(c), do not require informed consent.

On Dr. Lancaster's point, the Medicaid language, with a little change, got put into GS 122C-263 at the last legislative session. It says, "As used in this subsection, "telemedicine" is the use of two-way real-time interactive audio and video between places of lesser and greater medical capability or expertise to provide and support health care when distance separates participants who are in different geographical locations."

Richard Slipsky

Todd;

Thanks for taking time out this week to hear TelaDoc's oral comments to the draft Telemedicine Policy Statement issued by the North Carolina Medical Board. As a summary of our conference call with Dr. Boxer, the following are TelaDoc's comments to the draft Policy Statement.

TelaDoc is trying to view the policy, at your suggestion, from the broad view of the standard of care in the community. Many, if not all the board members, likely receive telephone calls from their patients, their colleagues' patients, or from patients who have had a friend or relative in the past refer the caller to the doctor. Because of the great promotion yet not uniform availability of medical electronic personal health records, and the compelling interest to keep them private, our comments reflect both the desired effect as well as the present reality of the standard of care..

TelaDoc is certain that the intent of the North Carolina Medical Board policy statement is to clarify and promote standard of care and not potentially act as a chilling factor in the daily use of the telephone by thousands of patients and doctors. Thus, we seek to broaden the policy without removing the objective of protecting the community while simultaneously proving enhanced quality and access recognizing the newest technology available to the citizens of North Carolina.

Thus, our specific wording below recognizes what we perceive as the present common practice and standard of care with a nod to the future for best efforts and best practices.

Telemedicine

We discussed the need to include "telephone" consultations within the definition of "telemedicine". It is our understanding that you view the term "electronic communications" as including telephone consultations. Therefore, the suggested wording is "the practice of medicine using electronic and/or telephone communication..." . If this is unacceptable, we would request confirmation from the Board that electronic communications does include "telephone consultations"

Training of Staff

No suggested changes.

Examinations

The current language in the Policy Statement section is generally well written and clear. However, for further clarification and to aim directly at the problem of Internet prescribing (which appears to be an intent of this paragraph) , we would suggest revising the last sentence to read as follows: "On the other hand, *only* a simple questionnaire may be a violation of law and/or subject the physician to discipline by the Board." (italics, highlighting, and underline are meant only for the identification of the proposed changes)

Informed Consent No suggested changes

Physician-Patient Relationship

The standard practice in a cross-covering or even a personal patient telephone call/consultation to a doctor too often occurs when no (electronic) health records are available. Furthermore, acceptable medical practice over the telephone commonly does not involve a mental health status examination, and in fact prevents or avoids "a physical examination and immediate appropriate diagnostic and laboratory testing." What it does give is immediate access and advice, possibly appropriate treatment to a patient. By the policy statement specifically mentioning "a physical examination and immediate appropriate diagnostic and laboratory testing..." the Board narrowly defines and potentially places an undesired inhibition to the common and greatly appreciated personal contact between patient and physician.

Thus, perhaps the language could either remove the examples given or read "i.e. ...", the following: "for illustrative purposes only and without limitation,..."

Medical Records

Just as the North Carolina Board has in the past recognized the extraordinary public good for patient protection and rights, the policy should be consistent with HIPAA privacy concerns. In addition, unless a cross-covering physician, the primary physician, or a consulting specialty physician has access to the (electronic) records of the patient who is seeking telephonic consultation, merging the patient's medical record telephonic incident into the general medical record is not necessarily easy or even possible. Certainly, this does not occur in the thousands of daily communications. Thus, even though it is a desired effect in the future, the policy places a potential undesired inhibition upon present day normal communication. Having said that, best efforts should be encouraged.

Thus, the suggested language would be either to remove the final sentence or add , after the word "then" in the last sentence, the phrase, "subject to the patient's HIPAA privacy rights. The physician performing the telephonic consultation should use best efforts to communicate with the patient's primary doctor the results of the telephonic consultation"

Licensure and Fees. No suggested changes.

We applaud and are fierce advocates for the medical home, but we recognize the need to work with, not against the present day system.

Thanks again for your assistance. If you I would like to discuss these comments in further detail, both Dr. Boxer and I are available for a conference call at your convenience. Thanks for your attention to this matter.

Paul Squire, Esq.

The basic issue is that the regulations as proposed fit a telemedicine model of personalized patient care with a physician care interaction.... but is not at all practical for teleradiology or perhaps telepathology. Literally interpreted, every case in the CHS system would have to sign releases, etc... ouch.

I have pasted below an email from Bill Thorwarth MD in Hickory on this issue as well...

We have a long track record of accountability and quality assurance built into our network infrastructure including hospital staff membership / privileges at those hospitals that we serve. Within CHS, we operate a single Radiology service across multiple hospitals and out patient facilities using a "teleradiology technology" wide area network technology. NCMB policy should not create new burdens on operating such services, nor do I think that is the Board's intentions.

I have copied this email to Valerie Jewels, current NCRS president, and Dr Thorwarth and Dr Moore.. I also copied Dr Huff, whom I have also emailed about this issue.

Thanks for listening.

Chris
Christopher G. Ullrich MD FACR
2623 Lemon Tree Lane
Charlotte NC 28211-3643

----- Original message from "DixMic" <dixmic@roadrunner.com>: -----

Dixie and Valerie,

Please forward, with Valerie's approval, to the NCRS Exec Committee this proposed NC Med Board policy on Telemedicine
(http://www.ncmedboard.org/articles/detail/policy_committee_offers_new_position/).

I think we need to make a coordinated comment on this proposed policy.

I think there is both benefit and potential threat to this policy. It parallels current NC legislation in requiring full licensure and accountability but also includes such things as a requirement for informed consent from the patients to use telemedicine. Unless I am missing something, this would mean that every patient having an imaging exam that would be transmitted electronically to a different location (even if in the same building) would have to consent to that transmission. Practices like ours that shunt exams to subspecialists at different sites would definitely require such consent which would be unnecessary and cumbersome.

As one commenter has already submitted, it would be wise for them to distinguish between teleradiology and telepathology in some of the considerations though not to mandate any less accountability. CMS, in their "Telehealth" standards makes distinction between teleradiology and other specialties.

Bill--
Christopher G. Ullrich MD FACR
2623 Lemon Tree Lane
Charlotte NC 28211-3643

I.B. BOARD CERTIFICATION DISTINCTION

7/2009 BOARD ACTION: Approve proposed rule. Proceed with rule-making process.

9/2009 COMMITTEE DISCUSSION: It was reported that the following rule has been submitted to the Office of Administrative Hearings to be published in the NC Register. A public hearing for the purpose of collecting any comments will be held at the Board's office on November 30, 2009 at 11:00 am. The proposed rule will be submitted to the Board at its December meeting for adoption.

9/2009 BOARD ACTION: Accept as information.

11/2009 COMMITTEE DISCUSSION: It was reported that the following rule has been submitted to the Office of Administrative Hearings and was published in the NC Register. A public hearing for the purpose of collecting any comments will be held at the Board's office on November 30, 2009 at 11:00 am. The Board continues to receive comments. The proposed rule and comments collected will be presented to the Board at its January 2010 meeting for consideration.

11/2009 COMMITTEE RECOMMENDATION: No action necessary.

11/2009 BOARD ACTION: No action necessary.

1/2010 COMMITTEE DISCUSSION: A public hearing was held on November 30, 2009, for the purpose of receiving comments regarding the proposed rule. A taskforce is currently being assembled to further research and consider this issue. No action is necessary at this time.

21 NCAC 32Y .0101 is proposed for adoption as follows:

Subchapter 32Y – SPECIALTY AND BOARD CERTIFICATION ADVERTISING

21 NCAC 32Y .0101 ADVERTISING OF SPECIALTY AND BOARD CERTIFICATION

(a) No physician shall 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 (1) the American Board of Medical Specialties; (2) the Bureau of Osteopathic Specialists of American Osteopathic Association; (3) the Royal College of Physicians and Surgeons of Canada; (4) a board or association with an Accreditation Council for Graduate Medical Education approved postgraduate training program that provides complete training in that specialty or subspecialty; or (5) a board or association with equivalent requirements approved by the North Carolina Medical Board.

(b) Any physicians advertising or otherwise holding himself or herself out to the public as “Board Certified” as contemplated in paragraph (a) shall disclose in the advertisement the specialty board by which the physician was certified.

(c) Physicians shall not list their names under a specific specialty in advertisements, including but not limited to, classified telephone directories and other directories unless: (1) they are board certified as defined in paragraph (a); or (2) they have successfully completed a training program in the advertised specialty that is accredited by the Accreditation Council for Graduate Medical Education or approved by the Council on Postdoctoral Training of the American Osteopathic Association.

History Note: Authority G.S.90-5.1, 90-5.2, 90-14.

I. C. DISRUPTIVE PHYSICIANS - Position Statement

Issue: The Continued Competence Committee has asked that the Policy Committee consider a Position Statement pertaining to disruptive physicians.

9/2009 COMMITTEE DISCUSSION: The Policy Committee reviewed several policies and statements in preparation of considering a Position Statement on disruptive physicians. It was agreed that the Committee should develop a Position Statement.

Mr. Brosius pointed out that we issue a number to private letters of concern addressing this issue and that it would be beneficial to have a Position Statement to support these letters.

Dr. Walker stated that the Position Statement should be a broad one that emphasized the importance of collaborating as a team to best manage patient care. Dr. Rhyne suggested that the issue be framed one of patient safety. Dr. Rhyne pointed out that the Position Statement should try to reach those physicians who tend to alienate themselves from the team and the ones practicing in rural areas. It was noted that many hospitals already have policies in place.

It was agreed that it is important to develop a Position Statement that was positive.

9/2009 COMMITTEE RECOMMENDATION: Mr. Brosius will draft a proposed Position Statement to be presented for the Committee to consider at the November 2009 meeting.

9/2009 BOARD ACTION: Accept Committee Recommendation.

11/2009 COMMITTEE DISCUSSION: The following proposed Position Statement was reviewed by the Committee and recommended edits have been incorporated.

11/2009 COMMITTEE RECOMMENDATION: The Policy Committee recommends adoption by the full Board. The Policy Committee does not recommend that the Position Statement be published in the Forum for comments. The Board might consider having the Position Statement published on the Board's website for comments.

11/2009 BOARD ACTION: Publish in Forum and on website for comments. Also, distribute to interested parties.

1/2010 COMMITTEE DISCUSSION: Comments received are provided for the Committee's review.

Collaborative Care Within the Healthcare Team

The North Carolina Medical Board (“the Board”) recognizes that the manner in which its licensees interact with others can significantly impact patient care.

The Board strongly urges its licensees to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. Licensees should consider it their ethical duty to foster respect among all health care professionals as a means of ensuring good patient care.

Disruptive behavior is a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care. Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that disruptive behavior is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. As a result, disruptive behavior may reach a threshold such that it constitutes grounds for further inquiry by the Board into the potential underlying causes of such behavior. In certain instances, behavior by a licensee that is disruptive could be grounds for Board discipline.

The Board distinguishes disruptive behavior from constructive criticism that is offered in a professional manner with the aim of improving patient care. The Board also reminds its licensees of their responsibility not only to patients, but also to themselves. Symptoms of stress, such as exhaustion and depression, can negatively affect a licensee’s health and performance. Licensees suffering such symptoms are encouraged to seek the support needed to help them regain their equilibrium.

Finally, licensees, in their role as patient and peer advocates, are obligated to take appropriate action when observing disruptive behavior on the part of other licensees. The Board urges its licensees to support their hospital, practice, or other healthcare organization in their efforts to identify and manage disruptive behavior, by taking an active role in this process whenever possible.

David,

I agree with this statement since on December 15, 2008 we had an incident with a physician that resulted in our being reported to the NC nuclear regulatory agency and I believe to the NC Board. The regulatory agency had jurisdiction over radiation safety but I do not believe that the NC board had anything that they could do to curb the physician's behavior in this matter. Radiation safety and observing them is crucial.

GFrelix, M.D.

Behavior Within the Healthcare Team (Disruptive Behavior)

The North Carolina Medical Board (“the Board”) recognizes that the manner in which healthcare practitioners interact with others can significantly impact patient care.

Disruptive behavior by a practitioner has a deleterious effect upon the health care system and increases the risk of patient harm. The American Medical Association defines disruptive behavior as a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care.

The Board strongly urges practitioners to fulfill their obligations to maximize the safety of patient care by behaving in a manner that promotes both professional practice and a work environment that ensures high standards of care. The Accreditation Council for Graduate Medical Education highlights the importance of interpersonal/communication skills and professionalism as two of the six core competencies required for graduation from residency. Practitioners should consider it their ethical duty to foster respect among all health care professionals as a means of ensuring good patient care.

Behaviors such as foul language; rude, loud or offensive comments; and intimidation of staff, patients and family members are commonly recognized as detrimental to patient care. Furthermore, it has become apparent that disruptive behavior is often a marker for concerns that can range from a lack of interpersonal skills to deeper problems, such as depression or substance abuse. As a result, disruptive behavior may reach a threshold such that it constitutes grounds for further inquiry by the Board into the potential underlying causes of such behavior. ~~In certain instances, b~~ Behavior by a practitioner that is disruptive could be grounds for Board discipline.

The Board distinguishes disruptive behavior from constructive criticism that is offered in a professional manner with the aim of improving patient care. The Board also reminds practitioners of their responsibility not only to patients, but also to themselves. Symptoms of stress, such as exhaustion and depression, can negatively affect a practitioner’s health and performance. Practitioners suffering such symptoms are encouraged to seek the support needed to help them regain their equilibrium.

Finally, practitioners, in their role as patient and peer advocates, are obligated to speak out when observing disruptive behavior on the part of other practitioners. The Board urges its licensees to support their hospital, practice, or other healthcare organization in

their efforts to identify and manage disruptive behavior, by taking an ~~active role~~ role in this process whenever possible appropriate.

David:

Attached are a couple of thoughts reference the statement under consideration. I am somewhat concerned, based on what I have observed in institutional situations particularly, that "political correctness" can be used as a weapon by underperformers to the detriment of competent conscientious providers who do not suffer fools lightly.

Also, the patient population needs more straight talk than they are often getting when failing to adhere to commonsense practices.

Personally, I want my provider to deal with my health in no uncertain terms and without excusing less than first rate performance by those providers who he relies upon in delivering my health care.

Yes, I plead guilty to being a little old fashioned and hard-nosed about some things.....but my experience has led me to the above concerns.

Thanks for allowing me to comment.

Best.....

Troy

I. D. POSITION STATEMENT REVIEW

11/2009 POLICY COMMITTEE DISCUSSION: The Policy Committee discussed its goal to begin reviewing all Position Statements on a rotating basis beginning with those that have been reviewed most remotely in time. One proposal was to attempt to have each position statement reviewed at least once every four years. Following is a chart of the current Position Statements. The Policy Committee will begin this process in January 2010.

11/2009 COMMITTEE RECOMMENDATION: The committee seeks the Board's consensus of this plan. Should the Board approve this plan the committee will formulate a review schedule to be reviewed in January.

11/2009 BOARD ACTION: Approve Committee recommendation.

1/2010 COMMITTEE DISCUSSION: The following review schedule is provided for the Committee's consideration.

POSITION STATEMENT	ADOPTED	SCHEDULED FOR REVIEW	LAST REVISED/ REVIEWED/ ADOPTED	REVISED/ REVIEWED	REVISED/ REVIEWED	REVISED/ REVIEWED	REVISED/ REVIEWED
Unethical Agreements in Complaint Settlements	Nov-93		May-96				
Professional Obligation to Report Incompetence, Impairment, and Unethical Conduct	Nov-98		Nov-98				
Medical, Nursing, Pharmacy Boards: Joint Statement on Pain Management in End-of-Life Care	Oct-99		Oct-99				
What Are the Position Statements of the Board and To Whom Do They Apply?	Nov-99		Nov-99				
Contact With Patients Before Prescribing	Nov-99		Feb-01				
Guidelines for Avoiding Misunderstandings During Physical Examinations	May-91		Oct-02	Feb-01	Jan-01	May-96	May-93
Office-Based Procedures	Sep-00		Jan-03				
Access to Physician Records	Nov-93		Aug-03	Mar-02	Sep-97	May-96	
Medical Supervisor-Trainee Relationship	Apr-04		Apr-04				
The Treatment of Obesity	Oct-87		Jan-05	Mar-96			
HIV/HBV Infected Health Care Workers	Nov-92		Jan-05	May-96			
Writing of Prescriptions	May-91		Mar-05	Jul-02	Mar-02	May-96	Sep-92
Laser Surgery	Jul-99		Jul-05	Aug-02	Mar-02	Jan-00	

Self- Treatment and Treatment of Family Members and Others With Whom Significant Emotional Relationships Exist	May-91		Sep-05	Mar-02	May-00	May-96	
Advertising and Publicity	Nov-99		Sep-05	Mar-01			
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		Nov-05	Jan-01	Jul-98		
Sale of Goods From Physician Offices	Mar-01		Mar-06				
Competence and Reentry to the Active Practice of Medicine	Jul-06		Jul-06				
Availability of Physicians to Their Patients	Jul-93		Jul-06	Oct-03	Jan-01	May-96	
Referral Fees and Fee Splitting	Nov-93		Jul-06	May-96			
Sexual Exploitation of Patients	May-91		Sep-06	Jan-01	Apr-96		
Care of the Patient Undergoing Surgery or Other Invasive Procedure	Sep-91		Sep-06	Mar-01			
The Physician-Patient Relationship	Jul-95		Sep-06	Aug-03	Mar-02	Jan-00	Jul-98
The Retired Physician	Jan-97		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			