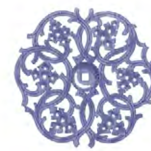

# COLORADO
## RESPONSIBILITIES OF PHYSICIANS WHEN EMPLOYING OTHER PROFESSIONALS

Increasingly, physicians are providing a wide array of services within their offices to complement their practices. Allied health professionals who have their own legally defined scope of practice provide many of these services. A common example would be the plastic or cosmetic surgeon who adds electrology or aesthetic services to his or her practice. The physician may have to comply with the requirements of other licensing programs, such as the Office of Barbering and Cosmetology licensure.

The Colorado Board of Medical Examiners adopted Rule 800 to provide further guidance to the physician who delegates the performance of medical services to office staff, employees, or other health care professionals not licensed in their own right to perform such services. It is the responsibility of the physician to ensure that the delegatee has the necessary education, training, or experience to perform the delegated services. The physician must also assume that any person in their employ or practicing within their office — who holds a license, certificate or registration in a limited field of the healing arts — not perform medical services beyond the scope of that license, certificate or registration, unless they have the additional education, training or experience qualifying the person to perform the medical service in question. All delegation of medical services must be in compliance with Board Rule 800.

See the complete text of Rule 800 on the board website at: http://www.dora.state.co.us/medical/Rule800.htm

Reprinted from the Volume 13, Number 2, issue of the *Examiner*, published by the Colorado Board of Medical Examiners.

# KENTUCKY
## DEFINITION OF "IMMEDIATE FAMILY"

Inquiry panels of the board have recently reviewed several cases of physicians prescribing to immediate family members. It is the position of the board that physicians shall not treat themselves or members of their immediate families except in emergencies. It is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

At its September 2005 meeting, the board adopted the following definition of immediate family as identified by federal statute. Immediate family is defined as "husband or wife; natural or adoptive parent; child, or sibling; stepparent, stepchild, stepbrother, stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild; and spouse of grandparent or grandchild".

## NEW LICENSURE PROCESS/FCVS

On March 1, 2005, the board began requiring all applicants for initial licensure to utilize the Federation of State Medical Boards' (FSMB), Federation Credentials Verification Service (FCVS). This service provides primary source verification of medical education, postgraduate training, licensure examination history, and board action history and identity information. It was designed to lighten the workload of credentialing staff and reduce duplication of effort by the applicant by gathering, verifying and permanently storing the physician's core credentials in a centralized repository located in the FSMB's national office.

The board elected to utilize this service in order to streamline and improve its application process. The use of FCVS also promotes license portability as the physician who has utilized the service can request to have his/her portfolio forwarded to any entity that has agreed to accept the documentation. Based on information from the FSMB, the processing time for initial application is eight to 10 weeks. In order to avoid delay in the application process, applicants are encouraged to allow sufficient time to complete the primary source verification process.

Reprinted from the Fall 2005 issue of the *Kentucky Board of Medical Licensure Newsletter*, published by the Kentucky Board of Medical Licensure.

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# NEW MEXICO
## PAIN MANAGEMENT UPDATE

The New Mexico Medical Board voted in May 2005 to initiate a Joint Statement on the Management of Chronic Pain. The Joint Statement, which can be found on the board website, acknowledges the significance of pain management as a major health issue today, and calls upon all health care professionals, within their scope of practice, to effectively assist patients in the management of chronic pain. This assistance should include, when appropriate:

- consistent and thorough assessment of patients for pain
- a collaborative and multi-disciplinary approach to develop and implement an individualized, written treatment plan utilizing pharmacologic and non-pharmacologic interventions with specific objectives for the patient;
- effective management of any side effects of pain medications;
- the provision of adequate and culturally appropriate information to patients and family members or caregivers to support patients in making informed decisions and participate in the management of their pain;
- recognition that individuals with chemical dependency may experience pain-requiring medications, including opioids, and may require specialized management;
- consultation with and referral of patients to other providers when appropriate; and
- development of organization-appropriate and evidence-based policies and protocols for pain management.

In addition, the Joint Statement calls for all health care providers to become and remain knowledgeable regarding effective pain management.

The boards of Osteopathic Examiners, Nursing and Pharmacy each voted to adopt the Joint Statement at their August meetings. This makes New Mexico one of the first states to present a united front on the issue of pain management.

## RULE CHANGE UPDATE

### Emergency Rule

At a special meeting on Sept. 20, 2005, the board adopted an Emergency Rule to ease licensure for physicians and physician assistants relocating to New Mexico from the federally declared disaster areas of Louisiana, Mississippi and Alabama. The Emergency Rule will allow physicians and physician assistants to apply at no cost during the next four months, and permits the board to waive requirements for some original source documentation that applicants may be unable to obtain under the circumstances, such as work verifications and letters of recommendation. In addition, the new rule exempts physician assistants working during a federally declared disaster from the customary physician supervision requirements.

The Emergency Rule received the necessary Concurrence from the Governor's Office and went into effect immediately upon filing on Sept. 22, 2005. Emergency Rules expire 120 days from establishment, so the board will hold a public hearing on Oct. 31, 2005, at 4:30 p.m. to consider making this a permanent change that can apply to any future disaster or emergency.

### Other Rule Changes

In May, the board approved several proposed rule changes. The proposed changes were posted on the board's website for public comment, provided to anyone who asked, and the proposed changes to the rule involving the use of medical lasers was mailed to over 100 dermatologists, dentists, medical spas and other interested parties.

Following a public hearing on Aug. 18, 2005, the board voted to adopt the changes to Part 2 of the rules, Physicians: Licensure Requirement; Part 3 of the rules, Examinations; and Part 15 of the rules, Physician Assistants: Licensure and Practice Requirements. The board also voted unanimously to repeal the existing policy on immunizations, effective immediately.

**Licensing examinations (16.10.3)**

The board has long required that applicants complete the three-part USMLE examination within a seven-year time period. The new rule will allow a 10-year time period under specific circumstances, such as when the physician has been continuously enrolled in a postgraduate training program or practicing in another country.

**Postgraduate training license (16.10.2)**

2005 amendments to the Medical Practice Act authorized the board to develop rules establishing the prerequisites for eligibility for a postgraduate, or resident, training license. The new rules require that applicants for resident licenses shall have graduated from a board approved medical



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school or completed a program determined by the board to be substantially equivalent to a U.S. medical school, and have passed Part 1 of the USMLE. This will prevent the problem that a resident who has trained in New Mexico may not be eligible for a permanent license.

**Physician Assistants (16.10.15)**

In response to a perception that the PA rules were overly burdensome, primarily in their paperwork and supervision requirements, the new rules remove the need for a written utilization plan, eliminate mandatory physician visits to the remote site every two weeks, and eliminate the requirement that the supervising physician be no more than 120 miles or two hours away from the physician assistant. Physicians must continue to be immediately available to any PA they are supervising. The board also approved a simplified process for licensing physician assistants already licensed by the New Mexico Board of Osteopathic Examiners. This change will allow physician assistants to have M.D. and D.O. supervising and alternate supervising physicians at the same time, without requiring them to go through two separate licensing processes.

Proposed rules changes regarding the management and retention of medical records and the use of devices and procedures by unlicensed personnel drew significant public comment and were returned to committee for reconsideration in light of that comment. The board considered the proposed changes to these rules, as well as emergency licensing provisions for physicians and PAs, and minor changes to Part 6, Complaint Procedures, at a public hearing on Oct. 31, 2005, at 4:30 p.m. For a copy of the draft language of all rules considered for changes, please visit the board's website at www.nmmb.state.nm.us or call the board office at (505) 476-7220.

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## NORTH CAROLINA
### TIENDAS AND SALES OF CONTRABAND PHARMACEUTICALS

A recent article in the *Charlotte Observer* pointed out the problems with North Carolina's Latino population obtaining prescription drugs in Mexican grocery stores known as tiendas. A segment followed this on WUNC-FM radio describing the dangers of this practice.

Many physicians are surprised to learn that we have two systems for consumer access to prescription drugs in this country: one for the Hispanic community and a different one for all other consumers. This is completely contrary to the principle of equal treatment for all citizens inherent in our society.

The normal procedure for access to prescription drugs includes a visit to a physician followed by a prescription order filled by a pharmacist. Hispanics in their native lands often have no physicians available, so they self-diagnose their conditions and obtain pharmaceuticals at food stores known as tiendas. Along with tacos and piñatas, they brought this self-treatment custom with them from their homeland.

Physicians in this state complain that Spanish-speaking patients arrive at emergency rooms with unprescribed antibiotics, steroids, and even controlled substances. Every hospital is obliged to treat patients who arrive under emergency conditions. Charges not covered by health plans are absorbed and contribute to the increasing costs in health care. The Latino population is a new and growing burden on hospitals, their health problems often complicated by their unorthodox and unsupervised use of pharmaceuticals.

One fundamental fact of drug use is that there is an immense difference between oral and injectable products. A patient who is in distress from an adverse reaction to an oral product can have their intestinal tract evacuated on both ends if necessary. This is uncomfortable but effective in removing the offending product from the body. Drugs administered by injection, however, are virtually impossible to remove once inside the skin. Treatment is much more difficult and sometimes it is not possible to save the patient from an adverse reaction from an injected drug.

Part of the transplanted Hispanic culture is self-diagnosis followed by the use of injectable drugs. This results in very powerful antibiotics such as Lincocin and Gentamicin being used indiscriminately without a competent diagnosis. Serious allergic reactions or runaway infections and deaths have resulted from using the wrong antibiotic to treat an infection. Even the injectable steroid Phenylbutazone, only used in horses in this country, is available for human use at some tiendas. This drug has not been available for human use in the United States for more than 30 years.

The Food and Drug Protection Division of the North

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Carolina Department of Agriculture has state jurisdiction over this conduct and has investigated complaints on this activity. When their investigators were stalked by an obvious criminal element, they wisely retreated to re-evaluate their procedures. These dedicated civil servants are not trained to deal with or expected to confront this kind of intimidating behavior.

Complaints filed for selling this contraband have come from Raleigh, Winston-Salem, Gastonia, Hickory, Morganton and Conover. The Burke County sheriff raided a store twice and seized over 75 products, including controlled substances. There are now nearly 400,000 Hispanics in the state, a population about the size of Greensboro and Winston-Salem combined.

This practice of distributing contraband drugs at Latino food stores must stop before serious damage is done. Recently in California, a young boy died from ad hoc treatment with illicit drugs. The coroner found that the child would be alive today had standard health care been applied. At least two other children had the same fate. I urge physicians, nurses, and pharmacists who encounter patients who have used these illegal products to contact their congressional representatives on this issue.

This is an interstate and international matter that needs to be addressed by the Food and Drug Administration. Meanwhile, the North Carolina Board of Pharmacy, the North Carolina Department of Agriculture, the Office of the Attorney General and other interested parties have formed a Task Force to build an educational effort directed at immigrants as well as tienda owners. Physicians can help in this effort by reporting adverse events from contraband products to the North Carolina Board of Pharmacy, attention Kristin Moore, P.O. Box 4560, Chapel Hill, North Carolina 27515-4560, (919) 942-4454, ext. 209, or e-mail: kmoore@ncbop.org.

## NCMB AMENDS ADMINISTRATIVE RULES

The North Carolina Medical Board has amended subchapter 32F, Annual Registration, and 32S, Physician Assistant Regulations, of the North Carolina Administrative Code. A copy of the rules is posted on the North Carolina Medical Board's website at www.ncmedboard.org, or you may access a copy through the Rules Division of the North Carolina Office of Administrative Hearing's website at http://www.oah.state.nc.us.

The amended rules include the following:

**21 NCAC 32F .0103**
Fee, which requires each physician pay an annual registration fee in accordance with G.S. 90-15.1; except that every physician who holds a limited volunteer license shall pay an annual registration fee of $25.

**21 NCAC 32S .0105**
Annual Registration, which requires each person holding a PA license in North Carolina to register his/her PA license each year no later than 30 days after his/her birthday. The license of any PA who fails to register and who remains unregistered for 30 days after certified notice of failure is automatically inactive.

**21 NCAC 32S .0117**
Fees, which states the PA license fee is $200, except that an applicant for a PA limited volunteer license need not submit an application fee. The annual registration fee is $100 if you register within 30 days of your birthday. Anyone who registers later than 30 days after your birthday, the fee is $120. Any PA who holds a limited volunteer license or who submits a statement to the board confirming that the PA is currently exclusively engaged in volunteer practice and has engaged exclusively in volunteer practice during the preceding year shall submit a reduced registration fee of $25.

## NCMB ANNOUNCES INCREASE IN CERTAIN FEES

At the request of the North Carolina Medical Board, the General Assembly approved changes to certain medical licensing and registration fees. Effective Nov. 1, 2005, the following fees were assessed:

- The physician application fee for license by endorsement will now be $388 (was $288) and includes a $38 fee for criminal background record check.
- The resident training license application fee will now be $138 (was $25) and includes a $38 fee for criminal background record check.
- The annual registration fee for physicians will now be $175 (was $125).
- The late registration fee will now be $50 (was $20).

Most of our licensees will be affected by the annual registration fee increase from $125 to $175. In this regard, it is important to note that, other than a modest increase five years ago ($25), the board has not had an annual registra-



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tion fee increase in almost 15 years. Also, even with an increase to $175, North Carolina physicians, ranked tenth by population in the U.S., will pay less than physicians in 22 other states (Connecticut's annual registration fee is $450) and less than many other North Carolina licensees (North Carolina optometrists pay $300 per year).

Although no one likes a fee increase, the NCMB must periodically seek additional funds in order to properly regulate the practice of medicine for the benefit and protection of the people of North Carolina. However, barring the unexpected, the increased revenue generated by the above fees should permit the NCMB to fulfill its public protection mandate for several more years without further fee increases.

## NCMB REPLACES POSITION STATEMENT ON MANAGEMENT OF CHRONIC NON-MALIGNANT PAIN

At meetings in late 2004 and early 2005, the North Carolina Medical Board's Policy Committee undertook and completed study of the board's position statement on the "Management of Chronic Non-Malignant Pain," which was originally adopted in September 1996. At its meeting in July 2005, the Committee recommended and the board then adopted an updated and more inclusive statement titled "Policy for the Use of Controlled Substances for the Treatment of Pain." This new statement is a slightly modified version of a document developed by the Federation of State Medical Boards (FSMB) and revised by the FSMB in 2004.

The new statement reflects the board's view that appropriate treatment of chronic pain may include both pharmacologic and non-pharmacologic modalities and that controlled substances, including opioid analgesics, may be an essential part of the treatment regimen. At the same time, it makes clear that all prescribing of controlled substances must comply with applicable state and federal law and that the guidelines for treatment include: (a) complete patient evaluation, (b) establishment of a treatment plan/contract, (c) informed consent, (d) periodic review and (e) consultation with specialists in various treatment modalities as appropriate. (Deviation from the guidelines will be considered on an individual basis for appropriateness.)

The complete text of the new statement can be found on the board website at http://www.ncmedboard.org/. Select the **For the Public/Media** button, and then the **Board Position Statements** link under the **Laws, Rules, Position Statements** heading.

## NCMB MODIFIES POSITION STATEMENT RELATING TO HAIR REMOVAL BY USE OF LASER

At its meeting in July 2005, the North Carolina Medical Board revised that section of its Position Statement on Laser Surgery that deals with the removal of hair by use of lasers and other devices that manipulate and/or pulse light causing it to penetrate human tissue. The revision stemmed from an extensive evaluation of the process conducted by the NCMB's Policy Committee in public meetings held over the previous year and involving testimony and comments offered by a wide variety of interested persons and groups.

The changes in the wording of the Laser Hair Removal section of the statement are underlined in the text of that section appearing below.

### Laser Hair Removal

Lasers are employed in certain hair-removal procedures, as are various devices that (1) manipulate and/or pulse light causing it to penetrate human tissue and (2) are classified as "prescription" by the U.S. Food and Drug Administration. Hair-removal procedures using such technologies should be performed only by a physician or by an individual designated as having adequate training and experience by a physician <u>who bears full responsibility for the procedure. The physician who provides medical supervision is expected to provide adequate oversight of licensed and non-licensed personnel both before and after the procedure is performed. The board believes that the guidelines set forth in this Position Statement are applicable to every licensee of the board involved in laser hair removal, whether as an owner, medical director, consultant or otherwise.</u>

<u>It is the position of the board that good medical practice requires that each patient be examined by a physician, physician assistant or nurse practitioner licensed or approved by this board prior to receiving the first laser hair removal treatment and at other times as medically indicated. The examination should include a history and a focused physical examination. Where prescription medication such as topical anesthetics are used, the board expects physicians to follow the guidelines set forth in the board's Position Statement titled "Contact with Patients Before Prescribing." When medication is prescribed or dispensed</u>



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in connection with laser hair removal, the supervising physician shall assure the patient receives thorough instructions on the safe use or application of said medication.

The responsible supervising physician should be on site or readily available to the person actually performing the procedure. What constitutes "readily available" will depend on a variety of factors. Those factors include the specific types of procedures and equipment used; the level of training of the persons performing the procedure; the level and type of licensure, if any, of the persons performing the procedure; the use of topical anesthetics; the quality of written protocols for the performance of the procedure; the frequency, quality and type of ongoing education of those performing the procedures; and any other quality assurance measures in place. In all cases, the board expects the physician to be able to respond quickly to patient emergencies and questions by those performing the procedures.

## PROFESSIONAL CORPORATIONS: TWO IMPORTANT REQUIREMENTS

The staff of the North Carolina Medical Board frequently receives questions regarding the formation and maintenance of professional corporations (PCs) that practice medicine. The purpose of this article is to address two issues that are often discussed: the requirement that all shareholders be certified as licensees of the board who are permitted to practice medicine, and the requirement that a PC notify the board when a shareholder dies. For the purpose of this article, the principles asserted regarding PCs apply to professional limited liability companies (PLLCs), as well.

In North Carolina, the only entities permitted by law to practice medicine are individuals licensed or approved by the board, professional corporations certified by the board, hospitals and HMOs. Professional corporations formed under Chapter 55B of the North Carolina General Statutes are permitted to practice medicine because all the owners are licensed by the board, which is responsible for regulatory oversight.

The Professional Corporation Act in N.C. Gen. Stat. § 55B-6 provides that "[n]o share or shares of any stock of a professional corporation shall be transferred upon the books of the corporation unless the corporation has received a certification of the appropriate licensing board that the transferee is a licensee." The Act also provides that the term " '[l]icensee' means any natural person who is duly licensed by the appropriate licensing board to render the same professional services which will be rendered by the professional corporation of which he is, or intends to become, an officer, director, shareholder or employee." The instructions for obtaining the certification from the board are available on the board website: www.ncmedboard.org. The board's legal staff interprets the above requirements to mean that every shareholder in the professional corporation must have an active license to practice medicine.

A licensee of the board who passes away no longer has an active license and cannot continue indefinitely to hold shares in the corporation. In fact, N.C. Gen. Stat. § 55B-7 requires that a PC practicing medicine report to the board the death of any of its shareholders within 30 days thereafter. The same statutory section also states that, "[w]ithin one year of the date of such death, all of the shares owned by such deceased shareholder shall be transferred to and acquired by the professional corporation or persons qualified to own such shares."

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