13:35–1A.9 Violations

Violation of the above requirements for establishing a clinical education program in this State, or maintaining or participating in an unapproved program whether as student or faculty, may be regarded as engaging in the unlicensed practice of medicine or aiding and assisting in the unlicensed practice, pursuant to the residual or other general powers of the Medical Practice Act, N.J.S.A. 45:9–1 et seq. and also, in particular, N.J.S.A. 18A:68–12 et seq., N.J.S.A. 45:9–6, 45:9–8, 45:9–18, 45:9–22, and 45:1–21(c) and 45:1–23. Violators shall be subject to the monetary penalties and/or other disciplinary sanctions authorized by law.

13:35–1A.10 Severability

If any provisions of this rule or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect any other provisions or applications of the rule which can be given effect without the invalid provision or application, and to this end the provisions of this rule are declared to be severable.

13:35–1A.11 Clerkship program approvals: effective date; limited waiver provision; no new applications

This rule shall apply to all clinical training programs, as defined in N.J.A.C. 13:35–1A.1, taking place in New Jersey on or after January 1, 1983. However, the Board recognizes that, prior to the adoption of this rule, it has granted to a number of foreign medical schools permission to sponsor modest clinical programs which were not required to meet the explicit standards now set forth herein, and which permission reserved all rights of the Board respecting the ultimate evaluation of the adequacy of any such program. No new applications for clinical clerkship programs shall be accepted.

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Reference to clerkship programs added.

SUBCHAPTER 2. LIMITED LICENSES: PODIATRY, DIAGNOSTIC TESTING CENTERS AND MISCELLANEOUS

13:35–2.1 Approved colleges of podiatry

An applicant for podiatric licensure shall have graduated from a college or colleges of podiatry approved during the entire course of the applicant's training by the American Podiatric Association and approved by the Board.

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Deleted N.J.S.A. reference.

13:35–2.2 Podiatry internship or postgraduate work

The applicant for licensure shall have successfully completed an internship or postgraduate program fully approved by the American Podiatric Medical Association in a duly licensed clinic, hospital or institution acceptable to the Board, which shall take into account the standards adopted by the Advisory Graduate Medical Education Council (AGMEC).

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Old text deleted, replaced with new text.

13:35–2.3 Military service in lieu of internship in podiatry

The Board may grant a license to practice podiatry to any person who shall furnish proof, satisfactory to the Board, that such person has fulfilled all of the formal requirements established by the Podiatric Practice Act, N.J.S.A. 45:5–1 et seq., and has served at least two years in active military service in the United States Army, Air Force, Navy, Marine Corps, Coast Guard or the United States Public Health Service as a commissioned officer and podiatrist in a medical facility which the Board determines constitutes the postgraduate training program required by law; provided, however, that such military service actively occurred subsequent to graduation from an approved school of podiatry.

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Reference to Podiatric Practice Act.

13:35–2.4 (Reserved)

Amended by R.1985 d.102, effective March 4, 1985.
See: 16 N.J.R. 3177(a), 17 N.J.R. 605(a).
(k) substantially amended.
Amended by R.1985 d.631, effective December 16, 1985.
See: 17 N.J.R. 2231(b), 17 N.J.R. 2991(b).
Deleted "effective date of this rule" and substituted "March 4, 1985"; deleted "August 1, 1987" and substituted "March 31, 1988."
Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
At (k), reference made to March 18, 1988 as date prior to which students are recognized.
Repealed by R.1994 d.522, effective October 17, 1994.
See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).
Section was "Requirements for approval of college of chiropractic."

Case Notes

Emphasis on common subjects in medical and chiropractic education noted; medical doctor competent as expert in chiropractic diagnosis and use of x-rays in each area which the disciplines share in common in terms of education, training and licensure (citing former N.J.A.C. 13:35–10.0 and 13:35–10.9). Rosenberg by Rosenberg v. Cahill, 99 N.J. 318, 492 A.2d 371 (1985).

13:35–2.5 Medical standards governing screening and diagnostic medical testing offices

(a) As used in this section, the following terms shall have the following meanings:

1. "Screening facility or office" means a private practice location not licensed by the State Department of Health, which practice offers services to the medical

profession or to the public in the form of one or more types of medical testing. Such a practice shall be owned and under the control, supervision and direction of a physician or group of physicians licensed and currently registered in New Jersey.

2. "Screening test" means a test which results in a determination less complete than a physical examination performed by a licensed physician and does not purport to substitute for a complete examination. The definition is not intended to include a community-sponsored one-modality service such as, for example, a hypertension or glaucoma screening sponsored by a municipal or regional health department or a community screening volunteered by a non-profit professional society at no cost to examinees.

3. "Diagnostic center" means a practice not licensed by the State Department of Health, which practice offers services to the medical profession or to the public and which contains the equipment and medical staff necessary to establish a medical diagnosis and which may recommend a course of treatment for the examinee who elects to become a patient. Such a practice shall be owned and under the control, supervision and direction of a physician or group of physicians licensed and currently registered in New Jersey.

(b) Medical screening or medical diagnostic testing (other than clinical laboratory testing), conducted primarily for persons not receiving medical treatment from the testing entity, is nevertheless deemed to be a medical service. Such a practice shall be owned and under the responsibility of one or more physicians each of whom holds a plenary license from the State Board of Medical Examiners. All such testing, irrespective of the stationary or mobile nature of the facility, shall be performed under the authority of a designated responsible physician who shall establish a protocol and a quality assurance program for the specific type of screening or study. Results of all such procedures shall be interpreted by a physician holding a plenary license in this State, and documented in a written report which is preserved by the physician as required by N.J.A.C. 13:35–6.5.

(c) A copy of the test report shall be issued promptly, by preliminary verbal report when necessary and no later than three business days from the date of receipt of the report by the testing facility, to the referring physician, if any, and upon request to the examinee or other authorized person, to the extent authorized by N.J.A.C. 13:35–6.5. An interpretation delayed pending receipt of additional material shall be issued as soon as possible thereafter. In the event that a report is directed by an examinee to a designated physician who has not personally ordered the test, said physician shall incur no obligation with respect to such report and the testing facility shall formally advise all examinees of this at the time of testing. All abnormalities shall be clearly identified for the attention of a physician. For an examinee without physician referral, an abnormal or questionable result shall be identified in the report with interpretation sufficient to strongly advise the examinee to seek medical consultation. The facility protocol shall make available a referral source for examinees with suspicious findings or suspected disease, which source identifies specialists pertinent to the pathology involved, such as internal medicine, gynecology, hematology, general surgery, surgical and medical oncology and radiation oncology, for follow-up when the examinee does not indicate a primary care provider as recipient of test results.

(d) Requirements for a screening or diagnostic facility not having a full-time physician present on the premises are as follows:

1. Non-invasive screening tests or diagnostic studies may be performed in facilities at which the responsible physician is not physically present at all times of facility operation. For such testing services, the responsible physician may delegate certain tasks to another licensed health care practitioner, such as a registered professional nurse or x-ray technician, consistent with that person's scope of practice. Tasks of a non-medical nature may be delegated to non-licensed employees under the supervision of a licensed employee, where not inconsistent with applicable law or rule and with accepted standards of practice pertinent to that screening or diagnostic procedure. The physician responsible for such screening or diagnostic service shall take the necessary measures to assure compliance with the requirements of this section and accepted standards of practice. Services performed from mobile facilities parked on the premises of or providing services to a licensed health care facility must have approval from the State Department of Health.

2. There shall be a written protocol which specifies at a minimum: equipment operation, procedure manuals, eligibility criteria for persons to be accepted for examination, methods for securing informed consent, record documentation, and provision for follow-up to examinees and/or referring physicians, as applicable. There shall be procedures for authorized billing, and other factors consistent with accepted standards of practice pertinent to the screening test or diagnostic procedure.

3. There shall be a quality assurance program which requires the following:

i. At least annually, documented inspection of personnel credentials upon hire and at least annually thereafter or sooner as required by circumstances including dates of certification and license renewal; review of the procedure manuals; determination of the qualifications, identity and supervision of employees designated to perform specific functions; and assessment of accuracy in test results;

ii. At least quarterly, evaluation of personnel skills and review of test performance techniques and data recordation or more frequently as required by demonstrated staff performance; verification of billing accuracy; and observance of other factors consistent with accepted standards of practice pertinent to the screening test or diagnostic study procedure;

iii. The required quality assurance program shall include documented regular mechanical inspections as customary for that equipment, but no less frequently than four times per year, and before re-use after the reporting of a mechanical or pertinent personnel problem; and

iv. Minimum safety precaution standards shall be established, observed by all personnel and confirmed by the supervising physician.

(e) For screening services accepting examinees without physician referral, the responsible physician shall prepare and produce, at the request of the Board, a report for a specified calendar year(s) designating the total number of examinees issued abnormality reports and the advisory letter required by (c) above.

(f) For radiologic procedures, the responsible physician shall assure compliance with the applicable requirements of the Radiation Protection Act, N.J.S.A. 26:2D–1 et seq. and the Radiation Protection Code, N.J.A.C. 7:28. Certification of inspection results shall be kept on the premises. The responsible physician may delegate certain tasks to a New Jersey-licensed x-ray technologist within that person's scope of practice, provided that the physician has complied with (d) above.

(g) In addition to compliance with all other subsections of this rule, a mammography screening program shall establish a written protocol which shall be documented in the facility policy and procedure manual and which shall be brought to the attention of pertinent personnel.

1. The protocol shall include specific criteria for screening: for example, age, family history, personal medical history, permissible frequency of testing and other indicators. It shall provide for palpation by a physician or by instructed licensed registered nurse personnel, and for appropriate positioning preparatory to the test. The screening program shall include instruction in breast self-examination, which may be provided in the form of written materials.

2. The physician shall require that anyone other than a physician operating mammography equipment shall be currently licensed as a diagnostic (or mammographic) radiologic technologist as shall be required by the Department of Environmental Protection and Energy in accordance with N.J.S.A. 26:2D–1 et seq. and N.J.A.C. 7:28–19 et seq. The equipment used shall conform to the applicable sections of N.J.A.C. 7:28. Baseline mammography images and periodic images shall be maintained as part of the record of the examinee or referred patient and preserved for seven years from date of last entry. The physician may release the original of any image, providing that signed documentation thereof is retained in the patient's file.

3. Mammography services offered in mobile settings shall be furnished only under the supervision of a doctor of medicine or of osteopathy who is certified by the American Board of Radiology or by the American Osteopathic Board of Radiology or who possesses equivalent certification requirements as determined by the Board of Medical Examiners and who successfully completes a minimum of 20 hours of post-graduate work in mammography interpretation every 24 months after the date he or she begins reading mammographies. Documentation shall be kept on the premises. Physicians practicing in any setting, mobile or otherwise, who offer mammography services as authorized Medicare providers or as meeting requirements of the American College of Radiology, must meet the more stringent training requirements of those programs.

4. The physician shall require that anyone operating mammography equipment, other than a physician, shall be currently licensed by the New Jersey Radiologic Technologist Board of Examiners to perform radiographic procedures. Documentation shall be kept on the premises.

(h) A physician may request a radiologist to perform diagnostic radiology services intended to confirm or rule out suspected pathology. The radiologist shall ascertain whether sufficient objective or clinical data have been provided to determine that the tests are appropriate to the apparent problem. When, in the opinion of a reasonable radiologist, further information is needed to select the appropriate test, then the radiologist, whenever feasible, shall personally consult with the referring doctor in advance of performing the test. In addition or as an alternative, at the professional discretion of the radiologist, he or she shall perform a focussed clinical examination in appropriate cases. Whenever feasible, the radiologist shall be notified of the patient's appearance at the radiologic facility and shall direct the licensed x-ray technologist as to procedure, method of obtaining the test data, scheduling of the physician's oral and written report, and timely notification to the patient or referring physician of results or the need to repeat the test.

(i) A patient or examinee shall not be billed for a test result which is professionally incomplete, or which is found to be non-diagnostic due to inadequate equipment or technique.

(j) This rule shall be effective April 6, 1992, except that subsections (d), (e), (f) and (g) shall be operative July 6, 1992.

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Recodification and reference made to specific Acts.
Repeal and New Rule, R.1992 d.169, effective April 6, 1992 (subsections (d), (e), (f) and (g) operative July 6, 1992.
See: 23 N.J.R. 2858(a), 24 N.J.R. 1367(a).
Section was "Standards concerning testing and diagnostic centers".

13:35–2.6 (Reserved)

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Exception of Certified Nurse Midwife added in (a), reference to specific statute deleted.
Repealed by R.1992 d.332, effective September 8, 1992.
See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).
Section was "Midwife and Certified Nurse Midwife Practice".

13:35–2.7 (Reserved)

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Deleted qualification of 2 years Obstetrical clinical experience.
Repealed by R.1992 d.332, effective September 8, 1992.
See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).
Section was "Qualifications".

13:35–2.8 (Reserved)

Repealed by R.1992 d.332, effective September 8, 1992.
See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).
Section was "Minimum conditions of practice".

13:35–2.9 (Reserved)

Repealed by R.1992 d.332, effective September 8, 1992.
See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).
Section was "Minimum standards for C.N.M. and lay midwife practice during prenatal stages".

13:35–2.10 (Reserved)

Repealed by R.1992 d.332, effective September 8, 1992.
See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).
Section was "Management by a physician C.N.M. team for high-risk patients".

13:35–2.11 (Reserved)

Repealed by R.1992 d.332, effective September 8, 1992.
See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).
Section was "Intrapartum management".

13:35–2.12 (Reserved)

Repealed by R.1992 d.332, effective September 8, 1992.
See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).
Section was "Postpartum and other care".

13:35–2.13 Limited privileges and conditions of practice permitted for a graduate physician pending licensure

(a) Persons who are graduates of medical schools recognized by the Board may commence a period of supervised post-graduate training in a licensed hospital with an Accreditation Council on Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved residency training program in this State immediately upon graduation. A training period commencing prior to the start of a formal ACGME or AOA approved post-graduate year term shall not exceed six months and shall be documented in the hospital record.

(b) Persons who are graduates of foreign medical schools recognized by the Board but who are not yet deemed eligible for licensure in this State because of the requirements of N.J.S.A. 45:9–8 and N.J.A.C. 13:35–3.11 may sit for the USMLE Step 3 upon completion of one year of approved post-graduate training and satisfaction of all other requirements of N.J.S.A. 45:9–1 et seq. and N.J.A.C. 13:35–3.1.

R.1984 d.138, effective April 16, 1984.
See: 16 N.J.R. 216(a), 16 N.J.R. 920(a).
Amended by R.1994 d.522, effective October 17, 1994.
See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

13:35–2.14 (Reserved)

R.1984 d.245, effective June 18, 1984.
See: 16 N.J.R. 685(a), 16 N.J.R. 1612(a).
Repealed by R.1992 d.332, effective September 8, 1992.
See: 23 N.J.R. 3682(a), 24 N.J.R. 3094(a).
Old section "Reserved" recodified to 13:35–2A.10. Section was "Limited privileges and conditions of practice permitted for a graduate nurse midwife pending results of certifying examination and licensure".

SUBCHAPTER 2A. LIMITED LICENSES: CERTIFIED NURSE MIDWIFERY

13:35–2A.1 Certified Nurse Midwife practice

(a) A Certified Nurse Midwife ("CNM") shall mean a registered professional nurse licensed in the State of New Jersey who, by virtue of added knowledge and skill gained through an organized program of study and clinical experience, is qualified to manage the care of women and/or newborns during the antepartum, intrapartum and postpartum periods and to provide well-woman health care as expressly limited and set forth below.

(b) A CNM shall maintain current registration with the Board of Medical Examiners (hereinafter the "Board") in order to discharge those responsibilities set forth in this subchapter.

11. Heat-treated and chemically-treated industrial safety eyewear

TOLERANCE: Tolerance for power, size and the like shall be as above, except that minimum thickness edge or center shall meet the requirements of American Standard Z80.1–1972 and subsequent revisions.

12. Heat-treated and chemically-treated dress eyewear

TOLERANCE: Tolerance for power, size and the like shall be as above, except that minimum thickness edge or center shall meet the requirements of American Standard Z80.1–1972 and subsequent revisions.

(b) Provided, however, that nothing herein shall be construed to prohibit deviations beyond those established by this rule, provided that good medical cause exists therefor.

SUBCHAPTER 6. GENERAL RULES OF PRACTICE

13:35–6.1 Practice identification

(a) A physician with a plenary license to practice medicine and surgery in the State of New Jersey shall make representation for professional purposes (office identification, stationery, professional cards, signature on insurance claim forms, education, etc.) in a manner clearly indicating such plenary licensure and/or practice specialty; for example: Dr. John Doe, physician and surgeon; or Dr. Jane Smith, physician; or Dr. John Doe, surgeon; or Dr. Jane Smith, licensed to practice medicine and surgery; or Dr. Jane Doe, physician, practice limited to (name of specialty); or similar accurate descriptive terms. In addition to or as an alternative to these titles, a licensee may use the standard and accepted abbreviation of professional degree conferred by the medical school; that is, John Smith, M.D.; Jane Smith, D.O., as the case may be.

(b) An applicant or current licensee who is a graduate of both an A.M.A.-accredited allopathic professional school and an A.O.A.-accredited osteopathic professional school may elect to use either M.D. or D.O. as the primary abbreviation following the name and shall notify the Board of such election.

(c) A licensee with a limited license issued by the Board shall identify himself or herself for professional purposes in a manner clearly indicating the licensed profession by name or by using the recognized and accepted abbreviation of the degree actually conferred by the professional college; for example: Jane Smith, Podiatrist or Jane Smith, D.P.M.; John Doe, Bioanalytical Laboratory Director or John Doe, B.L.D. or John Doe, Specialty Bioanalytical Laboratory Director in Chemistry, etc.; Jane Smith, Certified Nurse Midwife or C.N.M.

(d) The use of any letters in immediate conjunction with the name of a licensee shall be deemed a representation of earned academic professional degree. Any such degree shall have been conferred by an educational institution authorized by the appropriate higher education authorities in its state of domicile to do so. The licensee may also list abbreviations of membership in non-profit incorporated professional societies.

(e) All representations by licensees of degree abbreviations or of professional society affiliations shall comply with this rule, and any use of an academic degree or professional or membership abbreviation not in accordance with these standards shall be deemed a misrepresentation and professional misconduct.

New Rule, R.1985 d.103, effective March 4, 1985.
See: 16 N.J.R. 3178(a), 17 N.J.R. 606(a).
This adoption repealed former rule "Degree designation".
Amended by R.1994 d.522, effective October 17, 1994.
See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Case Notes

Sexually abusing patients while conducting gynecological examinations warranted revocation of license and imposition of fine. In Matter of Suspension or Revocation of License of Chunmuang, 93 N.J.A.R.2d (BDS) 27.

No proof of alleged sexual molestation by doctor. In Matter of Suspension and Revocation of License of Prada, 93 N.J.A.R.2d (BDS) 1.

Podiatrist's improper touching of female patients and relative of one patient constituted professional misconduct; license revoked and civil penalties imposed. In Matter of Suspension or Revocation of License of Schulman, 92 N.J.A.R.2d (BDS) 16.

13:35–6.2 Pronouncement of death

(a) The following words and terms, when used in this section, shall have the following meanings unless the context clearly indicates otherwise.

"Attending physician" means any Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who, prior to the person's death, had attended, supervised or directed ongoing medical treatment of the patient as a primary care physician or as a specialist undertaking to treat a significant chronic medical illness which could lead to death. A physician providing such ongoing treatment, who has issued or renewed a prescription issued to the person within the six month period preceding the death, will be deemed to be an attending physician, regardless of whether the physician has personally examined the person within that six month period.

"Certificate of death" means the official document prepared for filing pursuant to N.J.S.A. 26:6–6 et seq. which is signed by a physician and sets forth the information pertaining to a person's last sickness, immediate and contributing causes of death and burial and the identity of the medical personnel who made the pronouncement of death.

"Covering physician" means any physician who has assumed the responsibility for providing care and treatment to an attending physician's patients during his or her unavailability. A covering physician shall also bear a responsibility to exercise his or her best medical judgment when making a pronouncement of death or drawing the conclusions called for in completing the certificate of death.

"Pronouncement of death" means the act of conducting an inquiry concerning the circumstances of a death, checking for vital signs, ascertaining pertinent history and, where appropriate, performing a complete external examination of the unclothed body and providing a medical opinion as to conclusion and cause(s) of the death.

(b) Every physician licensed by the Board and engaged in the active practice of medicine in this State shall ensure that he or she meets the obligations set forth in this section. If the physician is unavailable, he or she shall arrange for another physician to assume these responsibilities.

(c) Upon notification of an apparent death, the attending physician or designated covering physician shall proceed without inordinate delay to the location of the presumed decedent and shall make the proper determination and pronouncement of the death.

(d) Where the apparent death has occurred outside a licensed hospital and the attending or covering physician has been notified but is unable to go to the location to make the determination and pronouncement, said physician may specify another physician or may arrange with a professional nurse (R.N.) or a paramedic in accordance with N.J.A.C. 8:41–7.5, which requires the relay of findings, including telemetered electrocardiograms, if feasible to attend the presumed decedent and make the determination and pronouncement. In every such instance a written record, which may be contained within a police record, shall be prepared describing the circumstance and identifying the physician and any other person designated as above to perform the death pronouncement responsibility. Such report shall be promptly communicated orally to the attending physician for use in preparation of the death certificate. A copy of the report shall be provided to the physician as soon as practicable.

(e) Where the probable death has occurred outside a licensed hospital and the attending or recovering physician is known but cannot be reached after exercise of reasonable diligence, or no attending physician is known, then any physician, professional nurse or paramedic in accordance with N.J.A.C. 8:41–7.5 may proceed to the scene and make the determination and pronouncement of death. A written record shall be prepared as set forth in (d) above. Following pronouncement of death, the information shall be promptly communicated to the physician for preparation of the death certificate and a copy of the report provided as soon as practicable. If no attending physician is known or if an attending physician is not available to sign in a reasonable period of time, the death shall be immediately reported to the County Medical Examiner.

(f) In cases of death within the jurisdiction of the County Medical Examiner, the examiner shall without inordinate delay require the proper and established means for the determination and pronouncement of death, and shall arrange for the removal of the body and completion of the death certificate.

(g) A certificate of death shall be prepared and completed by a physician within a reasonable period of time, not to exceed 24 hours after the pronouncement of death. The factual data set forth in the certificate shall be based, to the greatest extent possible, upon the personal knowledge of the physician preparing the certificate. The physician shall provide an immediate cause of death as well as such contributing causes as the physician can best determine from the medical history obtained from other health care professionals, family or friends of the decedent, from observation of the condition of the body when pronounced and the circumstances known concerning the death. If the physician lacks sufficient information to provide an immediate cause of death, he or she may indicate an underlying potentially fatal medical condition which in the professional judgment of the physician may, or is likely to, have caused death.

(h) Nothing contained in this section shall be deemed to impose an obligation upon any person not licensed by the Board of Medical Examiners to pronounce death.

Amended by R.1994 d.522, effective October 17, 1994.
See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).
Amended by R.1995 d.412, effective August 7, 1995.
See: 27 N.J.R. 1745(a), 27 N.J.R. 2960(a).

13:35–6.3 Sexual misconduct

(a) By this section, the Board of Medical Examiners is identifying for its licensees conduct which it shall deem to be violative of law. Specialized concerns with respect to those licensees who provide psychiatric or psychotherapeutic services are also identified.

(b) As used in this section, the following terms have the following meanings unless the context indicates otherwise:

1. "Licensee" means any person licensed or authorized to engage in a health care profession regulated by the Board of Medical Examiners.

2. "Patient" means any person who is the recipient of a professional service rendered by a licensee for purposes of diagnosis, treatment or a consultation relating to treatment. "Patient" for purposes of this section also means a person who is the subject of professional examination even if the purpose of that examination is unrelated to treatment.

3. "Patient–physician relationship" means an association between a physician and patient wherein the physician owes a continuing duty to the patient to be available to render professional services consistent with his or her training and experience. The performance of any professional medical service including, but not limited to, the issuance of a prescription or authorization of a refill of a prescription is deemed to be a professional service and evidence of a patient-physician relationship.

4. "Sexual contact" means the knowing touching of a person's body directly or through clothing, where the circumstances surrounding the touching would be construed by a reasonable person to be motivated by the licensee's own prurient interest or for sexual arousal or gratification. "Sexual contact" includes, but is not limited to, the imposition of a part of the licensee's body upon a part of the patient's body, sexual penetration, or the insertion or imposition of any object or any part of a licensee or patient's body into or near the genital, anal or other opening of the other person's body.

5. "Sexual harassment" means solicitation of any sexual act, physical advances, or verbal or non-verbal conduct that is sexual in nature, and which occurs in connection with a licensee's activities or role as a provider of medical services, and that either: is unwelcome, offensive to a reasonable person, or creates a hostile workplace environment, and the licensee knows, should know or is told this; or is sufficiently severe or intense to be abusive to a reasonable person in that context. "Sexual harassment" may consist of a single extreme or severe act or of multiple acts and may include, but is not limited to, conduct of a licensee with a patient, co-worker, employee, student or supervisee whether or not such individual is in a subordinate position to the licensee.

6. "Spouse" means either the husband or wife of the licensee or an individual in a long-term committed relationship with the licensee.

(c) A licensee shall not engage in sexual contact with a patient with whom he or she has a patient-physician relationship. The patient-physician relationship is considered ongoing for purposes of this section in all contexts other than the provision of psychiatric or psychotherapeutic services, unless: actively terminated, by way of written notice to the patient and documentation in the patient record; or the last professional service was rendered more than one year ago.

1. In the context of the provision of psychiatric or psychotherapeutic services, the patient-physician relationship shall be considered ongoing for purposes of this section unless the last professional service was rendered more than two years ago; provided, however, the patient-physician relationship shall be considered ongoing for an indefinite period of time if the patient, by reason of emotional or cognitive disorder, is vulnerable to the exploitative influence of the licensee.

(d) A licensee shall not seek or solicit sexual contact with a patient with whom he or she has a patient-physician relationship and shall not seek or solicit sexual contact with any person in exchange for professional services.

(e) A licensee shall not engage in any discussion of an intimate sexual nature with a patient, unless that discussion is related to legitimate patient needs. Such discussion shall not include disclosure by the licensee of his or her own intimate sexual relationships.

(f) A licensee shall provide privacy and examination conditions which prevent the exposure of the unclothed body of the patient unless necessary to the professional services rendered.

(g) A licensee shall not promote, permit or condone sexual contact between group members in therapy groups.

(h) A licensee shall not engage in sexual harassment, whether in a professional setting (including, but not limited to, an office, hospital or health care facility) or elsewhere.

(i) A licensee shall not engage in any other activity (such as, but not limited to, voyeurism or exposure of the genitalia of the licensee) which would lead a reasonable person to believe that the activity serves the licensee's personal prurient interests or is for the sexual arousal, the sexual gratification or the sexual abuse of the licensee or patient.

(j) Violation of any of the prohibitions or directives set forth at (c) through (i) above shall be deemed to constitute gross or repeated malpractice pursuant to N.J.S.A. 45:1–21(c) or (d) or professional misconduct pursuant to N.J.S.A. 45:1–21(e).

(k) Nothing in this section shall be construed to prevent a licensee from rendering medical examination or treatment to a spouse, providing that the rendering of such service is consistent with accepted standards of medical care and that the performance of medical services is not utilized to exploit the patient for the sexual arousal or sexual gratification of the licensee.

(*l*) It shall not be a defense to any action under this section that:

1. The patient solicited or consented to sexual contact with the licensee; or

2. The licensee was in love with or had affection for the patient.

APPENDIX

POLICY STATEMENT REGARDING SEXUAL ACTIVITY BETWEEN PHYSICIANS AND PATIENTS AND IN THE PRACTICE OF MEDICINE

It is beyond dispute that sexual contact with patients is in conflict with the very essence of the practice of medicine. Despite that fact, the Board of Medical Examiners continues to receive complaints of sexual activity involving physicians and other licensees with patients. While the Board is promulgating a regulation to specifically notify licensees of conduct which it deems to be violative of law and will subject them to disciplinary action, this statement is meant as an advisory to licensees to guide professional behavior

and further expand upon the Board's reasoning in promulgating such a regulation.

A. **Background.** It is well established that sexual activity between physicians and patients is almost always harmful to the patient and is prohibited. Whether harkening back to the proscription of the hippocratic oath[1], or referring to more recent pronouncements such as the Code of Medical Ethics of the Council of Ethical and Judicial Affairs of the American Medical Association which term sexual activities between physicians and patients harmful[2], commentators have uniformly condemned such activities by physicians.

(i) **Rationale for the Policy.** A patient must have absolute confidence and trust in his or her physician. Insertion of sexual activity into the professional relationship destroys such trust because the personal interest of the physician is in conflict with the interest of the patient.

(ii) **Inequality of Power Between Physician and Patient.** Physicians are in a unique position as to the physical and emotional vulnerability of patients. Physicians are expected to examine patients undressed who expose not only their bodies but the most intimate details of their personal lives.

(iii) **Physician in Position of Authority.** Patients seek assistance and guidance from physicians. The doctor/patient relationship is not one of equality, the patient being vulnerable to abuses of power.

(iv) **Negative Psychological Consequences for Patient.** Commentators and researchers have concluded that sexual activity between physicians and patients is almost always damaging to the patient.

(v) **Public Trust in the Profession.** In order to maintain the community perception of the integrity of the medical profession, personal boundaries must be maintained.

(vi) **Sexual or Romantic Relationships with Former Patients.** Sexual activity with a former patient may also be inappropriate if the patient has been unduly influenced by the prior professional relationship or if the physician utilizes trust, knowledge, or emotions derived from the previous professional relationship. The clearest example of this phenomenon is known as "transference" between a patient and psychotherapist, which may last for many years following the conclusion of therapy.

B. **Recommendations and Guidelines for Conduct.**

(i) **Licensee Responsibility**—The physician or other licensee is always responsible to ensure that the boundaries of the professional relationship are maintained. Licensees should therefore avoid verbal or physical behavior which might be interpreted as inviting a romantic or sexual relationship. Even if the patient encourages such behavior, it is the licensee's responsibility to maintain a professional manner.

(ii) **Maintaining Boundaries in Psychotherapeutic Relationships**—A licensee bears an even greater responsibility to establish and maintain boundaries between physician and patient in psychotherapeutic relationships. In furtherance of that obligation, a licensee should ensure that to the greatest extent possible, treatment should take place during the licensee's usual working hours in a professional setting, unless the specific therapy mandates otherwise (i.e. home visits for the housebound, in vivo desensitization as part of behavioral therapy). A licensee should not engage in economic dealings with psychotherapy patients.

(iii) **Explanation of Procedures, Tests and Need for Examinations**—This will ensure that patients do not misunderstand the appropriateness of the exposure of their bodies or the touching that occurs.

(iv) **Patient Privacy**—Examination conditions should ensure that patients are not embarrassed. To that end, licensees should provide privacy while a patient is removing or replacing undergarments and should provide examination gowns or draping cloths which limit exposure of the patient to the field of clinical interest.

(v) **Chaperon**—Consistent with promoting patient privacy, licensees should inform patients of the option of having a chaperon present during examination and should provide a chaperon when requested by a patient.

(vi) **Avoidance of Discussion of Personal Matters**—While it is appropriate for a licensee to discuss for example his or her training and qualifications with patients, in furtherance of the maintenance of appropriate boundaries, licensees should avoid any discussion of their own intimate personal problems or disclosure of details of their sexual lives.

[1] "... I will come for the benefit of the sick, remaining free ... of all mischief and in particular of sexual relations with both female and male persons ..."

[2] "sexual or romantic interactions between physicians and patients detract from the goals of the physician patient relationship, may exploit the vulnerability of the patient, may obscure the physician's objective judgment concerning the patient's health care, and ultimately may be detrimental to the patient's well being ... at a minimum, a physician's ethical duties include terminating the physician patient relationship before initiating a dating, romantic or sexual relationship with a patient . . . sexual or romantic relationships with former patients are unethical if the physician uses or exploits trust, knowledge, emotions or influence derived from the previous professional relationship."

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Deleted reference to specific statute.
Amended by R.1990 d.291, effective June 4, 1990.
See: 22 N.J.R. 905(a), 22 N.J.R. 1738(a).
Included podiatric physicians as those who can countersign orders and prescriptions written by a podiatric trainee.
Amended by R.1990 d.291, effective June 4, 1990.
See: 22 N.J.R. 905(a), 22 N.J.R. 1738(a).
Included podiatric physicians as those who can countersign orders and prescriptions written by a podiatric trainee.
Repealed by R.1994 d.522, effective October 17, 1994.
See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Section was "Countersigning of order and prescriptions of unlicensed physicians."
New Rule, R.1996 d.242, effective May 20, 1996.
See: 28 N.J.R. 65(a), 28 N.J.R. 2560(a).

13:35–6.4 Delegation of administration of subcutaneous and intramuscular injections to certified medical assistants

(a) The following words and terms, when used in this section, shall have the following meanings, unless the context clearly indicates otherwise:

1. "Physician" means a doctor of medicine (M.D.), a doctor of osteopathic medicine (D.O.), or a doctor of podiatric medicine.

2. "Certified medical assistant" means a graduate of a post-secondary medical assisting education program accredited by CAHEA (The Committee on Allied Health Education and Accreditation of the American Medical Association), or its successor; ABHES (Accrediting Bureau of Health Education Schools), or its successor; or any accrediting agency recognized by the U.S. Department of Education. The educational program shall include, at a minimum, 600 clock hours of instruction and shall encompass training in the administration of intramuscular and subcutaneous injections and instruction and demonstration in: pertinent anatomy and physiology appropriate to injection procedures; choice of equipment; proper technique including sterile technique; hazards and complications; and emergency procedures. The medical assistant must also maintain current certification from the Certifying Board of the American Association of Medical Assistants (AAMA), or registration from the American Medical Technologists (AMT), or any other recognized certifying body approved by the Board.

(b) A physician may direct a certified medical assistant employed in the medical practice in which the physician practices medicine, to administer to the physician's patients an intramuscular or subcutaneous injection in the limited circumstances set forth in this section, without being in violation of the pertinent professional practice act implemented by the Board, to the extent such conduct is permissible under any other pertinent law or rule administered by the Board or any other State agency.

(c) A physician may direct the administration of an injection by a certified medical assistant only where the following conditions are satisfied:

1. The physician has determined and documented that the certified medical assistant has the qualifications set forth in (a)2 above and has attained a satisfactory level of comprehension and experience in the administration of intramuscular and subcutaneous injection techniques.

2. The physician shall examine the patient to ascertain the nature of the trauma, disease or condition of the patient; to determine the appropriate treatment of the patient including administration of an injection; to assess the risks of such injection for a given patient and the diagnosed injury, disease or condition; and to determine that the anticipated benefits are likely to outweigh those risks.

3. The physician shall determine all components of the precise treatment to be given, including the type of injection to be utilized, dosage, method and area of administration, and any other factors peculiar to the risks, such as avoidance of administration sites on certain parts of the body. The physician shall assure that this information shall be written on the patient's record and made available at all times to the medical assistant carrying out the treatment instructions, who shall also be identified by name and credentials in the patient record on each occasion that an injection is administered.

4. The physician shall not direct the administration by a certified medical assistant of an injection which includes any of the following: controlled dangerous substances, experimental drugs including any drug not having approval of the Food and Drug Administration (FDA), or any substance used as an anti-neoplastic chemotherapeutic agent with the exception of corticosteroids.

5. The physician shall remain on the premises at all times that treatment orders for injections are being carried out by the assistant and shall be within reasonable proximity to the treatment room and available to observe, assess and take any necessary action regarding effectiveness, adverse reaction or any emergency.

6. The certified medical assistant shall wear a clearly visible identification badge indicating his or her name and credentials.

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
In (a)3, inserted "purchasing or" preceding "prescribing".
Repealed by R.1992 d.75, effective February 18, 1992 (operative April 15, 1992).
See: 23 N.J.R. 161(a), 23 N.J.R. 1063(a), 24 N.J.R. 626(a).
Section was "Prohibition of kickbacks, rebates or receiving a payment for services not rendered."
New Rule, R.1997 d.226, effective June 2, 1997.
See: 28 N.J.R. 2317(a), 28 N.J.R. 3512(a), 29 N.J.R. 2564(a).

13:35–6.5 Preparation of patient records, computerized records, access to or release of information; confidentiality, transfer or disposal of records

(a) The following terms shall have the following meanings unless the context in which they appear indicates otherwise:

"Authorized representative" means, but is not necessarily limited to, a person who has been designated by the patient or a court to exercise rights under this section. An authorized representative may be the patient's attorney or an agent of an insurance carrier with whom the patient has a contract which provides that the carrier be given access to records to assess a claim for monetary benefits or reimbursement. If the patient is a minor, a parent or guardian

who has custody (whether sole or joint) will be deemed to be an authorized representative.

"Examinee" means a person who is the subject of professional examination where the purpose of that examination is unrelated to treatment and where a report of the examination is to be supplied to a third party.

"Licensee" means any person licensed or authorized to engage in a health care profession regulated by the Board of Medical Examiners.

"Patient" means any person who is the recipient of a professional service rendered by a licensee for purposes of treatment or a consultation relating to treatment.

(b) Licensees shall prepare contemporaneous, permanent professional treatment records. Licensees shall also maintain records relating to billings made to patients and third-party carriers for professional services. All treatment records, bills and claim forms shall accurately reflect the treatment or services rendered. Treatment records shall be maintained for a period of seven years from the date of the most recent entry.

1. To the extent applicable, professional treatment records shall reflect:

i. The dates of all treatments;

ii. The patient complaint;

iii. The history;

iv. Findings on appropriate examination;

v. Progress notes;

vi. Any orders for tests or consultations and the results thereof;

vii. Diagnosis or medical impression;

viii. Treatment ordered, including specific dosages, quantities and strengths of medications including refills if prescribed, administered or dispensed, and recommended follow-up;

ix. The identity of the treatment provider if the service is rendered in a setting in which more than one provider practices;

x. Documentation when, in the reasonable exercise of the physician's judgment, the communication of test results is necessary and action thereon needs to be taken, but reasonable efforts made by the physician responsible for communication have been unsuccessful; and

xi. Documentation of the existence of any advance directive for health care for an adult or emancipated minor, and associated pertinent information. Documented inquiry shall be made on the routine intake history form for a new patient who is a competent adult or emancipated minor. The treating doctor shall also make and document specific inquiry of or regarding a patient in appropriate circumstances, such as when providing treatment for a significant illness, or where an emergency has occurred presenting imminent threat to life, or where surgery is anticipated with use of general anesthesia.

2. Corrections/additions to an existing record can be made, provided that each change is clearly identified as such, dated and initialled by the licensee.

3. A patient record may be prepared and maintained on a personal or other computer only when it meets the following criteria:

i. The patient record shall contain at least two forms of identification, for example, name and record number or any other specific identifying information;

ii. An entry in the patient record shall be made by the physician contemporaneously with the medical service and shall contain the date of service, date of entry, and full printed name of the treatment provider. The physician shall finalize or "sign" the entry by means of a confidential personal code ("CPC") and include date of the "signing";

iii. Alternatively, the physician may dictate a dated entry for later transcription. The transcription shall be dated and identified as "preliminary" until reviewed, finalized and dated by the responsible physician as provided in (b)3ii above;

iv. The system shall contain an internal permanently activated date and time recordation for all entries, and shall automatically prepare a back-up copy of the file;

v. The system shall be designed in such manner that, after "signing" by means of the CPC, the existing entry cannot be changed in any manner. Notwithstanding the permanent status of a prior entry, a new entry may be made at any time and may indicate correction to a prior entry;

vi. Where more than one licensee is authorized to make entries into the computer file of any professional treatment record, the physician responsible for the medical practice shall assure that each such person obtains a CPC and uses the file program in the same manner;

vii. A copy of each day's entry, identified as preliminary or final as applicable, shall be made available promptly:

(1) To a physician responsible for the patient's care;

(2) To a representative of the Board of Medical Examiners, the Attorney General or the Division of Consumer Affairs as soon as practicable and no later than 10 days after notice; and

(3) To a patient as authorized by this rule within 30 days of request (or promptly in the event of emergency); and

viii. A licensee wishing to continue a system of computerized patient records, which system does not meet the requirements of (b)3i through vii above, shall promptly initiate arrangements for modification of the system which must be completed by October 19, 1993. In the interim, the licensee shall assure that, on the date of the first treatment of each patient treated subsequent to October 19, 1992, the computer entry for that first visit shall be accompanied by a hard copy printout of the entire computer-recorded treatment record. The printout shall be dated and initialled by the attending licensee. Thereafter, a hard copy shall be prepared for each subsequent visit, continuing to the date of the changeover of computer program, with each page initialled by the treating licensee. The initial printout and the subsequent hard copies shall be retained as a permanent part of the patient record.

(c) Licensees shall provide access to professional treatment records to a patient or an authorized representative in accordance with the following:

1. No later than 30 days from receipt of a request from a patient or an authorized representative, the licensee shall provide a copy of the professional treatment record, and/or billing records as may be requested. The record shall include all pertinent objective data including test results and x-ray results, as applicable, and subjective information.

2. Unless otherwise required by law, a licensee may elect to provide a summary of the record in lieu of providing a photocopy of the actual record, so long as that summary adequately reflects the patient's history and treatment. A licensee may charge a reasonable fee for the preparation of a summary which has been provided in lieu of the actual record, which shall not exceed the cost allowed by (c)4 below for that specific record.

3. If, in the exercise of professional judgment, a licensee has reason to believe that the patient may be harmed by release of the subjective information contained in the professional treatment record or a summary thereof, the licensee may refuse to provide such information. That record or the summary, with an accompanying notice setting forth the reasons for the original refusal, shall nevertheless be provided upon request of and directly to:

i. The patient's attorney;

ii. Another licensed health care professional; or

iii. The patient's health insurance carrier.

4. Licensees may require a record request to be in writing and may charge a fee for the reproduction of records, which shall be no greater than $1.00 per page or $100.00 for the entire record, whichever is less. (If the record requested is less than 10 pages, the licensee may charge up to $10.00 to cover postage and the miscellaneous costs associated with retrieval of the record.) If the licensee is electing to provide a summary in lieu of the actual record, the charge for the summary shall not exceed the cost that would be charged for the actual record.

5. If the patient or a subsequent treating health care professional is unable to read the treatment record, either because it is illegible or prepared in a language other than English, the licensee shall provide a transcription at no cost to the patient.

6. The licensee shall not refuse to provide a professional treatment record on the grounds that the patient owes the licensee an unpaid balance if the record is needed by another health care professional for the purpose of rendering care.

(d) Licensees shall maintain the confidentiality of professional treatment records, except that:

1. The licensee shall release patient records as directed by a subpoena issued by the Board of Medical Examiners or the Office of the Attorney General, or by a demand for statement in writing under oath, pursuant to N.J.S.A. 45:1–18. Such records shall be originals, unless otherwise specified, and shall be unedited, with full patient names. To the extent that the record is illegible, the licensee, upon request, shall provide a typed transcription of the record. If the record is in a language other than English, the licensee shall also provide a translation. All x-ray films and reports maintained by the licensee, including those prepared by other health care professionals, shall also be provided.