CHAPTER 35

BOARD OF MEDICAL EXAMINERS

Authority

N.J.S.A. 26:6A-1 et seq., specifically 26:6A-4; 45:1-15.1 and 45:9-2.

Source and Effective Date

R.2005 d.120, effective March 17, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

Chapter Expiration Date

Chapter 35, Board of Medical Examiners, expires on March 17, 2010.

Chapter Historical Note

Chapter 35, Board of Medical Examiners, was adopted and became effective prior to September 1, 1969.

Chapter 35, Board of Medical Examiners, was repealed and Chapter 35, Board of Medical Examiners, was adopted as new rules by R.1983 d.314, effective August 1, 1983. See: 15 N.J.R. 503(a), 15 N.J.R. 1255(a).

Subchapter 7, Chiropractic Practice, was adopted as R.1984 d.533, effective November 19, 1984. See: 16 N.J.R. 686(a), 16 N.J.R. 3208(a).

Pursuant to Executive Order No. 66(1978), Chapter 35, Board of Medical Examiners, was readopted as R.1989 d.532, effective September 21, 1989. See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).

Subchapter 6A, Declarations of Death upon the Basis of Neurological Criteria, was adopted as R.1992 d.309, effective August 3, 1992. See: 23 N.J.R. 3635(a), 24 N.J.R. 2731(c).

Subchapter 2A, Limited Licenses: Certified Nurse Midwifery, was adopted as R.1992 d.332, effective September 8, 1992. See: 23 N.J.R. 3632(a), 24 N.J.R. 3094(a).

Subchapter 9, Acupuncture, was adopted as R.1993 d.299, effective June 21, 1993. See: 24 N.J.R. 4013(a), 25 N.J.R. 2689(c).

Subchapter 10, Athletic Trainers, was adopted as R.1993 d.546, effective November 1, 1993. See: 25 N.J.R. 265(a), 25 N.J.R. 4935(a), 26 N.J.R. 483(a).

Pursuant to Executive Order No. 66(1978), Chapter 35, Board of Medical Examiners, was readopted as R.1994 d.522, effective September 19, 1994, and Subchapter 7, Chiropractic Practice, was repealed by R.1994 d.522, effective October 17, 1994. See: 26 N.J.R. 2526(a), 26 N.J.R. 4195(a).

Subchapter 2B, Limited Licenses: Physician Assistants, was adopted as R.1994 d.538, effective November 7, 1994. See: 25 N.J.R. 5099(b), 26 N.J.R. 4411(b).

Subchapter 11, Alternate Resolution Program, was adopted as R.1995 d.339, effective June 19, 1995. See: 27 N.J.R. 1363(a), 27 N.J.R. 2412(a).

Subchapter 7, Prescription, Administration and Dispensing of Drugs, was adopted as R.1997 d.475, effective November 3, 1997. See: 29 N.J.R. 842(a), 29 N.J.R. 4706(a).

Subchapter 4A, Surgery, Special Procedures, and Anesthesia Services Performed in an Office Setting, was adopted as R.1998 d.294, effective June 15, 1998. See: 29 N.J.R. 2238(a), 30 N.J.R. 2236(b).

Petition for Rulemaking. See: 30 N.J.R. 740(c), 1642(a).

Pursuant to Executive Order No. 66(1978), Chapter 35, Board of Medical Examiners, was readopted as R.1999 d.356, effective September 20, 1999. See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).

Subchapter 12, Electrologists Advisory Committee; Licensure of Electrologists and Electrology Instructors; Electrology Standards of Practice, was adopted as R.2004 d.279, effective July 19, 2004. See: 35 N.J.R. 3263(a), 36 N.J.R. 3401(a).

Subchapter 13, Perfusionists, Advisory Committee, was adopted as R.2005 d.88, effective March 7, 2005. See: 36 N.J.R. 1721(a), 37 N.J.R. 782(a).

Chapter 35, Board of Medical Examiners, was readopted as R.2005 d.120, effective March 17, 2005. See: Source and Effective Date. See, also, section annotations.

Subchapter 6A, Declarations of Death Upon the Basis of Neurological Criteria, was repealed and Subchapter 6A, Declarations of Death Upon the Basis of Neurological Criteria, was adopted as new rules by R.2007 d.120, effective May 7, 2007. See: 38 N.J.R. 2021(a), 39 N.J.R. 1751(a).

Subchapter 1, Medical Schools, Colleges, Externships, Clerkships And Post-Graduate Work, was renamed Medical Schools, Colleges, Externships and Clerkships; and Subchapter 3, Licensing Examinations and Endorsements, Limited Exemptions from Licensure Requirements, was renamed Licensing Examinations and Endorsements, Limited Exemptions from Licensure Requirements; Post-Graduate Training by R.2008 d.100, effective April 21, 2008. See: 39 N.J.R. 3876(a), 40 N.J.R. 2115(a).

Law Review and Journal Commentaries

How New Jersey Regulates Doctors. Theodosia Tamborlane, 132 N.J.L.J. No. 15, S24 (1992).

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SUBCHAPTER 1. MEDICAL SCHOOLS, COLLEGES, EXTERNSHIPS AND CLERKSHIPS

13:35-1.1 Observership program

(a) "Observer" shall mean an undergraduate medical student of an allopathic or osteopathic school accredited either by the Liaison Committee on Medical Education or the American Osteopathic Association or a foreign medical school listed in the World Health Organization Directory and whose graduates are accepted by the New Jersey Board of Medical Examiners as eligible to sit for the licensure examination. Observerships are limited to the student's vacation period in an extra-curricular professional experience as delineated in this section.

(b) An observership program shall be limited to:

1. Observation of operative procedures;

2. The taking of histories;

3. The performance of physical examinations;

4. The performance of non-invasive procedures under the direct supervision of and in the immediate presence of the supervising licensed physician; and

5. The participation in patient rounds and other organized patient care activities of the supervising physician.

(c) At no time shall the observer be delegated any responsibility for the care of the patient, the patient's diagnosis or any aspect of the patient's treatment, including the prescription of medication for the patient. An observer shall make no entries on the patient's permanent record.

(d) The observer shall at all times of patient contact wear an identifying badge inscribed "Medical Student."

(e) Prior to commencing participation in an observership program, the student shall have obtained written permission from the Chief of Staff and the Administration of the participating hospital and shall retain such letter.

(f) Under no circumstances shall the performance of any of the duties listed in (b) above by an observer, while engaged in such a program, be construed as the practice of medicine.

(g) The time spent in an observership program shall not be considered as part of or credited toward fulfillment of any statutory academic or clinical requirements for licensure.

Amended by R.1999 d.356, effective October 18, 1999.
See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).
Substituted references to observers for references to externs and substituted references to observerships for references to externships throughout; in (a), substituted "delineated in this section" for "hereafter delineated" at the end; and in (f), substituted "duties listed in (b) above" for "above duties" following "any of the".

13:35-1.2 Fifth Pathway

(a) The Board shall accept application for licensure from an applicant who does not meet the usual statutory prerequisites for educational background, in the following circumstances to be known as the Fifth Pathway:

1. The applicant has completed the entirety of the academic curriculum in residence at a medical school in a foreign country located outside of the United States, Puerto Rico or Canada or in a school-authorized clinical training program;

2. The medical school was approved throughout the applicant's period of education by the government of the country of domicile to confer the degree of Doctor of Medicine and Surgery or its equivalent, and was listed in the World Health Organization Directory;

3. The applicant has satisfactorily completed all the requirements for a matriculated student of that foreign medical school to receive a diploma, except for internship and/or social service;

4. The applicant has achieved a passing score on a screening examination acceptable to the Educational Commission on Foreign Medical Graduates (ECFMG) even though not eligible for ECFMG certification; and

5. The applicant has had his or her academic record reviewed and approved by a medical school approved by the Liaison Committee on Medical Education, which school has accepted the applicant in a one-academic-year program of supervised clinical training under its direction, and the applicant has satisfactorily completed that program as evidenced by receipt of a certificate issued by the sponsoring medical school.

(b) The applicant meeting the requirements in (a) shall thereafter be deemed by the Board to be eligible to enter a graduate training program approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA). Upon satisfactory completion of the three years of post-graduate training required by N.J.A.C. 13:35-3.11, the applicant may apply for licensure in this State.

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

13:35-1.3 (Reserved)

Amended by R.1989 d.532, effective October 16, 1989.
See: 21 N.J.R. 2226(b), 21 N.J.R. 3307(a).
Rule deleted and replaced with new text.
Recodified to N.J.A.C. 13:35-3.15 by R.2008 d.100, effective April 21, 2008.
See: 39 N.J.R. 3876(a), 40 N.J.R. 2115(a).
Section was "Postgraduate training".

Case Notes

Reasonable regulation of advertising. Att'y Gen. Form Op. No. 20 (1977).

i. In a private practice which is not hospital based or institutionally affiliated, no more than two physician assistants to one physician at any one time;

ii. In all other settings, no more than four physician assistants to one physician at any one time.

(c) Upon application to the Board, the Board may alter the supervisory ratios set forth in (b) above.

(d) A supervising physician may assign physician assistants under his or her supervision to a physician designee, who shall be responsible for the practice of the physician assistant during the assignment.

Amended by R.2000 d.349, effective August 21, 2000.
See: 31 N.J.R. 2132(a), 32 N.J.R. 3174(a).
In (b)4ii, inserted an exception.
Amended by R.2005 d.120, effective April 18, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).
In (b), inserted "or physician designee" following "The supervising physician' in the introductory paragraph of 4; rewrote (d).

13:35–2B.11 Recordkeeping

(a) Licensees shall make contemporaneous, permanent entries into professional treatment records which shall accurately reflect the treatment or services rendered. To the extent applicable, professional treatment records shall reflect:

1. The dates and times of all treatments;

2. The patient complaint;

3. The history;

4. Findings on appropriate examination;

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

6. Diagnosis or medical impression; and

7. Treatment ordered. If medications are ordered, the patient record shall include:

i. Specific dosages, quantities and strengths of medications;

ii. A statement indicating whether the medication order is written pursuant to protocol or specific physician direction. Acceptable abbreviations are "prt" for protocol and "spd" for specific physician direction;

iii. The physician assistant's full name, printed or stamped, and the license number; and

iv. The supervising physician's full name, printed or stamped.

(b) If the information required pursuant to (a)8iii and iv appears at least once in the patient record, it need not be repeated each time a medication order is entered in the patient record.

(c) The physician assistant shall sign each entry in the patient record and record the designation "PA–C" following his or her signature.

(d) To the extent a physician assistant is charged with independent responsibility for the provision of information used to prepare bills and claims forms, such information shall accurately reflect the treatment or services rendered.

Amended by R.2005 d.120, effective April 18, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).
In (a), deleted former 5 and recodified former 6 through 8 as 5 through 7.

13:35–2B.12 Requirements for issuing prescriptions for medications; memorialization of verbal orders for CDS given by physicians

(a) A physician assistant may issue prescriptions only in accordance with the following conditions:

1. A physician assistant shall not issue prescriptions for controlled dangerous substances.

2. A physician assistant shall provide the following on all prescription blanks:

i. The physician assistant's full name, professional identification ("PA-C"), license number, address and telephone number. This information shall be printed or stamped on all prescription blanks;

ii. The supervising physician's full name, printed or stamped;

iii. A statement indicating whether the prescription is written pursuant to protocol or specific physician direction. Acceptable abbreviations are "prt" for protocol and "spd" for specific physician direction;

iv. The full name, age and address of the patient;

v. The date of issuance of prescription;

vi. The name, strength and quantity of drug or drugs to be dispensed and route of administration;

vii. Adequate instruction for the patient. A direction of "p.r.n." or "as directed" alone shall be deemed an insufficient direction;

viii. The number of refills permitted or time limit for refills, or both;

ix. The signature of the prescriber, hand-written; and

x. Every prescription blank shall be imprinted with the words "substitution permissible" and "do not substitute" and shall contain space for the physician assistant's initials next to the chosen option, in addition to the space required for the signature in (a)3ix above.

3. A physician assistant shall not initiate an order for controlled dangerous substances. However, a physician assistant may memorialize an order for a controlled dan-

gerous substance when the order has been verbally given by the supervising physician or physician designee in a licensed inpatient or outpatient setting, including, but not limited to, hospital emergency departments, licensed ambulatory surgery centers and nursing homes, when the following requirements are met. The controlled dangerous substance order shall be written on the order sheet of the patient's chart with:

i. The letters VO (meaning an order relayed to the physician assistant by the physician in person) or TO (meaning an order relayed to the physician assistant by the physician over the telephone);

ii. The supervising physician's or physician designee's name printed;

iii. The signature of the physician assistant directly under the order for the controlled dangerous substance; and

iv. The supervising physician's or the physician designee's countersignature of the controlled dangerous substance order within 24 hours in the inpatient setting and within 48 hours of the order in the outpatient setting.

Amended by R.1999 d.356, effective October 18, 1999.
See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).
In (a), deleted a former 1, and recodified former 2 and 3 as 1 and 2.
Amended by R.2005 d.120, effective April 18, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).
In (a), added 3.

13:35–2B.13 Eligibility for temporary licensure

(a) An individual who has filed an application for licensure and is waiting to take the next scheduled examination administered by the National Commission on Certification of Physician Assistants (NCCPA) or awaiting the results of the examination may apply to the Board for a temporary license to be employed under the direct supervision of a physician, as defined in N.J.A.C. 13:35–2B.2 and 2B.15.

(b) An applicant for temporary licensure shall submit to the Board, with the completed application form, the documents required pursuant to N.J.A.C. 13:35–2B.5, the required fee, and evidence that the applicant has filed an application for the NCCPA examination.

New Rule, R.1995 d.423, effective August 7, 1995.
See: 27 N.J.R. 1526(a), 27 N.J.R. 2959(a).

13:35–2B.14 Temporary licensure; scope of practice

(a) A temporary license holder who has complied with the practice requirements set forth in N.J.A.C. 13:35–2B.3 may perform all of the procedures within the scope of practice of a physician assistant, as set forth in N.J.A.C. 13:35–2B.4(a) and (b) and subject to the limitations therein, except that a temporary license holder shall not issue prescriptions. A temporary license holder may write orders for medication, treatment, or testing consistent with the provisions of N.J.A.C. 13:35–2B.15.

(b) A temporary license holder shall engage in practice only under the direct supervision of a physician pursuant to the provisions of N.J.A.C. 13:35–2B.15.

New Rule, R.1995 d.423, effective August 7, 1995.
See: 27 N.J.R. 1526(a), 27 N.J.R. 2959(a).
Amended by R.2005 d.120, effective April 18, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).
In (a), added the last sentence.

13:35–2B.15 Supervision of temporary license holder

(a) A temporary license holder shall not render care unless the following conditions are met:

1. In any setting, the supervising physician, physician designee or a designated physician assistant:

i. Is continuously present on-site; and

ii. Countersigns, immediately after its entry in the chart, any order for medication, treatment, or testing written by the temporary license holder.

2. In the event that the countersignature in (a)1 above is that of a designated physician assistant, the supervising physician or physician designee, within the appropriate conditions set in N.J.A.C. 13:35–2B.10(b)4, shall:

i. Personally review all charts and patient records and the temporary license holder's entry in the chart and record; and

ii. Countersign any order for medication, treatment, or testing written by the temporary licensee.

New Rule, R.1995 d.423, effective August 7, 1995.
See: 27 N.J.R. 1526(a), 27 N.J.R. 2959(a).
Amended by R.2005 d.120, effective April 18, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).
Rewrote (a).

13:35–2B.16 Expiration of temporary license; renewal

(a) A temporary license shall expire 30 days after the temporary license holder has received notification of successful completion of the examination or immediately upon the applicant's receipt of notification of failure to pass the examination referenced in N.J.A.C. 13:35–2B.13(a).

(b) An applicant who fails an examination shall cease and desist from the performance of his or her duties.

(c) Except in extenuating circumstances such as the applicant's critical illness or incapacitation, a temporary license may not be renewed. An applicant seeking to renew based upon extenuating circumstances shall be required to present to the Board satisfactory documentation of the basis for the renewal request.

New Rule, R.1995 d.423, effective August 7, 1995.
See: 27 N.J.R. 1526(a), 27 N.J.R. 2959(a).
Amended by R.2005 d.120, effective April 18, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).
In (a), inserted "referenced in N.J.A.C. 13:35–2B.13(a)" following "pass the examination".

(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 pursuant to N.J.A.C. 13:35–6.22, documentation in the patient record and a minimum of 30 days has passed

from the rendition of the last professional service; 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— Pursuant to N.J.A.C. 13:35–6.23, a licensee shall provide notice to a patient, or any other person who is to be examined, of the right to have a chaperon present during breast and pelvic examinations of females and during genitalia and rectal examinations of both males and females. In all other instances, 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.
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).
Amended by R.2004 d.135, effective April 5, 2004.
See: 35 N.J.R. 3262(a), 36 N.J.R. 1814(a).
In the appendix, rewrote B(v).
Amended by R.2005 d.120, effective April 18, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).
In (c), rewrote the introductory paragraph.

Case Notes

During years before adoption of regulation prohibiting licensee from engaging in sexual contact with a patient with whom he or she had a patient-physician relationship, it was not per se violation of the Medical Practices Act for a physician to engage in consensual sexual relations with patient. In the Matter of the Suspension or Revocation of the License of Costino, Jr. to Practice Medicine and Surgery in the State of New Jersey, 1998 WL 679751, N.J. Adm., Feb 24, 1998, (NO. BDS 10628-94).

Psychiatrist's engaging in sexual relations with patient warrants suspension of medical license. In the Matter of the Suspension or Revocation of the License of Tricarico, 96 N.J.A.R.2d (BDS) 18.

Florida's revocation of physician's license for sexual misconduct supports New Jersey's license revocation. In the Matter of Vatakencherry, 96 N.J.A.R.2d (BDS) 1.

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.

13:35–6.4 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), the National Center for Competency Testing (NCCT), 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 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.

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

(d) The physician shall not direct the administration by a certified medical assistant of an injection which includes any of the following: any substance related to allergenic testing or treatment, local anesthetics, controlled dangerous substances, experimental drugs including any drug not having approval of the Food and Drug Administration (FDA), or any substance used as an antineoplastic chemotherapeutic agent with the exception of corticosteroids.

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).
Amended by R.1998 d.560, effective December 7, 1998.
See: 29 N.J.R. 4740(a), 30 N.J.R. 4247(b).
In (c), deleted former 4 and recodified former 5 and 6 as 4 and 5; and added (d).
Amended by R.1999 d.356, effective October 18, 1999.
See: 31 N.J.R. 1742(a), 31 N.J.R. 3117(a).
In (a)2, inserted a reference to the National Center for Competency Testing.

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:

6. 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.

7. 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.

2. The licensee shall release information as required by law or regulation, such as the reporting of communicable diseases or gunshot wounds or suspected child abuse, etc., or when the patient's treatment is the subject of peer review.

3. The licensee, in the exercise of professional judgment and in the best interests of the patient (even absent the patient's request), may release pertinent information about the patient's treatment to another licensed health care professional who is providing or has been asked to provide treatment to the patient, or whose expertise may assist the licensee in his or her rendition of professional services.

4. The licensee, in the exercise of professional judgment, who has had a good faith belief that the patient because of a mental or physical condition may pose an imminent danger to himself or herself or to others, may release pertinent information to a law enforcement agency or other health care professional in order to minimize the threat of danger. Nothing in this paragraph, however, shall be construed to authorize the release of the content of a record containing identifying information about a person who has AIDS or an HIV infection, without patient consent, for any purpose other than those authorized by N.J.S.A. 26:5C–8. If a licensee, without the consent of the patient, seeks to release information contained in an AIDS/HIV record to a law enforcement agency or other health care professional in order to minimize the threat of danger to others, an application to the court shall be made pursuant to N.J.S.A. 26:5C–5 et seq.

(e) Where the patient has requested the release of a professional treatment record or a portion thereof to a specified individual or entity, in order to protect the confidentiality of the records, the licensee shall:

1. Secure and maintain a current written authorization, bearing the signature of the patient or an authorized representative;

2. Assure that the scope of the release is consistent with the request; and

3. Forward the records to the attention of the specific individual identified or mark the material "Confidential."

(f) Where a third party or entity has requested examination, or an evaluation of an examinee, the licensee rendering those services shall prepare appropriate records and maintain their confidentiality, except to the extent provided by this section. The licensee's report to the third party relating to the examinee shall be made part of the record. The licensee shall:

1. Assure that the scope of the report is consistent with the request, to avoid the unnecessary disclosure of diagnoses or personal information which is not pertinent;

2. Forward the report to the individual entity making the request, in accordance with the terms of the examinee's authorization; if no specific individual is identified, the report should be marked "Confidential"; and

3. Not provide the examinee with the report of an examination requested by a third party or entity unless the third party or entity consents to its release, except that should the examination disclose abnormalities or conditions not known to the examinee, the licensee shall advise the examinee to consult another health care professional for treatment.

(g) (Reserved)

(h) If a licensee ceases to engage in practice or it is anticipated that he or she will remain out of practice for more than three months, the licensee or designee shall:

1. Establish a procedure by which patients can obtain a copy of the treatment records or acquiesce in the transfer of those records to another licensee or health care professional who is assuming responsibilities of the practice. However, a licensee shall not charge a patient, pursuant to (c)4 above, for a copy of the records, when the records will be used for purposes of continuing treatment or care.

2. Publish a notice of the cessation and the established procedure for the retrieval of records in a newspaper of general circulation in the geographic location of the licensee's practice, at least once each month for the first three months after the cessation; and

3. Make reasonable efforts to directly notify any patient treated during the six months preceding the cessation, providing information concerning the established procedure for retrieval of records.

Repeal and New Rule, R.1990 d.176, effective March 19, 1990.
See: 21 N.J.R. 3253(a), 22 N.J.R. 978(a).
Amended by R.1992 d.429, effective October 19, 1992.
See: 24 N.J.R. 50(a), 24 N.J.R. 3729(d).
Revised (b).
Amended by R.1994 d.119, effective April 4, 1994.
See: 25 N.J.R. 4862(a), 26 N.J.R. 1522(a).
Amended by R.1998 d.184, effective April 6, 1998.
See: 29 N.J.R. 840(b), 30 N.J.R. 1295(a).
In (a), added exception at the end of the sentence; in (c)3, substituted "patient's mental or physical condition will be adversely affected upon being made aware" for "patient may be harmed by release"; in (c)3iii, added "through an employee thereof; or" at the end of the sentence and added a new iv; in (d)4, added the last two sentences; in (h)1, inserted "a copy of the" preceding "treatment records" and added the last sentence.
Petition for Rulemaking.
See: 36 N.J.R. 4333(a).
Amended by R.2005 d.120, effective April 18, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).
Rewrote (c).

Case Notes

Any error in trial court's failure to charge jury concerning duty specialist physician had to communicate his findings of stress test he performed on patient to patient's primary care physician, was harmless in medical malpractice action brought by executrix of patient's estate against specialist after patient died within two weeks after having undergone stress test; no dispute existed that specialist advised patient of his preliminary findings, told him that they were essentially normal, and sent a written report to primary physician, but alleged negligence at issue went to specialist's evaluation of patient's condition. Sinclair v. Roth. N.J.Super.A.D., 2002.

Physician's disclosure of patient's medical records to patient's husband's attorney in response to subpoena that did not include patient's authorization to disclose, or a notice of physician's deposition, and which patient and her attorney were not copied on, supported a cause of action against physician, in lawsuit against physician alleging breach of confidentiality, violation of physician-patient privilege, medical malpractice, intentional infliction of emotional distress, and negligent infliction of emotional distress. Crescenzo v. Crane, 350 N.J.Super. 531.

To the extent that a contract purports to insulate the examining physician from liability for breaching the duty to communicate abnormalities found in a pre-employment exam, it violates public policy of New Jersey in addition to common law notions. Reed v. Bojarski, 166 N.J. 89 (2001).

Board of Medical Examiners neither abused its statutory authority nor mistakenly exercised its discretion when it refused to expunge or otherwise modify consent order disciplining a doctor for failing to keep adequate patient medical records; consent order was legally entered into with doctor's consent, and the Board had authority to file order and fine doctor accordingly. In re D'Aconti, 316 N.J.Super. 1, 719 A.2d 652 (N.J.Super.A.D. 1998).

Verification may be required before personal injury protection benefits are paid. State Farm Mut. Auto. Ins. Co. v. Dalton, 234 N.J.Super. 128, 560 A.2d 683 (A.D.1989) certification denied 117 N.J. 664, 569 A.2d 1356, certiorari denied 110 S.Ct. 1131, 493 U.S. 1078, 107 L.Ed.2d 1037.

Reprimand by Board for failure to prepare patient record noted; transcript of Board proceeding not records within the meaning of the Right to Know Law, but are public records under common law; injury action's plaintiff's right to examine and inspect records superior to Board's interest in confidentiality (citing former N.J.A.C. 13:13–6.12). Beck v. Bluestein, 194 N.J.Super. 247, 476 A.2d 842 (App.Div.1984).

Use of improper procedures at abortion clinics and failure to supervise staff support suspension of doctors operating facility. In the Matter of Miro and Steck, 97 N.J.A.R.2d (BDS) 1.

Revocation of license; psychiatrist who engaged in sexual contact with patients. In the Matter of the Suspension or Revocation of the License of Schermer, 94 N.J.A.R.2d (BDS) 33.

Performing numerous cardiac procedures without sufficient medical justification, failing to maintain accurate patient records, along with other acts of negligence, malpractice and incompetence, warranted license revocation; penalty and costs also assessed. In Matter of Suspension or Revocation of License of Rodriguera, 93 N.J.A.R.2d (BDS) 33.

Surgeon's license revoked; unauthorized prescriptions for controlled dangerous substances, failure to maintain medical records, and prescribing medications in manner deviating from accepted professional standards. In Matter of Suspension or Revocation of License of Makarenko. 92 N.J.A.R.2d (BDS) 1.

13:35–6.6 Standards for joint protocols between advanced practice nurses and collaborating physicians

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

"Collaboration" means the ongoing process by which an advanced practice nurse and a physician engage in practice, consistent with agreed upon parameters of their respective practices.

"Device" means an article, other than medication, for use in the diagnosis, cure, mitigation, treatment or prevention of disease, injury, pain or deformity or physical or emotional condition or health problem in humans or intended to affect the structure or function of the human body.

"Joint protocol" means an agreement or contract between an advanced practice nurse and a collaborating physician which conforms to the standards established by the Director of the Division of Consumer Affairs pursuant to this rule.

"Medication" means any substance for which a prescription is required which is intended for use in the diagnosis, cure, mitigation, treatment or prevention of disease, injury, pain or deformity or physical or emotional condition or health problem in humans or intended to affect the structure or function of the human body.

(b) Advance practice nurses who seek to prescribe or order medications or devices and the collaborating physician(s) with whom they are in collaboration shall develop a joint protocol, which shall be:

1. In writing;

1. Notify the patient, in writing, that the licensee shall no longer provide care to the patient as of a date certain. The notification required by this paragraph shall be made no less than 30 days prior to the date on which care is to be terminated, and shall be made by certified mail, return receipt requested, sent to the patient's last known address;

2. Provide all necessary emergency care or services, including the provision of necessary prescriptions, until the date on which services are terminated. The provision of any such emergency care or services shall not be deemed to manifest any intention to reestablish a licensee-patient relationship; and

3. Comply with all requirements set forth in N.J.A.C. 13:35-6.5 for access to and transfer of patient records.

(d) Notwithstanding (c) above, a licensee shall not terminate a licensee-patient relationship in the following circumstances:

1. Where to do so would be for any discriminatory purpose and/or would violate any laws or rules prohibiting discrimination; or

2. Where the licensee knows, or reasonably should know, that no other licensee is currently able to provide the type of care or services that the licensee is providing to the patient.

(e) A licensee need not comply with the requirements set forth in (c)1 above if:

1. The licensee-patient relationship has been terminated by the patient as evidenced by conduct manifesting a deliberate intention to terminate the relationship; or

2. The reason for the termination of an ongoing licensee-patient relationship is because the licensee has discontinued providing services to a particular managed care provider or health maintenance organization, in which the patient is enrolled and such managed care provider or HMO has discharged its notice obligation pursuant to N.J.S.A. 26:2S-5a(1).

(f) When requested by the patient, the licensee shall make reasonable efforts to assist the patient in obtaining medical services from another licensee qualified to meet the patient's medical needs. These efforts may include, but are not limited to, providing referrals to the patient.

New Rule, R.2000 d.399, effective October 2, 2000.
See: 31 N.J.R. 2452(a), 32 N.J.R. 3574(b).

13:35-6.23 Presence of chaperones

(a) In all office settings, a licensee shall provide notice to a patient, or any other person who is to be examined, of the right to have a chaperone present:

1. During breast and pelvic examinations of females; and

2. During genitalia and rectal examinations of both males and females.

(b) The notice required by (a) above shall either be provided in written form to the patient or by conspicuously posting a notice in a manner in which patients or any other person who is to be examined are made aware of the right to request a chaperone and to decline care if a chaperone acceptable to the patient is not available. In circumstances where the posting or the provision to the patient of the written notice would not convey the right to have a chaperone present, the licensee shall use another means to ensure that the patient or person to be examined understands his or her right to have a chaperone present.

(c) A licensee shall not be obligated to provide further care for the immediate medical problem presented if the licensee is unable to provide a requested chaperone acceptable to the patient.

(d) A licensee shall not be obligated to provide further care for the immediate medical problem presented if the patient refuses to have a chaperone present and it is the licensee's desire to have a chaperone present during the examination.

(e) If care is not to be provided to a patient under the circumstances described in (c) or (d) above, the licensee shall, consistent with the principles of informed consent, discuss with the patient the risks of not receiving further care.

New Rule, R.2004 d.135, effective April 5, 2004.
See: 35 N.J.R. 3262(a), 36 N.J.R. 1814(a).

13:35-6.24 Reporting of communicable diseases by licensees

(a) A licensee shall report a case of a communicable disease in accordance with Department of Health and Senior Services regulations at N.J.A.C. 8:57-1.

(b) A licensee shall report a case of Acquired Immunodeficiency Syndrome (AIDS) and infection with Human Immunodeficiency Virus (HIV) in accordance with Department of Health and Senior Services regulations at N.J.A.C. 8:57-2.

(c) Failure to report pursuant to the requirements of this section shall constitute professional misconduct subjecting the licensee to disciplinary action by the Board.

New Rule, R.2005 d.120, effective April 18, 2005.
See: 36 N.J.R. 4633(a), 37 N.J.R. 1203(a).

13:35-6.25 Cultural competency training

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

"College of medicine" means a college accredited by the Liaison Committee on Medical Education, the American Osteopathic Association (AOA), or other accrediting agency with comparable accrediting standards as recognized by the

New Jersey Board of Medical Examiners. Schools accredited by the Council of Podiatric Medical Education (CPME) to confer the degree D.P.M. in New Jersey shall be considered colleges of medicine for purposes of this section.

"Continuing medical education" or "CME" means post-secondary educational activity, which must be: 1. designated Category 1, as defined in the American Medical Association (AMA) Physicians Recognition Award booklet, incorporated herein by reference, as amended and supplemented and available at www.ama-assn.org; 2. designated Category 1a, 1b or 2A in the AOA CME Guide for Osteopathic Physicians, incorporated herein by reference, as amended and supplemented, and available at www.do-online.org; 3. prescribed credit, as designated by the American Academy of Family Physicians (AAFP) Commission on Continuing Professional Development in the AAFP CME Guidelines, incorporated herein by reference, as amended and supplemented and available at www.aafp.org; or 4. approved contact hours, as designated by the Council on Podiatric Medical Education (CPME); and which must be provided by sponsors accredited, recognized or approved at the time of the educational activity by the Accreditation Council on Continuing Medical Education (ACCME), the AOA, the AAFP, or as to podiatrists, the CPME.

"Cultural competency training" means a curriculum developed in consultation with the Association of American Medical Colleges (AAMC) or another nationally recognized organization, which reviews medical school curricula, designed to address the problem of race and gender-based disparities in medical treatment decisions and to improve the sensitivity to and awareness of values in diverse communities that may affect the delivery of health care.

"Physician" means an individual holding an M.D. or D.O. degree licensed pursuant to N.J.S.A. 45:9-1 et seq.

"Podiatrist" means an individual holding a D.P.M. degree licensed pursuant to N.J.S.A. 45:5-1 et seq.

"Post-secondary education" means education obtained in a professional school, graduate medical education or continuing medical education consisting of courses with content deemed, by the Board, to be substantially equivalent to cultural competency curriculum criteria established by the Board.

"Practitioner" means a physician or a podiatrist.

(b) Each college of medicine in this State shall provide cultural competency training, as identified in (d) below, completion of which shall be required as a condition of receiving a diploma from a college of medicine in this State.

(c) Cultural competency training for CME credit shall be offered by each college of medicine in this State. The training shall satisfy the criteria for cultural competency training established by the Board.

(d) To be recognized in satisfaction of the cultural competency training requirement applicable to licensees, any CME program of instruction shall be of at least six hours duration, offered in the classroom, or through workshops, over the internet or through other venues, that provides:

1. A context for the training, common definitions of cultural competence, race, ethnicity and culture and tools for self-assessment;

2. An appreciation for the traditions and beliefs of diverse patient populations, at multiple levels — as individuals, in families and as part of a larger community;

3. An understanding of the impact that stereotyping can have on medical decision-making;

4. Strategies for recognizing patterns of health care disparities and eliminating factors influencing them;

5. Approaches to enhance cross-cultural clinical skills, such as those relating to history-taking, problem solving and promoting patient compliance; and

6. Techniques to deal with language barriers and other communication needs, including working with interpreters.

(e) A physician who was licensed to practice medicine prior to March 24, 2005, and who did not receive instruction in cultural competency training as part of the curriculum of a college of medicine shall, as a condition of the next renewal after March 24, 2008, document completion of CME or equivalent post-secondary education in cultural competency training pursuant to (d) above before being granted licensure renewal by the Board. Cultural competency training shall be in addition to the CME required by the Board at N.J.A.C. 13:35-6.15.

(f) A podiatrist who was licensed to practice podiatry prior to March 24, 2005, and who did not receive instruction in cultural competency training as part of the curriculum of a college of medicine shall, as a condition of the next renewal after March 24, 2008, document completion of CME or equivalent post-secondary education in cultural competency training pursuant to (d) above before being granted licensure renewal by the Board. Cultural competency training may be included in the CME required by the Board at N.J.A.C. 13:35-6.15.

(g) A practitioner licensed to practice after March 24, 2005, but on or before June 29, 2007, who did not receive instruction in cultural competency training as part of the curriculum of a college of medicine, as a condition of the next renewal after March 24, 2008, shall document completion of CME or equivalent post-secondary education in cultural competency training pursuant to (d) above before being granted licensure renewal by the Board. Cultural competency training may be included in the CME required by the Board at N.J.A.C. 13:35-6.15.