HEALTH POLICY COMPEMDIUM

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ACCESS TO HEALTH CARE

Supporting Better Organized and More Efficient Charity Care

RESOLVED, That the North Carolina Medical Society supports, where reasonable and appropriate, a system of tax credits and/or other state tax relief for physicians who donate their services through organized systems of charity care such as Project Access.

(Report L-2006, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-32, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 6, adopted 11/3/2018)
(reaffirmed, NCMS Board Report-2020, adopted 6/18/2020)

Access to Care and Social Supports for All Populations

The North Carolina Medical Society supports access to comprehensive, quality care and social supports as necessary to promote health, prevent and manage disease, reduce premature death and preventable morbidity, and achieve health equity for everyone in North Carolina. This includes meaningful access to:

- Adequate health insurance coverage without incurring burdensome, and often unmanageable medical expenses;
- An advanced medical home that can readily connect individuals to other needed health care providers and social supports;
- A competent health workforce with appropriate geographic distribution and specialized training to provide culturally competent care to diverse populations;
- Evidence-based preventive services that promote healthy behaviors and prevent illness in at-risk populations;
- Reliable, clinically-appropriate access points when care for illness or injury is needed;
- Office and telehealth visits as appropriate.

The North Carolina Medical Society supports the development and deployment of efforts to build a strong social support infrastructure in North Carolina as necessary to improving health and wellbeing, including:

- Accountable care communities, which involve multiple stakeholders working together to improve the health and well-being of their communities by addressing social determinants of health. Stakeholders include health care providers, public health and community organizations. See NCIOM Accountable Care Communities Task Force Report and Community Guide;
- NC Healthy Opportunity Pilots to test the impact of providing selected evidence-based interventions to Medicaid enrollees.
- NCCARE360 , a statewide coordinated care network to electronically connect hose with identified needs to community resources and allow for a feedback loop on the outcome of the connection to the need support(s).
- NCMS Foundation programs to address unmet needs (e.g., Project OBOT NC and Our Community Health Initiative)

The North Carolina Medical Society supports efforts to:

- Expand access to health insurance coverage to close the coverage gap and provide access to health insurance to those at or below 100% FPL;
- Ban or limit short-term health plans;
- Increase publicity and navigator funding for open enrollment; and
- Increase public education about insurance options.

(NCMS Board Report, adopted 6/18/2020)

National CLAS Standards

The NCMS supports the broad adoption of the U.S. Department of Health and Human Services Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care .

Principal Standard

1) Provide effective, equitable, understandable and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs.

Governance, Leadership and Workforce

2) Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices and allocated resources.
3) Recruit, promote and support a culturally and linguistically diverse governance, leadership and workforce that are responsive to the population in the service area.
4) Educate and train governance, leadership and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

Communication and Language Assistance

5) Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6) Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7) Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8) Provide easy-to-understand print and multimedia materials and signage in the language commonly used by the populations in the service area.

Engagement, Continuous Improvement and Accountability

9) Establish culturally and linguistically appropriate goals, policies and management accountability, and infuse them throughout the organizations' planning and operations.
10) Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into assessment measurement and continuous quality improvement activities.
11) Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12) Conduct regular assessments of community health assets and needs and use the result to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13) Partner with the community to design, implement and evaluate policies, practices and services to ensure cultural and linguistic appropriateness.
14) Create conflict- and grievance-resolution processes that are culturally and linguistically appropriate to identify, prevent and resolve conflicts or complaints.
15) Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents and the general public.

(NCMS Board Report, adopted 11/7/2020)

Telehealth

The North Carolina Medical Society supports efforts and funding for programs and innovations that resolve existing barriers to telehealth access for health care providers and persons of North Carolina;

The North Carolina Medical Society supports equitable telehealth coverage for all appropriate medical services, patient types, provider types, locations, secure devices and modalities, by all government and commercial payers;

The North Carolina Medical Society supports parity in payment for telehealth services provided and accurately documented by any licensed and qualified health care provider when medically appropriate;

The North Carolina Medical Society supports the promotion of transparency to patients and providers regarding their choice when accessing telehealth services, and for preserving continuity of care with the patient's established providers, including their medical home;

The North Carolina Medical Society supports continuing efforts to safeguard patient privacy and program integrity through effective and considerate regulations and requirements that allow for the support and innovations of technology-based care; and

The North Carolina Medical Society supports ongoing efforts to establish and define quality metrics for telehealth visits that align with the service standard of care as well as preserves and promotes patient safety and access.

The North Carolina Medical Society, for the purposes of this policy, supports the definition of telehealth as presented by the Center for Connected Health Policy (CCHP), which defines telehealth as a collection of means or methods for enhancing health care, public health, and health education delivery and support using telecommunication technologies.

(NCMS Board Report, adopted 5/15/2021)

Digital Health Equity

The North Carolina Medical Society supports the following efforts to achieve digital health equity for all in North Carolina:

- Promote efforts to achieve equal access to digital health care and equal outcomes from digital health care regardless of age, gender, ethnicity, income, and/or geography;
- Promote efforts to ensure equitable access to health equipment, information, and digital health literacy training opportunities across the state that are adaptive to individuals' diverse needs, skills, identities, languages, abilities, and disabilities;
- Promote efforts to incorporate digital health equity into health provider training at the individual and institutional levels. This includes assessing for those at risk for barriers to digital health and ways to close those gaps;

- Promote efforts to ensure health care providers, health systems, insurers, and government agencies have digital health strategies that identify and address potential gaps in digital health care and consider patients' sociocultural backgrounds and digital health literacy.

(NCMS Board Report, adopted 5/15/2021)

ACCOUNTABLE CARE ORGANIZATIONS (ACOs)

Accountable Care Organizations

1. That the North Carolina Medical Society supports community physician leadership and coordination of efforts by physicians of all specialties in the formation, governance and clinical management of Accountable Care Organizations and similar arrangements.
2. That the North Carolina Medical Society supports the delivery of health care through Accountable Care Organizations (ACOs) provided those arrangements are physician-led and comply with the following criteria:
   Organization and Governance
   - ACOs must have a formal legal structure that allows the organization to receive and disburse shared savings payments to participating providers.
   - ACOs must be voluntary, particularly because relationships will be redefined among health care entities that may not have worked together in the past.
   - Participating provider groups must be adequately represented on the governing board of each ACO; a majority of the Board, however, should be physicians. The governing board also should include reasonable administrative and financial expertise as well as community representation.
   - Each ACO must have sufficient human resource commitment to oversee the day-to-day operations of the ACO, to work with payors, monitor performance, and collect and distribute any shared savings. There should be adequate performance improvement mechanisms to monitor and coordinate utilization of services designed to ensure quality of care and control costs. ACOs should have widespread utilization of health information technology for provision of point-of-care information, data tracking, data aggregation, protocol dissemination, and performance monitoring. All data shall be clinically validated by physicians and severity adjusted.
   - Participating providers must be committed to working with other providers in the ACO to continually improve processes, coordination, quality, and efficiency of care and decreasing costs and eliminating waste.
   - ACOs should consider governance and tax-status options that encourage reinvestment of operating margins in quality improvement, incentives and bonuses for providers to optimize care, and that discourage windfall profit taking by large shareholders or originators of the ACO. ACOs should preferably be organized as a non-profit entity.

   Preservation of the Patient-Physician Relationship

- Adequate and independent physician input is necessary to ensure that appropriate evidence-based care is coordinated and delivered in the manner most beneficial to patients.
- The ACO should promote: evidence-based medicine and patient engagement; reporting on quality, cost, and patient satisfaction measures; and coordination of care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.
- Patients must retain the right to choose their physicians to the fullest degree possible.
- Patients should be incentivized to become engaged in health and wellness activities and compliance.
- ACOs must maintain flexibility in regards to site of care to ensure that care is delivered in the most appropriate and cost-effective setting.

Incentive Payments

- Equitable opportunities for collaboration and incentive sharing must apply to all participating providers.
- A clear, sustainable, transparent and fair method should be utilized for setting performance-based incentive payment rates and bonuses, which is physician-driven. The method should be based on accurate data and peer reviewed evidence-based methodology that applies to all participants, regardless of employment status. Patient satisfaction, where applicable, should be a factor.
- The ACO must have a mechanism to provide accurate and transparent reporting to the ACO member, who has an opportunity for peer review, feedback to the governing body and appeal rights of payment decisions.

3. The North Carolina Medical Society supports liability relief and peer review protections (including adequate appeal rights) for Accountable Care Organizations.
4. The North Carolina Medical Society supports assistance to providers participating in Accountable Care Organizations to procure, implement, and maintain interoperable electronic health records system, which will improve the ability to collect data and therefore improve and coordinate care.
5. The North Carolina Medical Society supports development of one or more physician-led Accountable Care Organization “models” for medical communities in North Carolina that include primary care physicians and specialty physicians, as well as hospitals and other providers where possible.

(Report G-2010, adopted 10/24/2010)
(reaffirmed, Board Report-2018, Item 9, adopted 11/3/2018)

ADVERTISING

Radio and Television Advertising of Alcoholic Beverages

RESOLVED, That the North Carolina Medical Society opposes radio and television advertising of alcoholic beverages, particularly those aimed directly at young audiences, those aired during

sporting events, and those that draw a positive correlation between physical performance and the consumption of alcoholic beverages.

(Resolution 19-1992, adopted as amended 11/8/92)
(revised, Report H-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-37, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 19, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 10, adopted 11/3/2018)

Medical Advertisements

RESOLVED, That the North Carolina Medical Society supports the portrayal of an accurate and fair image of the medical profession to the public.

(Substitute Resolution 24-2001, adopted 11/11/2001)
(revised, Report R-2007, Item 3-2, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-1, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 11, adopted 11/3/2018)

Deceptive Advertising

RESOLVED, That the North Carolina Medical Society opposes deceptive advertising as a means of attracting patients.

(Resolution 16-1978, adopted 5/6/78) (reaffirmed, Report II-1989, Item 7, adopted 11/11/89) (revised, Report L-1999, Item 17, adopted 11/14/99)
(revised, Report C-2005, Item 12, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-35, adopted 10/24/2010) (reaffirmed, NCMS Policy Review Report, Item 1, adopted 10/24/2015)

Direct to Consumer Marketing of Health Screenings and Testing

That the North Carolina Medical Society opposes diagnostic testing that has not been scientifically validated for screening purposes that is offered without prior referral by the patient’s personal physician.

(Report E-2010, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 29, adopted 10/24/2015)

Designation and Advertising of Health Care Practitioners

RESOLVED, That the North Carolina Medical Society supports the clear disclosure by physicians of their osteopathic or allopathic status in all commonly used media; and be it further

RESOLVED, That the North Carolina Medical Society supports the clear disclosure by non-physician health care practitioners of their respective license, certification, or registration in all commonly used media.

(Substitute Resolution 24-2000, adopted 11/12/00)
(revised, Report R-2006, Item 5, adopted 10/29/2006)
(revised, Report H-2011, Item 1-3, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 12, adopted 11/3/2018)

ALLIED HEALTH PERSONNEL

Posting of Professional Credentials

RESOLVED, That the North Carolina Medical Society supports posting of all relevant professional credentials by health care practitioners.

(Report Q, 2001, adopted 11/11/01)
(revised, Report R-2007, Item 3-32, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-2, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 13, adopted 11/3/2018)

Criminal Record Check

RESOLVED, That the North Carolina Medical Society supports a pre-employment criminal record check for non-licensed individuals seeking positions in licensed health care facilities.

(Report GG-1996, adopted 11/17/96)
(revised, Report L3-2004, Item 2, adopted 11/14/2004)
(revised, Report I-2009, Item 3-8, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 15, adopted 10/24/2015)

Regulation of Medical Acts by Nurses

RESOLVED, That the North Carolina Medical Society supports joint adoption of regulations governing nurse practitioners by the North Carolina Board of Nursing and the North Carolina Medical Board; and be it further

RESOLVED That the North Carolina Medical Society supports the use of a joint subcommittee comprised of representatives from the North Carolina Medical Board and the North Carolina Board of Nursing as the entity to formulate regulatory proposals for nurse practitioners; and be it further

RESOLVED, That the North Carolina Medical Society supports a professional regulatory system whereby nurse practitioners obtain their nursing license from the North Carolina Board of Nursing and their authorization to perform medical acts from the North Carolina Medical Board.

(Resolution 5-1972, adopted 5/24/72) (Report S-1984, Item 8, adopted 5/5/84) (reaffirmed, Report CC-1994, Item 13, adopted 11/6/94)
(revised, Report L3-2004, Item 3, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-66, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 47, adopted 10/25/2014)

Electromyographic Consultations

RESOLVED, That the North Carolina Medical Society supports the position that electromyographic consultations to determine the location and possible type of disease of nerve and muscle are part of the practice of medicine; and be it further

RESOLVED, That the North Carolina Medical Society supports the position that electromyographic consultations be performed only by or under the direct supervision of a qualified, licensed physician.

(Resolution 3-1988, adopted 5/7/88
(revised, Report MM-1998, Item 45, adopted 11/15/98)
(revised, Report L3-2004, Item 10, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-65, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 48, adopted 10/25/2014)

Home Health

RESOLVED, That the North Carolina Medical Society supports the use of home health programs and services, with appropriate guidelines and under the supervision of licensed physicians; and be it further

RESOLVED, That the North Carolina Medical Society supports adequate state and federal funding for home nursing and support services.

(Resolution 10-1977, adopted 5/7/77)
(reaffirmed, Report II-1988, Item 4, adopted 5/8/88)
(reaffirmed, Report MM-1998, Item 9, adopted 11/15/98)
(revised, Report L1-2004, Item 55, adopted 11/14/2004)
(revised, Report I-2009, Item 3-32, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 49, adopted 10/25/2014)

Physician Relationship with Non-Physician Practitioners

RESOLVED, That the North Carolina Medical Society supports the following guidelines for supervising physicians and non-physician practitioners who perform medical acts, tasks, and functions:

1. Each professional is responsible for meeting practice standards of her/his professional group and regulatory board.

2. Each professional is responsible for maintaining a working environment in which there is mutual trust and respect, and open, active communication, promoting the optimum contribution of skills and knowledge to the services offered to patients.
3. A clear understanding of the circumstances requiring consultation with the supervising physician as documented.
4. Geographic separation is not a barrier when consultation can be accomplished in a reasonable time frame by telephone or other means of communication.
5. Professional credentials of each are communicated by signage, name tags, etc.
6. Practice arrangements include a negotiated method for addressing ongoing quality assurance.
7. Each professional is aware of limitations of knowledge or skills, and willing to refer for appropriate consultation and care as necessary; and be it further

RESOLVED, That the North Carolina Medical Society supports the requirement of physician supervision of health care providers who perform medical acts, tasks, and functions.

(Report DD-1996, adopted 11/17/96)
(revised as amended, Report H-2003, Item 3 #31, adopted as amended 11/16/03)
(revised, Report N-2008, Item 3-46, adopted 10/19/2008)
(revised, Report G-2013, Item 1-6, adopted 10/26/2013)

Physician Supervision of Nurse Anesthetists

RESOLVED, That the North Carolina Medical Society supports physician supervision of nurse anesthesia activities that involve prescribing a medical treatment regimen or making a medical diagnosis.

(Report B-1998, adopted 11/15/98)
(revised, Report L3-2004, Item 37, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-55, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 50, adopted 10/25/2014)

School Health Professionals

RESOLVED, That the North Carolina Medical Society supports sufficient funding to ultimately ensure a school nurse to a student ratio of at least 1:750; school social worker to student ratio of at least 1:250; and school psychologist to student ratio of at least 1:500.

(Report A-1994, adopted as amended 11/6/94)
(revised, Report L3-2004, Item 38, adopted 11/14/2004)
(revised, Report I-2009, Item 3-42, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 51, adopted 10/25/2014)
(technical correction, Board Report-2019, Page 5, Item 2-13, adopted 7/27/2019)

Utilization Review Decisions

RESOLVED, That the North Carolina Medical Society supports holding nurse reviewers and health plan medical directors to the same standard of medical care as practicing physicians in the determination of medical necessity.

(Substitute Resolution 14-1997, adopted as amended 11/16/97)
(revised, Report L2-2004, Item 27, adopted 11/14/2004)
(revised, Report I-2009, Item 3-21, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 52, adopted 10/25/2014)

Supervision of Physicians Assistants and Advanced Nurse Practitioners

RESOLVED, That the North Carolina Medical Society supports a requirement that the name, address, physical location, contact information and supervisory role of any physician that supervises an advanced nurse practitioner or physician assistant be available in a prominent location accessible to patients.

(Resolution 4-2006, adopted as amended, 10/29/2006)
(reaffirmed, Report H-2011, Item 3-33, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 14, adopted 11/3/2018)

Credentials Disclosure

RESOLVED, That the North Carolina Medical Society supports the practice of advising patients at the time an appointment is made whether they will be evaluated by a physician or a non-physician practitioner.

(Resolution 5-2008, adopted as amended, 10/19/2008)
(revised, Report G-2013, Item 1-10, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 15, adopted 11/3/2018)

Physician Assistants as Part of the Patient-Centered Medical Home

RESOLVED, That the North Carolina Medical Society supports and endorses the use of Physician Assistants as part of a physician-led team, including within the Patient-Centered Medical Home model.

(Resolution 10-2012, adopted as amended 10/27/2012)

AMA (AMERICAN MEDICAL ASSOCIATION)

Endorsement of AMA Statement of Collaborative Intent

RESOLVED, That the North Carolina Medical Society endorse a Statement of Collaborative Intent that was endorsed by the AMA House of Delegates in June 1997.

STATEMENT OF COLLABORATIVE INTENT
At its 1997 Annual Meeting, the AMA House of Delegates endorsed the following Statement of Collaborative Intent and asked that it be distributed to members of the Federation of Medicine for endorsement by their policy making bodies.

Preamble
The Federation of Medicine is a collaborative partnership in medicine. This partnership is comprised of the independent and autonomous medical associations in the AMA House of Delegates and their component and related societies. As the assemblage of the Federation of Medicine, the AMA House of Delegates is the framework for this partnership.

Goals
The goals of the Federation of Medicine are to:

- achieve a unified voice for organized medicine;
- work for the common good of all patients and physicians;
- promote trust and cooperation among members of the Federation;
- advance the image of the medical profession; and
- increase overall efficiency of organized medicine for the benefit of our member physicians.

Principles

1. Organizations in the Federation will collaborate in the development of joint programs and services that benefit patients and member physicians.
2. Organizations in the Federation will be supportive of membership at all levels of the Federation.
3. Organizations in the Federation will seek ways to enhance communications among physicians, between physicians and medical associations, and among organizations in the Federation.
4. Each organization in the Federation of Medicine will actively participate in the policy development process of the AMA House of Delegates.
5. Organizations in the Federation have a right to express their policy positions.
6. Organizations in the Federation will support, whenever possible, the policies, advocacy positions, and strategies established by the Federation of Medicine.
7. Organizations in the Federation will support an environment of mutual trust and respect.
8. Organizations in the Federation will inform other organizations in the Federation in a timely manner whenever their major policies, positions, strategies, or public statements may be in conflict.
9. Organizations in the Federation will support the development and use of a mechanism to resolve disputes among member organizations.
10. Organizations in the Federation will actively work toward identification of ways in which participation in the Federation could benefit them.

(Report X-1998, adopted 11/15/98)
(revised, Report L-1-2004, Item 1, adopted 11/14/2004)

(reaffirmed, Report I-2009, Item 2-2, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 1, adopted 10/25/2014)

BIOMEDICAL RESEARCH AND EDUCATION

Animals in Biomedical Research

RESOLVED, That the North Carolina Medical Society supports appropriate and humane use of animals in biomedical research as an ethical, effective, and necessary method of improving the health of animals and humans.

(Report P-1990, adopted 11/10/90) (reaffirmed, Report Q-2000, Item 3, adopted 11/12/00)
(revised, Report L1-2004, Item 13, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-7, adopted 11/01/2009) (reaffirmed, NCMS Policy Review Report, Item 2, adopted 10/24/2015)

Medical Research Involving Animals

RESOLVED, That the North Carolina Medical Society supports civil and criminal penalties for nefarious activities intended to interfere with animal research, including the unauthorized release of research animals and the theft of data derived from animal research.

(Resolution 35-1990, adopted 11/10/90) (revised, Report Q-2000, Item 49, adopted 11/12/00)
(revised, Report R-2006, Item 13, adopted 10/29/2006)
(reaffirmed, Report I-2009, Item 2-8, adopted 11/01/2009) (reaffirmed, NCMS Policy Review Report, Item 3, adopted 10/24/2015)

CONTRACEPTIVES

Education and Emergency Contraception

RESOLVED, That the North Carolina Medical Society supports efforts to inform the public and physicians about emergency contraceptive availability, its optimal use, potential concerns, and success rate; and be it further

RESOLVED, That the North Carolina Medical Society supports education and dissemination of accurate information on Emergency Contraception to the medical community, women's health groups, the public, and the media.

(Resolution 17-2006, adopted 10/28/2006)
(reaffirmed, Report H-2011, Item 3-51, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 17, adopted 11/3/2018)
(reaffirmed, Board Report – Maternal & Infant Health Workgroup Recommendations, adopted 8/24/2020)

CRIME AND PUNISHMENT

Health Care Services to Institutionalized Youth in the Juvenile Justice System

RESOLVED, That the North Carolina Medical Society supports health care coverage for appropriate and necessary medical and mental health care for juveniles suspected of being abused, neglected, or maltreated; and be it further

RESOLVED, That the North Carolina Medical Society supports health care coverage for institutionalized youth in the juvenile justice system and coverage for appropriate and necessary services that allow for the timely diagnosis, treatment, and/or follow-up of appropriate medical and mental health concerns and conditions. Care should also include close monitoring through periodic assessments for medical and mental health risks and needs.

(Resolution 3-1995, adopted as amended 11/16/1997)
(revised, Report C-2005, Item 34, adopted 10/16/2005)
(revised, Report J-2010, Item 3-20, adopted 10/24/2010) (reaffirmed, NCMS Policy Review Report, Item 4, adopted 10/24/2015)

Jury Duty

RESOLVED, That the North Carolina Medical Society supports physician participation in jury duty as a civic responsibility and a beneficial educational experience provided it does not interfere unnecessarily in adequate patient care.

(Resolution 10-1989, adopted 11/11/89)
(revised, Report L-1999, Item 5, adopted 11/14/99)
(revised, Report R-2006, Item 45, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-43, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 18, adopted 11/3/2018)

Expert Witness

RESOLVED, That the North Carolina Medical Society supports physician participation as retained or independent expert witnesses (as defined by the NC Medico-Legal Guidelines) to assure readily available and objective testimony in court proceedings; and be it further

RESOLVED, That the North Carolina Medical Society supports the following qualifications for retained or independent physician expert witnesses (as defined by the NC Medico-Legal Guidelines) who testify as to the standard of care in professional liability cases;

1. The physician expert witnesses must have a currently valid and unrestricted license to practice medicine in the state in which they practice.
2. The physician expert witnesses must show evidence of competence in the specialty or area of medical care of the defendant physician. Acceptable evidence of competence

would include such accomplishments as Board Certification by a specialty recognized by the American Board of Medical Specialties and/or demonstrated experience in the area of medical care from which the complaint arose.
3. The physician expert witnesses must document that he or she dedicated the majority of his or her professional time, during the year immediately preceding the date of the occurrence that is the basis for the action, to either one or more of the following: (1) the active clinical practice of the same health profession in which the party against whom or on whose behalf the testimony is offered, (2) if the party is a specialist, the active clinical practice of the same specialty or a similar specialty which includes within its specialty the performance of the procedure that is the subject of the complaint and have prior experience treating similar patients; or (3) the instruction of students in an accredited health professional school or accredited residency or clinical research program in the same health profession as the party against whom or on whose behalf the testimony is offered; and be it further

RESOLVED, That the North Carolina Medical Society supports physician cooperation as fact expert witnesses as defined by and in accordance with the NC Medico-Legal Guidelines (PDF).

(Report K-1991, adopted 11/9/1991)
(revised, Report U-2001, Item 33, adopted 11/11/2001)
(revised, Report R-2007, Item 3-6, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-13, adopted 10/27/2012)
(reaffirmed,Board Report-2019, Item 1-8, adopted July 27, 2019)

Prosecution of Persons Practicing Medicine without a License

RESOLVED, That the North Carolina Medical Society supports increasing the criminality of the unlicensed practice of medicine from a Class I misdemeanor to a Class I felony.

(Report Y-1989, adopted 11/11/89)
(revised, Report L-1999, Item 30, adopted 11/14/99)
(revised, Report R-2006, Item 50, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-48, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 19, adopted 11/3/2018)

Proper Care of Psychiatric Patients

RESOLVED, That the North Carolina Medical Society support cooperation between the North Carolina Department of Public Safety, the North Carolina Post-Release Supervision and Parole Commission, and the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services to:

1. Provide proper medical and psychiatric care to prisoners suffering from a psychiatric illness while incarcerated.
2. Arrange for proper follow-up care of former prisoners upon their release from prison, and
3. Provide follow-up care for mentally ill offenders upon return to the community.

(Report E-1982, adopted 5/7/1982) (reaffirmed, Report JJ-1992, Item 2, adopted 11/8/1992) (revised, Report H-2002, adopted 11/17/2002) (reaffirmed, Report R-2007, Item 2-8, adopted 10/21/2007) (revised, Report F-2012, Item 1-3, adopted 10/27/2012) (reaffirmed, Board Report-2018, Item 20, adopted 11/3/2018)

Criminalization of Medical Acts

RESOLVED, That the North Carolina Medical Society opposes the criminalization of medical acts performed by licensed practitioners.

(Resolution 49-1998, adopted 11/15/98) (revised, Report L3-2004, Item 8, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-57, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 31, adopted 10/24/2015)

Executions

RESOLVED, That the North Carolina Medical Society supports the following position of the American Medical Association regarding physician involvement in capital punishment and the individual. A physician, as a member of a profession dedicated to preserving life when there is hope of doing so, should not be a participant in a state execution. "Physician extension of this position to those who may perform services as agents of physicians:

1. An individual's opinion on capital punishment is a personal moral decision. However, participation in execution is defined generally as actions that would fall into one or more of the following categories: (a) an action that would directly cause the death of the condemned; (b) an action that would assist, supervise, or contribute to the ability of another individual to directly cause the death of the condemned; (c) an action that could automatically cause an execution to be carried out on a condemned prisoner.
2. Physician participation in an execution includes but is not limited to the following actions: prescribing or administering tranquilizers and other psychotropic agents and medications that are part of the execution procedure; monitoring vital signs on site or remotely (including monitoring electrocardiograms); attending or observing an execution as a physician; and rendering of technical advice regarding execution or the means of execution.
3. In the case where the method of execution is lethal injection, the following actions by the physician would also constitute physician participation in execution: selecting injection sites; starting intravenous lines as a port for a lethal injection device; prescribing, preparing, administering, or supervising injection drugs or their dose or types; inspecting, testing or maintaining lethal injection devices; consulting with or supervising lethal injection personnel.
4. The following actions do not constitute physician participation in execution: (a) testifying as to medical history and diagnoses or mental state as they relate to competence to stand trial, testifying as to relevant medical evidence during trial, testifying as to medical aspects of aggravating or mitigating circumstances during the penalty phase of a capital case, or testifying as to medical diagnoses as they relate to the legal assessment of competence for execution; (b) certifying death provided that the condemned has been

declared dead by another person not under the direct supervision of a physician; (c) witnessing an execution in a totally non-professional capacity; (d) witnessing an execution at the specific voluntary request of the condemned person, providing that the physician observes the execution in a non-physician capacity and takes no action which would constitute physician participation in an execution; and (e) relieving the acute suffering of a condemned person while awaiting execution, including providing tranquilizers at the specific voluntary request of the condemned person to help relieve pain or anxiety in anticipation of the execution.

5. Physicians should not determine legal competence to be executed. A physician's medical opinion should be merely one aspect of the information taken into account by a legal decision maker such as a judge or hearing officer. When a condemned prisoner has been declared incompetent to be executed, physicians should not treat the prisoner for the purpose of restoring competence unless a commutation order is issued before treatment begins. The task of re-evaluating the prisoner should be performed by an independent physician examiner. If the incompetent prisoner is undergoing extreme suffering as a result of psychosis or any other illness, medical intervention intended to mitigate the level of suffering is ethically permissible. No physician should be compelled to participate in the process of establishing a prisoner's competence or be involved with treatment of an incompetent, condemned prisoner if such activity is contrary to the physician's personal beliefs. Under those circumstances, physicians should be permitted to transfer care of the prisoner to another physician.
6. Organ donation by condemned prisoners is permissible only if (1) the decision to donate was made before the prisoner's conviction, (2) the donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber, and (3) physicians do not provide advice on modifying the method of execution for any individual to facilitate donation.

(Resolution 27-1983, adopted 5/7/83) (revised, Report FF-1993, Item 4, adopted as amended 11/7/93) (revised, Report H-2003, Item 3 #26, adopted as amended 11/16/03) (reaffirmed, Report N-2008, Item 2-2, adopted 10/19/2008) (revised, Report G-2013, Item 1-1, adopted 10/26/2013)
(technical correction, Board Report-2019, Page 5, Item 2-22, adopted 7/27/2019)

Medical Care of Prisoners

RESOLVED, That the North Carolina Medical Society and its component societies support authorities in developing a plan for medical care of prisoners in local confinement facilities and obtaining the services of licensed physicians specifically responsible for medical services for prisoners required by law under GS 130-97 and GS 130-121, with physicians providing these services being compensated fairly.

(Report S-1971, adopted 5/18/71) (revised, Report II-1988, Item 35, adopted 5/7/88) (revised, Report MM-1998, Item 7, adopted 11/15/98) (revised, Report L1-2004, Item 66, adopted 11/14/2004) (revised, Report J-2010, Item 3-24, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 32, adopted 10/24/2015)

DENTISTRY

Dental Care for Children

RESOLVED, That the North Carolina Medical Society supports best medical practices in early assessment, identification of oral health needs, and timely referral to dental professionals for management of children.

(Resolution 43-2000, adopted 11/12/00)
(revised, Report R-2006, Item 17, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-26, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 21, adopted 11/3/2018)

Oral Health

RESOLVED, That the North Carolina Medical Society supports statewide, school-based and community-based efforts that focus on oral health education.

(Resolution 3-1998, adopted as amended 11/15/98)
(revised, Report L1-2004, Item 35, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-85, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 55, adopted 10/25/2014)

Dental Services for the People of North Carolina

RESOLVED, That the North Carolina Medical Society supports improved access to dental services for all of the people in North Carolina, especially for special needs populations.

(Substitute Resolution 15-2005, adopted as amended 10/16/2005)
(revised, Report J-2010, Item 3-9, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 33, adopted 10/24/2015)

DISEASE/DISEASE MANAGEMENT

Obesity

Obesity affects approximately 34.2% of the adult population in North Carolina and approximately 33.6% of the youth population in North Carolina. It is a multifactorial and complex chronic disease that contributes to preventable health conditions and even death. Addressing the prevalence of obesity in North Carolina requires a multifaceted and collaborative approach from all levels across the state, as well as a societal shift in how people think about obesity.

The North Carolina Medical Society supports the Healthy North Carolina (HNC) 2030 levers for change to improve access to healthy food options and safe physical environments, and to decrease sugary/sweetened beverage consumption.

The North Carolina Medical Society supports obesity prevention and management through evidence-based programs and treatments, education and guidance, and a patient-centered support structure that promotes health equity and the destigmatization of obesity.

The North Carolina Medical Society supports a patient-centered, team-based care, and non-stigmatizing approach to addressing the drivers of obesity.

The North Carolina Medical Society supports comprehensive coverage and reimbursement for lifestyle and preventative medicine that enhances patient education and counseling, increases resources and treatment options, and reduces chronic conditions associated with obesity.

(Adopted 05/19/2024)

North Carolina Medical Society AIDS Policies

HIV Prevention and Education
RESOLVED, That the North Carolina Medical Society supports AMA and state policies advocating HIV prevention and education composed of scientific, evidence-based, and non-restrictive language targeting elementary, secondary, and college students, including the high-risk groups of young adults and others with barriers to informed education; and be it further

RESOLVED, That the North Carolina Medical Society supports evidence-based programs that decrease the spread of communicable diseases via needle injections; and be it further

RESOLVED, That the North Carolina Medical Society supports needle exchange programs; and be it further

RESOLVED, That the North Carolina Medical Society supports public education regarding (1) the importance of HIV testing of pregnant women and neonates; (2) the use of appropriate treatment to decrease vertical transmission of HIV; and (3) other ways to decrease maternal HIV transmission.

Discrimination against HIV-Infected Persons
RESOLVED, That the North Carolina Medical Society supports the enforcement of existing federal, state, and local anti-discrimination laws against persons who illegally discriminate against HIV-infected persons based on their disease; and be it further

RESOLVED, That the North Carolina Medical Society supports uniform strict confidentiality at all levels of government, business, and medical care of the identity of persons with HIV infection, except where public health requires; and be it further

RESOLVED, That the North Carolina Medical Society supports laws providing immunity for physicians for confidential communications regarding an HIV-infected person's serostatus with appropriate health care professionals involved in the person's treatment.

HIV Testing
RESOLVED, That the North Carolina Medical Society supports public education about the importance of HIV testing and recognizes the right of each patient to refuse HIV testing; and be it further

RESOLVED, That the North Carolina Medical Society supports public availability of HIV testing with counseling and treatment for the general public; and be it further

RESOLVED, That the North Carolina Medical Society supports HIV testing in all health care setting as a routine part of any medical evaluation for persons age 13-64, if not already done, and after notifying the patient that testing will be done unless the patient declines (opt-out screening); and be it further

RESOLVED, That the North Carolina Medical Society supports annual testing of persons at high-risk for HIV infection; and be it further

RESOLVED, That the North Carolina Medical Society supports non-mandatory prevention counseling in conjunction with HIV testing; and be it further

RESOLVED, That the North Carolina Medical Society supports HIV testing be included in the routine panel of prenatal screening tests for all pregnant women after notifying the patient that the testing will be done unless the patient declines; and be it further

RESOLVED, That the North Carolina Medical Society supports HIV testing of pregnant women in the third trimester or rapid HIV testing at the time of labor or delivery, with or without patient consent, if there is no record of an HIV test result during the current pregnancy.

HIV Transmission
RESOLVED, That the North Carolina Medical Society supports the establishment of confidential community contact tracing and partner notification systems for sexual partners or intravenous drug users sharing needles who might be HIV infected; and be it further

RESOLVED, That the North Carolina Medical Society supports reporting of individuals suspected of knowingly and willingly risking infection of unsuspecting persons to local public health officials and preemptive sanctions for individuals engaging in such behaviors.

HIV Treatment
RESOLVED, That the North Carolina Medical Society supports adequate treatment of HIV-infected individuals including ongoing monitoring by competent health care professionals so as to reduce the risk of HIV transmission, decrease long-term medical costs, and ensure HIV-infected persons remain healthy and productive members of society.

HIV in Health Care Settings
RESOLVED,That the North Carolina Medical Society supports the implementation of appropriate laws, rules, and regulations requiring HIV-infected persons who are aware of their status to divulge it to appropriate health care professionals; and be it further

RESOLVED, That the North Carolina Medical Society supports laws and regulations that provide strict confidentiality laws and due process protections for HIV-infected health care professionals; and be it further

RESOLVED, That the North Carolina Medical Society supports adherence to Centers for Disease Control and Prevention guidelines for infection control including the following conduct by health care professionals:

1. Strict observance of universal precautions
2. Self-testing and self-reporting of HIV-infected status to State Health Director by persons performing invasive medical procedures; and be it further

RESOLVED, That the North Carolina Medical Society supports continued training and education regarding HIV prevention and treatment for all health care professionals.

HIV in Schools
RESOLVED, That the North Carolina Medical Society supports school attendance by HIV-infected children at facilities adhering to the North Carolina Commission for Health Services regulations on the management of HIV-infected children in schools and day care centers; and be it further

RESOLVED, That the North Carolina Medical Society supports temporary removal of an HIV-infected child from a school setting that would likely pose a threat to his/her health or risk of HIV transmission to others; and be it further

RESOLVED, That the North Carolina Medical Society supports strict confidentiality by a school system regarding communication of a child's HIV-infected status with such information being given only to school personnel with a clear and compelling need to know.

(Report PP-1996, adopted as amended 11/17/96)
(revised, Report R-2006, Item 15, adopted 10/29/2006)
(revised, Report N-2008, Item 3-20, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 3, adopted 10/26/2013)

Breast Reconstruction Availability

RESOLVED, That the North Carolina Medical Society supports access to breast reconstruction for patients recovering from breast cancer surgery or prophylactic mastectomy to prevent cancer whether at the time of or subsequent to initial surgery; and be it further

RESOLVED, That the North Carolina Medical Society opposes discrimination against reconstructive surgery coverage; and be it further

RESOLVED, That the North Carolina Medical Society supports measures to ensure health insurance coverage of all stages of reconstruction that may be necessary, including symmetry operations.

(Resolution 13-1996, adopted 11/17/96)
(revised, Report C-2005, Item 40, adopted 10/16/2005)
(revised, Report J-2010, Item 3-25, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 34, adopted 10/24/2015)

North Carolina Comprehensive Cancer Program

RESOLVED, That the North Carolina Medical Society supports the North Carolina Comprehensive Cancer Program in the areas of cancer treatment for indigent patients and public education about cancer and data gathering through the North Carolina Central Cancer Registry.

(Report S-1984, Item 2, adopted 5/5/84)
(reaffirmed, Report II-1995, Item 1, adopted 11/12/95)
(revised, Report L1-2004, Item 3, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-84, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 35, adopted 10/24/2015)

Tuberculosis

RESOLVED, That the North Carolina Medical Society supports screening and treatment of tuberculosis cases and potential cases in accordance with North Carolina public health guidelines.

(Report E-1975, adopted 5/3/75)
(revised, Report D-1986, Item 7, adopted 5/3/86)
(revised, Report Y-1996, Item 11, adopted 11/7/96)
(amended, Report OO-1997, Item 13, adopted 11/16/97)
(revised, Report L1-2004, Item 64, adopted 11/14/2004)
(revised, Report I-2009, Item 3-60, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 36, adopted 10/24/2015)

Diabetes Self-Care Education

RESOLVED, That the North Carolina Medical Society supports the availability of statewide individualized diabetes mellitus patient education.

(Resolution 22-1993, adopted as amended 11/7/93)
(revised, Report H-2003, Item 3 #4, adopted as amended 11/16/03)
(revised, Report N-2008, Item 3-13, adopted 10/19/2008)

(reaffirmed, Reaffirmation Report-2013, Item 21, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 22, adopted 11/3/2018)

Sexually Transmitted Disease Prevention, Reporting, Surveillance and Treatment

RESOLVED, That the North Carolina Medical Society supports practicing physicians in North Carolina taking a collaborative role with helping to prevent sexually transmitted disease and with providing adequate community resources for case-finding and treatment of sexually transmitted disease, and be it further

RESOLVED, That the North Carolina Medical Society encourages the cooperation of physicians with prevention, reporting, and surveillance of sexually transmitted disease.

(Report E-1973, adopted 5/22/1973)
(reaffirmed, Report D-1986, Item 15, adopted 5/3/1986)
(revised, Report Y-1996, Item 3, adopted 11/17/1996)
(revised, Report L1-2004, Item 65, adopted 11/14/2004)
(revised, Report J-2010, Item 3-10, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 37, adopted 10/24/2015)

Informed Consent

RESOLVED, That the North Carolina Medical Society opposes legislation requiring restrictive informed consent procedures that apply solely to specific diseases; and be it further

RESOLVED, That the North Carolina Medical Society supports providing every patient or person from whom informed consent is sought with clear, scientifically-based treatment options, whenever possible; and be it further

RESOLVED, That the North Carolina Medical Society supports obtaining informed consent at a time when the patient, or person from whom informed consent is being sought, is best able to understand and comprehend the treatment options and associated risks.

(Report U-1984, adopted 5/5/84)
(reaffirmed, Report CC-1994, Item 16, adopted 11/6/94)
(revised, Report L3-2004, Item 46, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-58, adopted 11/01/2009) (reaffirmed, NCMS Policy Review Report, Item 5, adopted 10/24/2015)

Osteoporosis Education, Prevention and Treatment

RESOLVED, That the North Carolina Medical Society supports osteoporosis education, prevention, and treatment programs to achieve a reduction in the prevalence of osteoporosis and its costly consequences.

(Resolution 16-1995, adopted as amended 11/12/95)
(revised, Report C-2005, Item 31, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-3, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 38, adopted 10/24/2015)

Sexually Transmitted Disease

RESOLVED, That the North Carolina Medical Society supports practicing physicians in providing adequate community services for screening, case-finding, and treatment of sexually transmitted disease and encourage cooperation with public health authorities in the investigation and control of such diseases.

(Resolution 32-1985, adopted 5/4/85)
(revised, Report II-1995, Item 27, adopted 11/12/95)
(revised, Report L1-2004, Item 72, adopted 11/14/2004)
(revised, Report I-2009, Item 3-61, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 39, adopted 10/24/2015)

Cancer Patient Access to Care

RESOLVED, That the North Carolina Medical Society supports access to oncology care determined by the patient and the physician, and be it further

RESOLVED, That the North Carolina Medical Society opposes efforts by Blue Cross Blue Shield of North Carolina or other payors to limit access to community care for cancer patients, and be it further

RESOLVED, That the North Carolina Medical Society supports only objective, evidence-based reasons for any change in reimbursement policies by Blue Cross Blue Shield of North Carolina or other payors.

(Report D-2010, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 40, adopted 10/24/2015)

Funding of the AIDS Assistance Program

RESOLVED,That the North Carolina Medical Society supports funding of the AIDS Drug Resistance Program at both the state and federal levels.

(Resolution 19-2013, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 23, adopted 11/3/2018)

DOCTOR MD/DO

Use of the Designation “MD” or “DO”

RESOLVED, That the North Carolina Medical Society supports the use of the designation "MD" or "DO" where appropriate, instead of the more general term of "Dr."

(Resolution 1-1979, adopted 5/5/79)
(revised, Report II-1989, Item 9, adopted 11/11/89)
(reaffirmed, Report L-1999, Item 3, adopted 11/14/99)
(revised, Report C-2005, Item 13, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-40, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 41, adopted 10/24/2015)

Definition of "Physician"

RESOLVED, That the North Carolina Medical Society supports the position that only fully trained and licensed MDs and DOs be identified as physicians.

(Resolution 42-1998, adopted as amended 11/15/98)
(revised, Report L3-2004, Item 5, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-54, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 57, adopted 10/25/2014)
(reaffirmed, NCMS Board Report-2019, Item 1, 3-16, adopted 7/26/2019)

Is the Doctor a Physician?

RESOLVED, That the North Carolina Medical Society support the American Medical Association's Truth in Advertising campaign for public and legislative awareness of use of the term "doctor" by non-physician health care providers.

(Report D-2013, adopted 10/25/2013)
(reaffirmed, Board Report-2018, Item 24, adopted 11/3/2018)

EMERGENCY MEDICAL SERVICES

Statewide Trauma System

RESOLVED, That the North Carolina Medical Society supports continued adequate funding for a statewide trauma system.

(Report L-1993, adopted 11/7/93)
(revised, Report H-2003, Item 3 #15, adopted as amended 11/16/03)
(reaffirmed, Report N-2008, Item 2-7, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 22, adopted 10/26/2013)
(technical correction, Board Report-2018, item 25, adopted 11/3/2018)

Physician Participation in Disaster Planning and Response

RESOLVED, That the North Carolina Medical Society supports physicians' active participation in local and state disaster planning and response activities.

(Report T-1992, adopted 11/8/92)
(revised, Report H-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-32, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 4, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 26, adopted 11/3/2018)

Limitation of Professional Liability for Physicians Who Serve as Medical Directors for Emergency Medical Service (EMS) Agencies Without Compensation

RESOLVED, That the North Carolina Medical Society support Good Samaritan immunity for those physicians who provide medical direction without financial compensation for EMS agencies in their communities.

(Report U-1992, adopted 11/8/92)
(revised Report H-2002, adopted 11/17/02)
(reaffirmed, Report N-2008, Item 2-9, adopted 10/19/2008)
(revised, Report G-2013, Item 1-2, adopted 10/26/2013
(reaffirmed, Board Report-2018, Item 27, adopted 11/3/2018)

Enhanced 911 Service in North Carolina

RESOLVED, That the North Carolina Medical Society supports statewide implementation of enhanced 911 phone service.

(Report V-1992, adopted 11/8/92)
(revised, Report H-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-16, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 23, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 28, adopted 11/3/2018)

Emergency Medical Services

RESOLVED, That the North Carolina Medical Society supports the concept of the development of emergency medical services in the State of North Carolina and training of emergency response personnel with (a) the development of minimum level statewide training criteria and evaluation with certification; (b) the development of minimum level standards for emergency response vehicles; (c) the development of an integrated statewide communication program; (d) a categorization of hospitals to assist in identifying area resources and ultimately to assist in coordinating emergency medical care delivery; (e) the development of specialized training programs for such personnel and (f) the coordination and encouragement of efficient, dependable, and safe air emergency response transportation wherever appropriate through the state; and be it further

RESOLVED, That the North Carolina Medical Society supports implementation of the statewide program of emergency medical care by the Office of Emergency Medical Services.

(Report B-1975, adopted 5/3/75)
(revised, Report T-1987, Item 1, adopted 5/2/87)
(amended, Report OO-1997, Item 9, adopted 11/16/97)
(revised, Report L3-2004, Item 12, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-72, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 42, adopted 10/24/2015)

Funding for North Carolina Office of Emergency Medical Services

RESOLVED, That the North Carolina Medical Society supports adequate funding for the North Carolina Office of Emergency Medical Services to provide emergency medical services across the state and implement the statewide trauma system plan.

(Report N-1987, adopted 5/2/87)
(amended, Report OO-1997, Item 10, adopted 11/16/97)
(revised, Report L3-2004, Item 11, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-73, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 43, adopted 10/24/2015)

Medical Direction of Prehospital Care During Medical Emergencies

RESOLVED, That the North Carolina Medical Society supports the active involvement and participation of physicians in all aspects of the organization and provision of basic (including first responder) and advanced life support emergency medical services, including assistance from a physician on the scene in accordance with emergency medical services protocols; and be it further

RESOLVED, That the North Carolina Medical Society supports the involvement of emergency medical services medical directors with the ongoing design, operation, evaluation, and revision of the emergency medical services system; and be it further

RESOLVED, That the North Carolina Medical Society supports emergency medical services medical director authority over patient care, including the ability to limit immediately the patient care activities of those who deviate from established standards or do not meet training standards, and the responsibility to develop and implement medical policies and procedures. The emergency medical services medical director's qualifications, responsibilities, and authority must be delineated in writing within each emergency medical services system. The emergency medical services system has an obligation to provide the emergency medical services medical director with the resources and authority commensurate with these responsibilities.

(Report E-1994, adopted as amended 11/6/94)
(revised, Report C-2005, Item 17, adopted 10/16/2005)
(revised, Report R-2006, Item 37, adopted 10/29/2006)

(reaffirmed, Report H-2011, Item 3-42, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 29, adopted 11/3/2018)

Emergency Room/In Hospital Violence

RESOLVED, That the North Carolina Medical Society supports classifying as a felony the assault of any health care provider while discharging or attempting to discharge their formal duties.

(Resolution 8-2011, adopted in lieu of Resolution 8, 10/23/2011)
(technical corrections, Board Report-2018, Item 30, adopted 11/3/2018)

North Carolina Trauma Care System

RESOLVED, That the North Carolina Medical Society supports the regionalized trauma care system and categorization of hospitals by the level of trauma care they can provide, and the continuation of the North Carolina Statewide Trauma Registry and inclusion of E codes in all hospital and emergency department discharge data.

(Report M-1989, adopted 11/11/89)
(revised, Report L-1999, Item 22, adopted 11/14/99)
(revised, Report C-2005, Item 23, adopted 10/16/2005)
(reaffirmed, Reaffirmation Report-2013, Item 5, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 31, adopted 11/3/2018)

END OF LIFE ISSUES

Death and Dying and Care of the Terminally Ill

RESOLVED, That the North Carolina Medical Society supports working with other organizations concerned with the care of the sick and dying such as the North Carolina Hospital Association, the North Carolina Council of Churches, the North Carolina Health Care Facilities Association, the Carolinas Center for Hospice and End of Life Care, and the North Carolina Hospital Chaplains Association to preserve the dignity and peace of the individual in all matters pertaining to death and dying; and be it further

RESOLVED, That the North Carolina Medical Society supports hospice and palliative care and physician participation in this approach to the care of the terminally ill patients; and be it further

RESOLVED, That the North Carolina Medical Society supports the involvement of medical schools and other institutions in educating health professionals about the importance of devoting increased attention in their teaching programs to the special problems involved in the care of terminally ill patients; and be it further

RESOLVED, That the North Carolina Medical Society supports the provision of in-service education programs by hospitals and nursing homes for all health workers to increase their understanding of and sensitivity to the special needs of the dying patients and their families; and be it further

RESOLVED, That the North Carolina Medical Society supports cooperation between organized medicine and educational, religious, or other interested organizations in sponsoring community forums for public education on the realities of caring for the dying patient.

(Report E-1979, adopted 5/5/79)
(revised, Report II-1989, Item 14, adopted 11/11/89)
(revised, Report L-1999, Item 18, adopted 11/14/99)
(revised, Report C-2005, Item 9, adopted 10/16/2005)
(revised, Report J-2010, Item 3-2, adopted 10/24/2010) (reaffirmed, NCMS Policy Review Report, Item 6, adopted 10/24/2015)

End of Life Issues

RESOLVED, That the North Carolina Medical Society supports public and private efforts to enhance understanding of end-of-life issues so that health care professionals are better able to provide optimal compassionate palliative care of terminally ill patients; and be it further

RESOLVED, That the North Carolina Medical Society supports the use of the portable Do Not Resuscitate (DNR) and Medical Orders for Scope of Treatment (MOST) forms approved by the North Carolina Department of Health and Human Services.

(Report LL-1998, adopted 11/15/98)
(revised, Report L1-2004, Item 8, adopted 11/14/2004)
(revised, Report I-2009, Item 3-2, adopted 11/01/2009) (reaffirmed, NCMS Policy Review Report, Item 7, adopted 10/24/2015)

End-of-Life Education

RESOLVED, That the North Carolina Medical Society supports the development of educational materials and programs for physicians, patients, and families about end-of-life issues.

(Report N-1990, adopted as amended 11/10/1990)
(revised, Report U-2001, Item 45, adopted 11/11/2001)
(revised, Report R-2007, Item 3-3, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-3, adopted 10/27/2012)
(reaffirmed, NCMS Board Report-2019, Item 1, 2-6, adopted 7/26/2019)

Enhance Utility of Medical Orders for Scope of Treatment (MOST) and Portable Do Not Resuscitate (DNR) Forms

RESOLVED, That the North Carolina Medical Society supports electronic options for MOST and Portable DNR forms to further improve communication of patients' end-of-life care wishes.

(Resolution 5-2011, adopted, 10/23/2011)
(reaffirmed, NCMS Board Report-2019, Item 1, 2-29, adopted 7/26/2019)

Futile Treatment

RESOLVED, That the North Carolina Medical Society supports a physician's right not to provide futile treatment.

(Substitute Resolution 14-2005, adopted as amended 10/16/2005)
(revised, Report G-2013, Item 1-3, adopted 10/26/2013)

Long-Term Feeding Tubes

RESOLVED, That the North Carolina Medical supports educational efforts for physicians and other allied health professionals, as well as for patients and their families, on the appropriateness of the placement of long-term feeding tubes in decisionally incapable adult patients who suffer from a chronic, progressive illness.

(Report E-2003, adopted as amended 11/16/03)
(revised, Report N-2008, Item 3-1, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 6, adopted 10/26/2013)
(reaffirmed, NCMS Board Report-2019, Item 1-41, adopted 7/26/2019)

No Code and Do Not Attempt Resuscitation Orders

The North Carolina Medical Society supports the provision of services to dying patients in the most sensitive and humane manner under the circumstances. North Carolina's Right to a Natural Death Act recognizes a patient's right to a peaceful and natural death. It outlines an optional and nonexclusive procedure for respecting this right that provides a safe harbor of protection from liability in circumstances involving withholding or withdrawing life-prolonging measures including artificial nutrition or hydration from a patient who: is unable to make and communicate decisions and who has an incurable or irreversible condition that will result in the declarant's death within a relatively short period of time; or becomes unconscious and, to a high degree of medical certainty, will never regain consciousness; or suffers from advanced dementia or any other condition resulting in the substantial loss of cognitive ability and that loss, to a high degree of medical certainty, is not reversible. The statute defines "life-prolonging measures" as "medical procedures or interventions that in the judgment of the attending physician would serve only to postpone artificially the moment of death by sustaining, restoring, or supplanting a vital function, including mechanical ventilation, dialysis, antibiotics, artificial nutrition and hydration, and similar forms of treatment. Life-prolonging measures do not include care necessary to provide comfort or to alleviate pain." It encompasses CPR in circumstances where the physician has determined that this intervention would serve only to postpone artificially the moment of death.

While these procedures are useful and recommended as a liability management device under appropriate circumstances, the Act also authorizes following the common law, and so doing may allow greater sensitivity to patient needs. The common law continues to grow through court decisions and addresses questions relative to the patient's right to control his or her medical care decisions and to die with dignity. While the statutory procedures are available, the physician has a degree of freedom in this area to use the often less stringent common law sensitively to mesh patient needs and rights with legal constraints. In addition to recognizing a Declaration for a Natural Death, North Carolina law further provides for a Health Care Power of Attorney, Portable Do Not Resuscitate Orders and a Medical Orders for Scope of Treatment. Immunity protects persons and institutions that honor these documents in good faith.

The presence of a do not resuscitate (DNR) order or an order to limit, withhold or discontinue life-prolonging measures does not relieve the physician of responsibility to continue monitoring the condition of the patient, to provide all necessary symptomatic relief, and to write other orders consistent with the plan of care.

Should a conflict arise between and among the medical staff, the nursing staff and/or the patient's family regarding the issuance of a DNR order to limit, withhold or discontinue life-prolonging measures, the institution's ethics committee or other similar mechanism should be consulted to provide a forum for resolving the conflict.

General guidelines applicable to all "No Code Blue" or DNR orders:

1. Orders shall be entered only on the authority of the patient's physician. A second physician's opinion or signature is not required.
2. The orders shall be in writing and placed in the physician's order section of the medical record.
3. The physician shall state in a progress note of the patient's medical record the basis for entering the DNR order. The entry should include the patient's medical status and prognosis and should indicate that the order is in keeping with the patient's rights, known wishes or values and best interest.
4. Further supporting documentation also may summarize conversations with family members or the patient's representative(s). In the event the patient has an advance directive, a copy should be included in the patient's record.
5. The acceptability of telephone or oral DNR orders shall be established in individual health care institutions or agencies by policies jointly developed by the medical staff and the administration.
6. Orders to limit, withhold or discontinue life-prolonging measures, including a DNR order, shall be regularly reviewed and renewed in writing in a timely manner under policies established by the medical staff and the administration of the institution or agency.
7. DNR orders shall also be reviewed whenever there is: (a) a change in the patient's condition or prognosis, including decisional capacity; (b) a change in the patient's, family's or surrogate's wishes; (c) a change in the patient's physician; or (d) a transfer to another care setting.

(Board Report-2019, Issue 3, adopted 07/27/2019)

PALLIATIVE CARE

The North Carolina Medical Society supports the provision of palliative care for individuals regardless of age who have a serious illness and seek support and relief from suffering, whether or not those individuals continue to receive curative treatment. Palliative care, also known as supportive care, is a patient-centered, whole-person approach that helps improve the quality of life for individuals suffering from serious illness; it also provides needed support to personal caregivers and loved ones. The level of palliative care needed may fluctuate over the course of an illness based on a patient's symptoms or other needs. The NCMS endorses the National Consensus Project's definition of palliative care and supports the application of national standards to define high-quality palliative care (1).

The NCMS supports interprofessional collaboration for optimal delivery of palliative care and the provision of hospital-based, outpatient, and home-based palliative care where appropriate.

The NCMS supports efforts to raise awareness among physicians, physician assistants, care teams, and the general population of the significant need for effective relief of the physical, psychological, and spiritual distress that frequently accompanies serious illness.

The NCMS supports programming in undergraduate, graduate, and continuing medical education to promote knowledge of palliative care and the integration of palliative care into clinical practice.

The NCMS supports the adoption and expansion of primary palliative care, that is, palliative care provided by clinicians who are not palliative care specialists. Primary palliative care includes basic symptom management and discussions about goals of care, treatment decisions, preferences for resuscitation, and transition to hospice care. Other aspects of palliative care, however, such as complex symptom management and difficult decisions about treatment, goals of care, or transitions to hospice, may require the involvement of a palliative care specialist.

National Consensus Project's Definition of Palliative Care:

"Beneficial at any stage of a serious illness, palliative care is an interdisciplinary care delivery system designed to anticipate, prevent, and manage physical, psychological, social, and spiritual suffering to optimize quality of life for patients, their families and caregivers. Palliative care can be delivered in any care setting through the collaboration of many types of care providers. Through early integration into the care plan of seriously ill people, palliative care improves quality of life for both the patient and the family."

National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018. https://www.nationalcoalitionhpc.org/ncp .

(Adopted, NCMS BOD Report 5/2022)

Patient Self-Determination at End-of-Life

RESOLVED, That the North Carolina Medical Society supports efforts to ensure that a patient's wishes regarding the level of end-of-life treatment are solicited and honored including, but not limited to, the use of tools such as advanced directives, such as a living will and a health care power of attorney, and portable physician orders, such as the portable Do Not Resuscitate (DNR) order and the Medical Order for Scope of Treatment (MOST); be it further

RESOLVED, That the North Carolina Medical Society supports immunity for health care professionals who rely and act in good faith on reliable sources of information communicating the patient's wishes with regard to the desired level of end-of-life treatment.

(Report K-1982, adopted 5/7/82)
(revised, Report JJ-1992, Item 5, adopted 11/8/92)
(revised, Report Q-2000, Item 42, adopted 11/12/00)
(revised, Report R-2006, Item 4, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-41, adopted 10/23/2011)
(reaffirmed, NCMS Board Report-2019, Item 1, 2-14, adopted 7/26/2019)

ENVIRONMENTAL HEALTH

Fluoridation of Public Water Supplies

RESOLVED, That the North Carolina Medical Society supports the use of fluoridation in all public water supplies, where appropriate.

(Resolution 6-1980, adopted 5/3/1980)
(reaffirmed, Report M-1990, Item 3, adopted 11/10/1990)
(reaffirmed, Report Q-2000, Item 9, adopted 11/12/2000)
(revised, Report R-2006, Item 21, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-21, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 34, adopted 11/3/2018)

Environmental Health

The North Carolina Medical Society affirms that all individuals and families in North Carolina deserve to live, work, learn, and play in a clean environment with healthy air, water, and land, free of toxins and other hazards to their physical, mental, behavioral, and emotional health.

The North Carolina Medical Society affirms that all individuals and families in North Carolina deserve to live in a safe, healthy environment regardless of income, race, gender, ethnicity, creed, culture, disability, or geography.

The North Carolina Medical Society supports the following principles when discussing, developing, and implementing programs, policies, processes, and projects that impact the natural,

social, and built environments in North Carolina, which may directly affect the health and well-being of people in North Carolina.

Therefore, The North Carolina Medical Society:

- Supports the role of the clinician in determining environmentally related illness, disease, or injury, through diagnostic and preventative care.
- Supports the clinician's commitment to environmental determinants of health, referrals of patients to a specialist if needed, incorporation of environmental questions into their diagnostic screenings, and to report potential environmental exposures to local and state health department officials, preventing future illness and injury for others in North Carolina.
- Supports the protection of the people in North Carolina from evidence based harmful exposure to, toxins, such as pesticides, heavy metals, and other potential exposures with special attention to protecting children, pregnant persons, elderly, and other more susceptible populations.
- Supports the inclusion of clinicians on boards and commissions making decisions on acceptable levels of toxins, pesticides, heavy metals, and other potential exposures that may impact the health of North Carolinians.
- Supports the collaborative efforts of federal, state, and local officials to improve air quality and to strengthen air pollution abatement standards.
- Supports all coastal and inland water quality monitoring activities of federal, state, and local officials, including the North Carolina Department of Environmental Quality, to keep North Carolina water clean, drinkable, and safe.
- Supports and agrees with scientific consensus on the detrimental impacts of climate change and endorses efforts to mitigate the impact of climate change on the health of communities in North Carolina.
- Supports increased sustainability, recycling, and proper disposal of hazardous materials, with emphasis on the health care industry. These sustainable actions include encouraging the use of recyclable and reusable products in lieu of substances shown to be deleterious to the environment.
- Supports additional training and education for medical students and residents in understanding how environmental toxins may impact health.
- Supports limiting the environmental exposures from chemical producing manufacturing facilities and waste disposal facilities. NCMS acknowledges the disproportionately severe impact these facilities have on historically marginalized communities, especially those in low-income areas, and supports the promotion of environmental justice for all North Carolinians.

(*Affirmed, Board Report- 2024, adopted 11/2/2025*)

ETHICS & PROFESSIONALISM

Health Facility Ownership by a Physician

RESOLVED, That the North Carolina Medical Society supports the American Medical Association Council on Ethical and Judicial Affairs' Code of Medical Ethics Opinion 9.6.9: Physician Self-Referral;

Code of Medical Ethics Opinion 9.6.9: Physician Self-Referral

Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients' medical interests can be in tension with physicians' financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility. Physicians who enter into legally permissible contractual relationship — including acquisition of ownership or investment interests in health facilities, products or equipment; or contracts for service in group practices — are expected to uphold their responsibilities to patients first. When physicians enter into arrangements that provide opportunities for self-referral they must:

(a) Ensure that referrals are based on objective, medically relevant criteria.

(b) Ensure that the arrangement:

1. Is structured to enhance access to appropriate, high-quality health care services or products.
2. Is within the constraints or applicable law.
3. Does not require physician-owners/investor to make referrals to the entity or otherwise generate revenues as a condition of participation.
4. Does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services.
5. Adheres to fair business practices vis-á-vis the medical professional community — for example, by ensuring that the arrangement does not prohibit investment by non-referring physicians.

(c) Take steps to mitigate conflicts of interest, including:

1. Ensuring that financial benefit is not dependent on the physician-owner/investor's volume of referrals for services or sales of products.
2. Establishing mechanisms for utilization review to monitor referral practices.
3. Identifying, or if possible making alternate arrangements for, care of the patient when conflicts cannot be appropriately managed/mitigated.

(d) Disclose their financial interest in the facility, product or equipment to patients; inform them of available alternatives for referral; and assure theme that their ongoing care is not conditioned on accepting the recommended referral.

(Report B-1992, adopted 11/8/1992)
(revised Report H-2002, adopted 11/17/2002)
(revised, Report N-2008, Item 3-2, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 73, adopted 10/26/2013)
(technical correction, Board Report-2019, Item 2-36, adopted July 27, 2019)

Physician-Assisted Suicide

RESOLVED, That the North Carolina Medical Society supports educational programming to improve physician awareness of their patients' overwhelming need to be adequately and effectively relieved of the physical and psychological pain that can accompany terminal and incurable illness; and be it further

RESOLVED, That the North Carolina Medical Society opposes physician-assisted suicide.

(Substitute Report PP-1992, adopted 11/8/92)
(reaffirmed, Report H-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-47, adopted 10/18/2008)
(reaffirmed, Reaffirmation Report-2013, Item 7, adopted 10/26/2013)

Position on Gifts to Physicians and Physician Assistants from Industry

The North Carolina Medical Society supports the Council on Ethical and Judicial Affairs of the American Medical Association's ethical opinion 9.6.2 – Gifts to Physicians from Industry .

The North Carolina Medical Society supports the American Academy of Physician Assistants' Guidelines for Ethical Conduct for the PA Profession .

The North Carolina Medical Society also supports efforts by physicians and physician assistants to carefully reflect on, examine, and manage their relationships with representatives from pharmaceutical, biotechnology, and medical device companies so as to avoid the creation and/or appearance of any undue influence or bias.

(Report EE-1991, adopted 11/9/1991)
(revised, Report U-2001, Item 30, adopted 11/11/2001)
(revised, Report R-2007, Item 3-5, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-4, adopted 10/27/2012)
(revised, NCMS Board Report, adopted 5/15/2021)

Professional Services for Immediate Family Members

RESOLVED, That the North Carolina Medical Society supports the North Carolina Medical Board position statement "Self-Treatment and Treatment of Family Members and Others with Whom Significant Emotional Relationships Exist" as amended in September 2005.

(Report Z-1988, adopted 5/7/88)
(revised, Report MM-1998, Item 20, adopted 11/15/98)
(revised, Report L1-2004, Item 9, adopted 11/14/2004)
(revised, Report I-2009, Item 3-5, adopted 11/01/2009) (reaffirmed, NCMS Policy Review Report, Item 8, adopted 10/24/2015)

Professionalism

RESOLVED, That the North Carolina Medical Society supports the fundamental principles and the set of professional responsibilities articulated in the 2004 American Board of Internal Medicine/American College of Physician Foundation statement, *Medical Professionalism in the New Millennium, A Physician Charter* :

The fundamental principles of medical professionalism are:

- Primacy of patient welfare;
- Patient autonomy;
- Social justice.

The set of responsibilities are commitments to:

- Professional competence;
- Honesty with patients;
- Patient confidentiality;
- Maintaining appropriate relations with patients;
- Improving quality of care;
- Improving access to care;
- A just distribution of finite resources;
- Scientific knowledge;
- Maintaining trust by managing conflicts of interest; and
- Professional responsibilities;

(Report C-2007, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-6, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 42, adopted 11/3/2018)

Professionalism in the Use of Social Media

1. The North Carolina Medical Society supports physician participation in social networking and other similar Internet opportunities that create avenues for personal expression, enable individual physicians to have a professional presence online, foster

collegiality and camaraderie within the profession, and provide opportunity to widely disseminate public health messages.

2. The North Carolina Medical Society supports the use of social networking by physicians, provided that such activity follows certain standards:
    - Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.
    - When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, contents posted about them by others, is accurate and appropriate.
    - If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just as they would in any other context.
    - To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.
    - When physicians see content posted by colleagues that is obviously unprofessional, such as the disclosure of identifiable patient information or displays that undermine societal trust in the profession of medicine, they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to appropriate authorities.
    - Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession.

(Report F-2011, adopted as amended, 10/23/2011)
(reaffirmed, Board Report-2018, Item 43, adopted 11/3/2018)

Sale of Products from Physicians' Offices

RESOLVED, That the North Carolina Medical Society opposes the sale of non-health related products by physicians' offices; and be it further

RESOLVED, That the North Carolina Medical Society opposes the sale of health-related products except in limited circumstances. The in-office sale of health-related products by physicians presents a financial conflict of interest, risks placing undue pressure on the patients, and threatens to erode patient trust and the primary obligation of physicians to serve the interests of their patients before their own. The sale of practice-related health items (such as ointments, creams, and lotions by dermatologists; splints and appliances by orthopedists; eye glasses by

ophthalmologists; etc.), however, may be acceptable provided: (1) the patient is informed about the availability of those items, or generically similar items, from other sources; (2) the health-related products have some scientific validity as demonstrated in peer-reviewed literature and other unbiased scientific sources; and (3) the charges for such items are reasonable and the nature of the financial arrangement with the manufacturer or supplier is disclosed; and be it further

RESOLVED, That the North Carolina Medical Society opposes physician participation in exclusive distributorships and/or personal branding, due to the potential for patient exploitation.

(Substitute Resolution 21-1999, adopted 11/14/99)
(revised, Report C-2005, Item 10, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-34, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 44, adopted 10/24/2015)

Sexual Misconduct in the Practice of Medicine

RESOLVED, That the North Carolina Medical Society supports the position of the North Carolina Medical Board on Sexual Exploitation of Patients as amended in 2012.

(Report M-1992, adopted 11/8/92)
(revised, Report H-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-3, adopted 10/19/2008)
(revised, Report G-2013, Item 1-4, adopted 10/26/2013)

FIREARMS

Firearms

The North Carolina Medical Society (NCMS) recognizes firearm injury as a public health crisis, that requires a community-aligned approach of public policy and practice to successfully address. The need for effective measures, evidence-based data, and public education and awareness, is imperative to mitigate the injury and death caused by firearms.

The North Carolina Medical Society supports measures and actions to improve firearm safety and education, reduce firearm morbidity and mortality, and increase access to needed supports and services for people in North Carolina.
Therefore, the North Carolina Medical Society:

1. Supports the role and training of the clinician in preventing firearm injury and promoting firearm safety.

2. Supports community awareness campaigns and educational programs aimed at firearm owners, especially those with children or at-risk individuals in the home, about the importance of safe storage, safe use, and the efficacy of firearm safety locks in decreasing intended or unintended firearm-related injuries or death.

3. Supports the enforcement of safe storage and firearm safety lock requirements for firearm owners, as well as the implementation of statewide storage options outside of the home for firearm owners with children or at-risk factors.

4. Supports state funding and implementation of comprehensive, multidisciplinary violence prevention and intervention and/or mitigation programs, developed with community input and considerations.

5. Supports a statewide education and awareness campaign, including increased availability of behavioral health services, centered on firearm-related suicide prevention for all ages.

6. Supports the rights of health care organizations/facilities/practices to enhance the safety of all persons onsite through the enactment of policies that restrict or prohibit firearms on the premises.

7. Supports the enactment of legislation and policy that allows for the temporary removal of firearms from persons at risk of harming themselves or others.

8. Supports strengthening efforts and enforcement to regulate the sale or transfer of guns through permitting and universal background checks.

9. Supports restrictions on the sale of high-capacity magazines and a full ban on the unauthorized creation of 3D printed firearms and firearm components.

10. Supports engineering changes to improve public safety (such as trigger locks, trigger cables, and safe storage options).

11. Supports evidence-driven research and reporting to further inform future firearm safety and education, and violence prevention initiatives.

(Adopted 11/4/2023)

HEALTH EQUITY

Health Equity

The North Carolina Medical Society supports the achievement of health equity across all populations regardless of race and ethnicity, sex, gender identity, sexual orientation, age, income, class, disability, health, immigration status, nationality, religious beliefs, language proficiency, or geographic location.

The North Carolina Medical Society supports the elimination of structural racism and all forms of structural discrimination whether overt or unconscious that thwart the achievement of health equity.

The North Carolina Medical Society supports efforts to work across health care and other sectors to achieve the goals outlined in the NCIOM Health NC 2030 Task Force Report .

(NCMS Board Report, adopted 11/7/2020)

HEALTH INFORMATION TECHNOLOGY (HIT)

Electronic Health Information

RESOLVED, That the North Carolina Medical Society supports efforts to facilitate the development, adoption, and meaningful use of interoperable electronic health records with appropriate privacy and security safeguards to ensure that patients' protected health information is not compromised.

(Report FF-1997, adopted 11/16/97)
(revised, Report L3-2004, Item 34, adopted 11/14/2004)
(revised, Report I-2009, Item 3-16, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 62, adopted 10/25/2014)

Support Standardized Communication Technology by MCOs and Insurers

RESOLVED, That the North Carolina Medical Society supports the development of uniform communication, data exchange, and information systems applicable to all physicians and all insurers that are current, efficient, and physician office-friendly.

(Report S-1999, adopted 11/14/99)
(revised, Report C-2005, Item 46, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-19, adopted 10/24/2010)
(reaffirmed, Board Report-2018, Item 44, adopted 11/3/2018)

Electronic Health Records

RESOLVED, That the North Carolina Medical Society supports financial incentives and other initiatives to assist physicians in their compliance with mandatory electronic health records requirements.

(Resolution 5-2005, adopted as amended, 10/16/2005)
(reaffirmed, Report J-2010, Item 2-15, adopted 10/24/2010)
(reaffirmed, Board Report-2018, Item 45, adopted 11/3/2018)

Electronic Health Records Triggered Audits

RESOLVED, that the North Carolina Medical Society supports reporting of excessive payment audits of electronic health record users by health plans to NCMS.

(Resolution 6-2006, substitute resolution adopted with title change, 10/28/2006)
(reaffirmed, Report H-2011, Item 3-1, 10/23/2011)
(reaffirmed, Board Report-2018, Item 46, adopted 11/3/2018)

HEALTH SAVINGS ACCOUNTS

Tax-Free Individual Medical Accounts

RESOLVED, That the North Carolina Medical Society supports the development of methods, such as tax-free individual medical accounts intended (1) to provide incentives for individual cost containment, (2) to increase access to health care, and (3) to allow patients to choose their health care providers.

(Resolution 5-1993, adopted as amended 11/7/93)
(revised, Report H-2003, Item 3 #2, adopted as amended 11/16/03)
(reaffirmed, Report I-2009, Item 2-45, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 63, adopted 10/25/2014)

Health Savings Accounts

RESOLVED, That the North Carolina Medical Society supports the education of its members about the availability of Health Savings Accounts; and be it further

RESOLVED, That the North Carolina Medical Society supports Health Savings Accounts.

(Substitute Resolution 12-1995, adopted 11/12/95)
(revised, Report L2-2004, Item 9, adopted 11/14/2004)
(reaffirmed, Report J-2010, Item 2-24, adopted 10/24/2010)
(technical corrections, Board Report-2018, Item 48, adopted 11/3/2018)

Health Care Savings Accounts

RESOLVED, That the North Carolina Medical Society supports the education of its members about the availability of Health Savings Accounts; and be it further

RESOLVED, That the North Carolina Medical Society supports establishment of Health Savings Accounts as an option for personal health care financing.

(Report M-2006, adopted as amended 10/29/2006)
(revised, Report I-2009, Item 3-24, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 64, adopted 10/25/2014)

IMMUNIZATION

Insurance Coverage for Immunizations

RESOLVED, That the North Carolina Medical Society supports requirements for health plans to provide full coverage and reimbursement for all vaccines recommended by the CDC's Advisory

Committee on Immunization Practices, including reimbursement for both the vaccine product and appropriate administration fees.

(Resolution 15-2001, adopted as amended 11/11/2001)
(revised, Report R-2007, Item 3-40, adopted 10/21/2007)
(reaffirmed, Report I-2009, Item 2-35, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 65, adopted 10/25/2014)

College Student Immunizations

RESOLVED, That the North Carolina Medical Society supports immunization requirements for all students in four-year colleges and universities, including immunizations recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunizations Practices.

(Resolution 41-1998, adopted 11/15/98)
(revised, Report L3-2004, Item 1, adopted 11/14/2004)
(revised, Report I-2009, Item 3-37, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 66, adopted 10/25/2014)

Senior Citizen Immunization

RESOLVED, That the North Carolina Medical Society supports efforts to provide senior citizens with access to all vaccines recommended for adults by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

(Report Q-1996, adopted 11/17/96)
(revised, Report L1-2004, Item 57, adopted 11/14/2004)
(revised, Report I-2009, Item 3-38, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 67, adopted 10/25/2014)

Universal Childhood Vaccine Distribution Program (UCVDP)

RESOLVED, That the North Carolina Medical Society supports routine immunization of children through the reinstatement of the Universal Childhood Vaccine Distribution Program (UCVDP), which provided state-purchased, required vaccines at no cost to all public and private health care providers for all children from birth through eighteen (18) years of age and expansion of the UCVDP to include all vaccines recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices.

(Resolution 4-1996, adopted 11/17/96)
(revised, Report N-2008, Item 3-43, adopted 10/19/2008)
(revised, Report I-2009, Item 3-36, adopted 11/01/2009) (revised, Report F-2014, Item 2, adopted 10/25/2014)

Immunization Registry

RESOLVED, That the North Carolina Medical Society supports the electronic availability of immunization records through the North Carolina Immunization Registry and initiatives to facilitate the exchange of this information to improve immunization rates.

(Resolution 5-1996, adopted as amended 11/17/96)
(revised, Report L2-2004, Item 33, adopted 11/14/2004)
(revised, Report I-2009, Item 3-39, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 68, adopted 10/25/2014)

Influenza (Flu) Vaccine

RESOLVED, That the North Carolina Medical Society supports the distribution of influenza vaccine on a priority basis to physician offices and local health departments to assure high-risk patients are provided vaccinations.

(Resolution 6-2005, adopted as amended, 10/16/2005)
(reaffirmed, Report I-2009, Item 2-78, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 69, adopted 10/25/2014)

LABORATORY SERVICES

Referrals for Laboratory Services

RESOLVED, That the North Carolina Medical Society supports the position that a physician should be able to utilize lab services from a physician office lab, private pathologists' lab or hospital lab that meets approved lab accreditation standards and is capable of providing quality, cost-efficient lab services.

(Report X-1997, adopted as amended 11/16/97)
(revised, Report L1-2004, Item 14, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-29, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 45, adopted 10/24/2015)

LONG-TERM CARE

Prescribing Regulations in Long-Term Care

RESOLVED, That the North Carolina Medical Society supports timely access to appropriate care for long-term care residents without imposing unreasonable expectations on clinicians providing that care.

(Resolution 8-2009, adopted, 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 46, adopted 10/24/2015)

Enhance Availability of Nursing Home Beds

RESOLVED, That the North Carolina Medical Society supports the development and maintenance of a health planning process that will ensure availability of nursing home beds that fully meets the needs of North Carolinians.

(Report HH-1989, adopted 11/11/1989)
(revised, Report L-1999, Item 12, adopted 11/14/1999)
(revised, Report R-2006, Item 47, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-50, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 49, adopted 11/3/2018)

Long-Term Care

RESOLVED, That the North Carolina Medical Society supports efforts to develop a system of public and private programs to efficiently address the long term care needs of the citizens of North Carolina; and be it further

RESOLVED, That the North Carolina Medical Society supports the employment of North Carolina licensed physicians as medical directors in all long-term care facilities in North Carolina; and be it further

RESOLVED, That the North Carolina Medical Society supports formal and structured training for personal aides in domiciliary facilities that would include but not be limited to correct and appropriate procedures for administering medications and caring for patients with emotional, mental and physical disabilities, and the use of physical restraints; and be it further

RESOLVED, That the North Carolina Medical Society supports evidence-based treatment for patient behavioral intervention in long term care facilities that does not involve seclusion and limits the use of physical restraints while ensuring safety of all residents and staff.

(Report FF-1996, adopted as amended 11/17/96)
(revised, Report L3-2004, Item 20, adopted 11/14/2004)
(revised, Report I-2009, Item 3-31, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 47, adopted 10/24/2015)

MATERNAL AND INFANT HEALTH

Midwifery and Home Deliveries

RESOLVED, That the North Carolina Medical Society opposes home deliveries, and be it further

RESOLVED, That the North Carolina Medical Society opposes the practice of midwifery by persons not licensed in North Carolina as a physician, physician assistant or certified nurse midwife.

(Report E-1977, adopted 5/7/77)
(reaffirmed, Report II-1988, Item 12, adopted 5/7/88)
(revised Report MM-1998, Item 18, adopted 11/15/98)
(revised, Report R-2006, Item 39, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-13, adopted 10/23/2011)
(reaffirmed, Board Report – Maternal & Infant Health Workgroup Recommendations, adopted 8/24/2020)

Maternal and Infant Health

The North Carolina Medical Society supports the following areas of focus [1] to improve maternal and infant health:

Developing a Risk Appropriate Regional Perinatal System of Care

- Promote the adoption of national maternal and infant risk-appropriate level of care standards
- Encourage use of multi-disciplinary assessment teams to utilize the CDC Levels of Care Assessment Tool to assist facilities in establishing self-identified maternal and neonatal levels of care
- Support required external verification of birthing facilities' maternal and neonatal level of care designations
- Encourage re-establishment of North Carolina's perinatal and neonatal outreach coordinator program
- Support outpatient risk-appropriate perinatal system of care

Ensuring Access to Perinatal Care

- Ensure access to comprehensive prenatal care for women ineligible for Medicaid
- Support efforts to extend coverage for group prenatal care and doula support
- Ensure that all pregnant women and high-risk infants have access to the appropriate level of care through a well-established regional perinatal system
- Promote increased utilization and completion percentages of childbirth education classes
- Encourage clinicians providing perinatal care to practice in rural areas of the State
- Support efforts to ensure the availability of obstetrical care by family medicine physicians and obstetricians, the continuation of obstetrical training in family medicine programs, and statewide access to quality and cost-effective obstetrical care
- Encourage standardized screening and treatment for perinatal mental health and substance use
- Support expanded perinatal access to mental health services

Promoting Patient-Centered and Evidence-Based Perinatal Care

- Expand the use of evidence-based clinical standards and models of prenatal care
- Support efforts to improve access to and utilization of first trimester prenatal care.

- Promote care coordination/case management/home visiting services that includes promotion of resiliency, mental health screening, substance use intervention, tobacco cessation and prevention, reproductive life planning, chronic disease management, perinatal mood disorders and access to health care
- Promote the provision of evidence-based culturally competent patient education and anticipatory guidance
- Support activities and programs that promote healthy behaviors including activities that prevent smoking initiation and promote smoking cessation and programs that promote healthy diet and physical activity during pregnancy
- Encourage efforts to increase the quality and frequency of risk assessment at the postpartum clinic visit

Promoting Perinatal Care Quality Improvement

- Encourage data collection on outcomes and quality improvement efforts that address racial and ethnic disparities in care
- Support the review of all pregnancy-related deaths in North Carolina on an annual basis to discover ways to reduce or prevent such deaths
- Support birthing facilities in quality improvement efforts to address racial and ethnic disparities in care
- Support patient and family advisory councils in quality improvement efforts related to maternal-fetal health
- Support education of health care providers and community health workers on the implications of racism and bias on perinatal health
- Support the linkage of clinically significant maternal prenatal testing results to neonatal health information reports for epidemiological and outcomes analysis with full protection of patient privacy and confidentiality

Enhancing Services and Supports

- Encourage alignment of perinatal care regional maps with Medicaid transformation maps
- Support parent navigator programs in birthing facilities
- Use community health workers to support families in their communities
- Encourage family-friendly workplace policies including paid parental and sick leave policies
- Encourage the use of evidence-based strategies to promote healthy family relationships, promote parenting and co-parenting skills, and include parents and partners in preconception, prenatal, and interconception services
- Promote access to comprehensive breastfeeding support services including medical lactation services
- Support evidence-based practices for patient education that encourages breastfeeding.
- Support policies and programs that decrease barriers to breastfeeding
- Promote affordable, available, and accessible high-quality childcare
- Promote access to and utilization of immunization according to the CDC's Advisory Committee on Immunization Practices guidelines

[1] Several of the policy statements contained herein are consistent with recommendations from the North Carolina Institute of Medicine Perinatal System of Care Task Force Report and the North Carolina Division of Public Health's 2016-2020 Perinatal Health Strategic Plan.

(NCMS Board Report-Maternal and Infant Health Workgroup Recommendations, adopted 8/24/2020)

Preconception and Reproductive Health Education to Women and Men

The North Carolina Medical Society supports the following areas of focus to improve and promote preconception and reproductive health education to women and men:

- Support efforts to integrate the use of evidence-based and evidence-informed preconception health care curricula with adolescent and young adult populations in educational and community settings and into primary care for people of reproductive age
- Promote reproductive life planning
- Support efforts to ensure healthy pregnancy intervals through access to effective methods of contraception, including increased access to Long-Acting Reversible Contraception
- Support efforts and programs of the State of North Carolina to reduce incidence of adolescent pregnancy

(NCMS Board Report – Maternal and Infant Health Workgroup Recommendations, adopted 8/24/2020)

MEDICAL EDUCATION

Approved Education Programs, Postgraduate Training Programs, and Board Certification

RESOLVED, That the North Carolina Medical Society supports the exclusive recognition of education programs approved by the Liaison Committee on Medical Education (LCME) and the American Osteopathic Association (AOA) postgraduate training programs approved by the Accreditation Council for Graduate Medical Education, the AOA, the Royal College of Physicians and Surgeons of Canada (RCPSC), and the College of Family Physicians of Canada (CFPC); and board certification through the American Board of Medical Specialties and the AOA.

(Resolution 5-2001, adopted 11/11/2001)
(revised, Report R-2007, Item 3-4, adopted 10/21/2007) (reaffirmed, NCMS Policy Review Report, Item 10, adopted 10/24/2015)

Tax Deduction on Education Loans

RESOLVED, That the North Carolina Medical Society supports the concept that interest on student loans be made a deductible item from personal income taxes; and be it further

RESOLVED, That the North Carolina Medical Society support legislation in the United States Congress and the North Carolina General Assembly that favorably addresses the concept of tax deductibility of interest on education loans.

(Resolution 27-1990, adopted 11/10/90)
(reaffirmed, Report Q-2000, Item 7, adopted 11/12/00)
(revised, Report R-2006, Item 53, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-37, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 50, adopted 11/3/2018)

Physicians as Preceptors in Ambulatory Care Education of Medical Students

RESOLVED, That the North Carolina Medical Society supports physician preceptors in the ambulatory care education of medical students and promotes reimbursement for preceptor services.

(Report E-1992, adopted 11/8/92)
(reaffirmed, Report H-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-30, adopted 10/19/2008) (reaffirmed, NCMS Policy Review Report, Item 11, adopted 10/24/2015)

Area Health Education Centers Ambulatory-Based Medical Education Efforts

RESOLVED, That the North Carolina Medical Society support adequate funding for Area Health Education Centers for its ambulatory-based medical education efforts.

(Report F-1992, adopted 11/8/92)
(revised, Report H-2002, adopted 11/17/02)
(reaffirmed, Report N-2008, Item 2-14, adopted 10/19/2008) (reaffirmed, NCMS Policy Review Report, Item 12, adopted 10/24/2015)

Support of Medical Students and Residents in Community-Based Ambulatory Settings

RESOLVED, That the North Carolina Medical Society supports and encourages physician participation in the teaching of medical students and residents in community-based ambulatory settings as part of the medical school curriculum.

(Report P-1991, adopted 11/9/1991)
(reaffirmed, Report U-2001, Item 4, adopted 11/11/2001)
(revised, Report R-2007, Item 3-20, adopted 10/21/2007) (reaffirmed, NCMS Policy Review Report, Item 13, adopted 10/24/2015)

Continuing Medical Education Requirements

RESOLVED, That the North Carolina Medical Society supports the continuing medical education requirements contained in the North Carolina Medical Board regulations.

(Report V-2001, adopted 11/11/01)
(revised, Report L1-2004, Item 22, adopted 11/14/2004)
(reaffirmed, Reaffirmation Report-2013, Item 25, adopted 10/26/2013)

Continuing Medical Education for Limited Scope Practitioners

RESOLVED, That the North Carolina Medical Society supports North Carolina medical schools and other entities certifying continuing medical education, in restricting certification to perform procedures that are the subject of a continuing medical education course to health care professionals who are licensed or otherwise authorized by North Carolina law to perform the procedure.

(Report Y-1999, adopted 9/24/2000 by Executive Council, referred for action by HOD)
(revised, Report R-2006, Item 63, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-12, adopted 10/23/2011)

Initial Residency Period and Limitations on Residency Slots

RESOLVED, That the North Carolina Medical Society supports adequate funding for post-graduate medical education, which should include sufficient flexibility in funding to permit residents who wish to change careers to be funded through the end of their new training program.

(Substitute Resolution 3-1999, adopted as amended 11/14/99)
(revised, Report C-2005, Item 51, adopted 10/16/2005) (reaffirmed, NCMS Policy Review 2015 Report, Item 14, adopted 10/24/2015)

Participation in Organized Medicine Conferences for Postgraduate Medical Education Residents in North Carolina

RESOLVED, That the North Carolina Medical Society supports the practice of resident physicians attending conferences sponsored by organized medicine, including North Carolina Medical Society and American Medical Association activities; and be it further

RESOLVED, That the North Carolina Medical Society supports seeking external funding sources for such conferences.

(Substitute Report U-1998, adopted as amended 11/15/98)
(revised, Report L1-2004, Item 17, adopted 11/14/2004) (reaffirmed, NCMS Policy Review 2015 Report, Item 15, adopted 10/24/2015)

Diversity in Medical Education

RESOLVED, That the North Carolina Medical Society supports efforts to increase physician workforce diversity, including opportunities in education.

(Resolution 23-1997, adopted as amended 11/16/97)
(amended by addition of third resolve, Report V-1998, adopted 11/15/98)
(revised, Report L1-2004, Item 18, adopted 11/14/2004)
(reaffirmed, NCMS Policy Review 2015 Report, Item 16, adopted 10/24/2015)

Role of North Carolina Medical Society in Accrediting Programs for Continuing Medical Education

RESOLVED, That the North Carolina Medical Society supports maintaining its status with the Accreditation Council for Continuing Medical Education (ACCME) as an organization approved to accredit sponsors of intrastate continuing medical education programs in North Carolina; and be it further

RESOLVED, That the North Carolina Medical Society supports the "Essentials and Guidelines" of the ACCME as a statement of basic criteria to be met by organizations/institutions applying for accreditation through the North Carolina Medical Society; and be it further

RESOLVED, That the North Carolina Medical Society supports the use of the "Accreditation Manual for Continuing Medical Education Activities in North Carolina" to be used with the above cited in conjunction with the "Essentials and Guidelines" in the continuing medical education accreditation program of the Medical Education Committee, and that the Medical Education Committee be authorized to make modifications in these documents as necessary to the continued successful implementation of the accreditation program; and be it further

RESOLVED, That the Medical Education Committee be authorized to:

1. Accept the report of a continuing medical education accreditation survey team.
2. Determine whether an accreditation applicant fulfills the criteria for accreditation as a provider of CME.
3. Transmit this decision, over the signature of the Designee of the NCMS, to the Accreditation Council for Continuing Medical Education.
4. Inform the applicant organization, over the same signature, of the action of the Medical Education Committee as approved by the Board of Directors on behalf of the North Carolina Medical Society.
5. Provide those accredited with an appropriate certificate, signed by the President of the North Carolina Medical Society and the Chair of the Medical Education Committee, attesting to the applicant's accreditation status.

(Resolution 12-1975, adopted 5/3/75) (revised, Report II-1988, Item 21, adopted 5/7/88) (revised, Report MM-1998, Item 41, adopted 11/15/98)
(revised, Report L1-2004, Item 20, adopted 11/14/2004) (revised, NCMS Policy Review 2015 Report, Item 1, adopted 10/24/2015)

Medical Student Financial Assistance

RESOLVED, That the North Carolina Medical Society in conjunction with the American Medical Association and the Medical Student Section support programs that provide need-based student debt relief opportunities.

(Resolution 13-1971, adopted 5/18/71)
(revised, Report T-1987, Item 12, adopted 5/2/87)
(revised, Report II-1988, Item 24, adopted 5/7/88)
(reaffirmed, Report MM-1998, Item 44, adopted 11/15/98)
(revised, Report L1-2004, adopted 11/14/2004) (revised, NCMS Policy Review 2015 Report, Item 2, adopted 10/24/2015)

Community Practice Physicians on Admitting Committees or Boards of Medical Schools

RESOLVED, That the North Carolina Medical Society supports including community practice physicians on Admitting Committees or Boards of North Carolina Medical Schools.

(Report G-1973, adopted 5/22/73)
(reaffirmed, Report T-1987, Item 10, adopted 5/2/87)
(amended, Report OO-1997, Item 20, adopted 11/16/97)
(revised, Report L1-2004, Item 21, adopted 11/14/2004) (reaffirmed, NCMS Policy Review 2015 Report, Item 18, adopted 10/24/2015)

Innovative Prevention and Health Promotion Continuing Medical Education (CME) Programs

RESOLVED, That the North Carolina Medical Society supports the development and promotion of methods that will enable medical practices to engage in more effective and efficient health promotion, prevention, and patient self-management efforts with their patient populations; and be it further

RESOLVED, That the North Carolina Medical Society and North Carolina Medical Society Foundation supports the development of innovative CME programs to help physicians learn effective and efficient strategies for promoting preventive care and the integration of self-management as a key component of performance improvement.

(Report CC-1996, adopted as amended 11/17/96)
(revised, Report L1-2004, Item 19, adopted 11/14/2004) (revised, NCMS Policy Review 2015 Report, Item 3, adopted 10/24/2015)

Support for Community-Based Medical Education

RESOLVED, That the North Carolina Medical Society, in recognition of the need for more primary care physicians, supports the State's schools of medicine and osteopathy the NC Area

Health Education Centers Program (AHEC) in promoting community-based medical education; and be it further

RESOLVED, That the North Carolina Medical Society supports individual member involvement in community-based medical education by serving as preceptors for medical students training in their communities.

(Report P-1995, adopted 11/12/95)
(revised, Report L1-2004, Item 23, adopted 11/14/2004) (revised, NCMS Policy Review 2015 Report, Item 4, adopted 10/24/2015)

CME Financing

RESOLVED, That the North Carolina Medical Society supports full and detailed written financial disclosure by physicians, faculty, or program organizers of all income related to continuing medical education (CME) activities at the specific time of that activity, including compensation in any form, honoraria, or profits for hosts, businesses, individuals, professional organizations, professional boards, or regulatory boards.

(Report G-2007, adopted 10/21/2007) (reaffirmed, NCMS Policy Review 2015 Report, Item 20, adopted 10/24/2015) (revised, NCMS Policy Review 2015 Report, Item 5, adopted 10/24/2015)

Continuing Medical Education for the Treatment of Veterans

RESOLVED, That the North Carolina Medical Society supports voluntary continuing medical education to prepare physicians, physician assistants, and medical students to care for the unique issues our returning veterans and their families face.

(Resolution 1-2012, adopted as amended 10/27/2012)
(reaffirm, Board Report-2018, Item 51, adopted 11/3/2018)

MEDICAL EXAMINER

North Carolina Medical Examiner System

RESOLVED, That the North Carolina Medical Society supports ongoing participation and continuing education of North Carolina physicians in the medical examiner system; and be it further

RESOLVED, That the North Carolina Medical Society supports fees for medical examiner investigations and autopsies performed by physicians commensurate with the time and expertise involved.

(Resolution 29-1990, adopted 11/10/90)
(revised, Report Q-2000, Item 50, adopted 11/12/00)

(revised, Report R-2006, Item 28, adopted 10/29/2006)
(revised, Report I-2009, Item 3-49, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 48, adopted 10/24/2015)

MEDICAL RECORDS

Access to Shared Medical Information for Victims of Child Abuse and Juveniles in Protective Custody

RESOLVED, That the North Carolina Medical Society supports:

1. In the case of a disabled adult or juvenile under protective custody of the Department of Social Services, the release of medical and psychiatric records maintained by the Department of Social Services relative to that individual to the individual's primary care and/or treating physician.
2. In the case of a disabled adult or juvenile victim, the release of medical and psychiatric records that are necessary for the medical care of the individual to the individual's primary care and/or treating physician.

(Substitute Resolution 18-2001, adopted 11/11/2001)
(revised, Report R-2007, Item 3-21, adopted 10/21/2007)
(reaffirmed, Report I-2009, Item 2-18, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 49, adopted 10/24/2015)

Charges for Patient Record Information

RESOLVED, That the North Carolina Medical Society supports reasonable compensation to cover the costs of providing patient record information.

(Resolution 22-1990, adopted as amended 11/10/90)
(revised, Report Q-2000, Item 45, adopted 11/12/00)
(revised, Report R-2006, Item 7, adopted 10/29/2006)
(reaffirmed, Report I-2009, Item 2-19, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 50, adopted 10/24/2015)

MEDICARE / MEDICAID

Health Insurance for Immigrant Children and Pregnant Women

RESOLVED, That the North Carolina Medical Society supports the expansion of the State Children's Health Insurance Plan and Medicaid benefits to include legal immigrant children and pregnant women without a waiting period.

(Substitute Resolution 42-2000, adopted 11/12/00)
(revised, Report L2-2004, Item 5, adopted 11/14/2004)

(revised, Report J-2010, Item 3-16, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 51, adopted 10/24/2015)

Community Care of North Carolina Program and Medicaid

RESOLVED, That the North Carolina Medical Society supports the Community Care of North Carolina Program, which contracts with physicians to deliver and coordinate health care for Medicaid recipients; and be it further

RESOLVED, That the North Carolina Medical Society supports member participation in the Medicaid Program.

(Report M-1991, adopted 11/9/91)
(reaffirmed, Report U-2001, Item 3, adopted 11/11/01)
(revised, Report R-2007, Item 3-1, adopted 10/21/2007)
(revised, Report F-2012, Item 1-2, adopted 10/27/2012)
(technical correction, Board Report-2018, Item 52, adopted 11/3/2018)

Medicaid Coverage for Uninsured Workers

RESOLVED, That the North Carolina Medical Society supports appropriate funding of the Medicaid program to improve provider reimbursement and extend coverage to the working poor who are not currently eligible for Medicaid coverage or any other third-party health insurance.

(Resolution 12-1988, adopted 5/7/88)
(revised, Report MM-1998, Item 52, adopted 11/15/98)
(revised, Report L2-2004, Item 7, adopted 11/14/2004)
(revised, Report J-2010, Item 3-22, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 52, adopted 10/24/2015)

Dispense As Written

RESOLVED, That the North Carolina Medical Society supports elimination of the Medicaid requirement of writing by hand, “Dispense as Written” or “Brand Necessary,”on the face of prescriptions to prevent generic substitution.

(Substitute Resolution 22-1988, adopted as amended 5/7/88)
(revised, Report MM-1998, Item 53, adopted 11/15/98)
(revised, Report L3-2004, Item 30, adopted 11/14/2004)
(reaffirmed, Report J-2010, Item 2-14, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 53, adopted 10/24/2015)

Mental Health Benefits in Medicaid Programs

RESOLVED, That the North Carolina Medical Society supports inclusion of mental health benefits in all Medicaid programs.

(Report B-1997, adopted as amended 11/16/97)
(revised, Report L2-2004, Item 4, adopted 11/14/2004)
(reaffirmed, Report J-2010, Item 2-9, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 54, adopted 10/24/2015)

Medicaid Reimbursement for Children's Dental Services

RESOLVED, That the North Carolina Medical Society supports adequate Medicaid reimbursements for dental care services for the children of North Carolina.

(Resolution 6-1997, adopted as amended 11/16/97)
(revised, Report L2-2004, Item 10, adopted 11/14/2004)
(reaffirmed, Report J-2010, Item 2-8, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 55, adopted 10/24/2015)

Access to Pediatric and Obstetrical Care by Medicaid Patients

RESOLVED, That the North Carolina Medical Society supports NC Division of Medical Assistance impact studies to assess changes in Medicaid provider enrollment and patient access to pediatric and obstetrical care due to provider credentialing requirements.

(Resolution 4-1995, adopted as amended 11/12/95)
(revised, Report L2-2004, Item 1, adopted 11/14/2004)
(revised, Report J-2010, Item 3-23, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 56, adopted 10/24/2015)

Medicaid Coverage for Family Planning Services

RESOLVED, That the North Carolina Medical Society supports the extension of Medicaid coverage for family planning for two years postpartum to all women currently eligible for Medicaid during their pregnancies.

(Report Q-1994, adopted 11/6/94)
(revised, Report R-2007, Item 3-37, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-18, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 53, adopted 11/3/2018)

Assignment of Medicare Benefits

RESOLVED, That the North Carolina Medical Society supports the physician's right to accept or decline assignment of Medicare benefits from patients on a case-by-case basis.

(Resolution 11-1983, adopted 5/7/83)
(reaffirmed, Report FF-1993, Item 8, adopted 11/7/93)
(revised, Report H-2003, Item 3 #21, adopted as amended 11/16/03)
(revised, Report L3-2004, Item 36, adopted 11/14/2004)

(reaffirmed, Report I-2009, Item 2-22, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 70, adopted 10/25/2014)

Equitable Physician Payment

RESOLVED, That the North Carolina Medical Society supports Medicare physician payment reform based upon a Resource-Based Relative Value Scale (RBRVS); and be it further

RESOLVED, That the North Carolina Medical Society opposes any attempt by Centers for Medicare & Medicaid Services (CMS) to use volume offset assumptions to implement Medicare Physician Payment Reform; and be it further

RESOLVED, That the North Carolina Medical Society supports measures that would require an appeal mechanism for timely remedy of inaccuracies associated with implementation of RBRVS.

(Substitute Report D-1991, adopted as amended 11/9/91)
(revised, Report U-2001, Item 34, adopted 11/11/01)
(revised, Report L2-2004, Item 46, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-23, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 71, adopted 10/25/2014)

Medicare and Medicaid Practitioner Fees

RESOLVED, That the North Carolina Medical Society opposes any measure that would impose fees on licensed practitioners providing services to individuals enrolled in Medicare or Medicaid programs.

(Resolution 50-1998, adopted 11/15/98)
(revised, Report L3-2004, Item 35, adopted 11/14/2004)
(revised, Report I-2009, Item 3-65, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 72, adopted 10/25/2014)

Medicare and Medicaid Reimbursement Rates

RESOLVED, That the North Carolina Medical Society supports an adequate reimbursement rate for Medicare and Medicaid to promote equal access to health care for Medicare and Medicaid recipients.

(Substitute Report M-2001, adopted 11/11/2001)
(revised, Report R-2007, Item 3-35, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-19, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 54, adopted 11/3/2018)

Participation in Medicare and Medicaid

RESOLVED, That the North Carolina Medical Society opposes any legislation that requires mandatory participation of physicians in Medicare and Medicaid programs as a basis for licensure.

(Resolution 8-2001, adopted 11/11/01)
(revised, Report R-2007, Item 3-36, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-20, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 55, adopted 11/3/2018)

Recovery Audit Contractors

RESOLVED, That the North Carolina Medical Society opposes contingency fees as a basis for payment to Medicare and Medicaid Recovery Audit Contractors.

(Substitute Resolution 12-2013, adopted in lieu of Resolutions 9-2013 and 12-2013, 10/26/2013)
(reaffirmed, Board Report-2018, Item 56, adopted 11/3/2018)

MEDICO-LEGAL GUIDELINES

North Carolina Medico-Legal Guidelines

RESOLVED, That the North Carolina Medical Society supports the use and promotion of the North Carolina Medico-Legal Guidelines in partnership with the North Carolina Bar Association.

View the Medico-Legal Guidelines.

(Report O-2000, adopted 11/12/2000)
(revised, Report R-2006, Item 8, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-44, adopted 10/23/2011)
(technical correction, Board Report-2018, Item 57, adopted 11/3/2018)

MENTAL HEALTH

Suicide Prevention Among Youth

RESOLVED, that the North Carolina Medical Society supports statewide mandated educational sessions on suicide prevention for all children at an appropriate level of education, and the dissemination of outreach materials to parents outlining risk factors and resources for crisis assistance.

(Substitute Resolution 1-2005, adopted as amended 10/16/2005)
(reaffirmed, Report J-2010, Item 2-42, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 57, adopted 10/24/2015)

Mental Health Programs in Communities

RESOLVED, That the North Carolina Medical Society supports high quality public mental health programs at the state and local level.

(Report G-1983, adopted 5/7/83)
(reaffirmed, Report FF-1993, Item 9, adopted 11/7/93)
(revised, Report H-2003, Item 3 #30, adopted as amended 11/16/03)
(reaffirmed, Report R-2007, Item 2-5, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-42, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 58, adopted 11/3/2018)

Mental Health System Reform

RESOLVED, That the North Carolina Medical Society supports state and local mental health care system reforms that include appropriate program requirements for ongoing monitoring of patients' clinical outcomes and adequate physician input to ensure the provision of high-quality public mental health care; and be it further

RESOLVED, That the North Carolina Medical Society supports the inclusion of the following general principles in any mental health system reform effort:

1. Every individual with psychiatric symptoms has the right to a comprehensive evaluation and an accurate diagnosis, which leads to an appropriate, individualized plan of treatment.
2. Mental health care should be patient- and family-centered, community-based, culturally sensitive, and easily accessible without discriminatory administrative or financial barriers or obstacles.
3. Mental health care should be readily available for patients of all ages, with particular attention to the specialized needs of children, adolescents, and the elderly. Unmet needs of ethnic and racial minorities require urgent action.
4. Access to mental health care should be provided across numerous settings, including the workplace, schools, and correctional facilities. An emphasis should also be placed on the early recognition and treatment of mental illness.
5. Patients deserve to be treated with dignity and respect. They are entitled to choose their own physicians or community-based agencies and to make decisions regarding their care. When they are incapable of making these decisions, they should receive the treatment they need and when able, they should choose future care.
6. Patients deserve to receive care in the least restrictive, community-based setting possible that encourages maximum independence with access to a continuum of clinical services, including emergency/crisis, acute inpatient, outpatient, intermediate level, and long-term residential programs.
7. Since mental illness and substance abuse occur together so frequently, mental health care should be fully integrated with the treatment of substance use disorders, primary care and other general medical services.
8. Research must expand into the etiology and prevention of mental illness and into the ongoing development of safe and effective treatment interventions.

9. Efforts must be intensified to combat and overcome the stigma historically associated with mental illness through enhanced public understanding and awareness.
10. Health benefits, access to effective services, and utilization management must be the same for people with mental illness as for other medical illnesses, preferably funded by integrated financing systems.
11. Funding for care should be commensurate with the level of disability caused by a psychiatric illness.
12. Mental health treatment plans should include a cooperative relationship and communication between a patient's mental health and other health professional(s) to ensure the patient receives ongoing, appropriate treatment; and be it further

RESOLVED, That the North Carolina Medical Society supports sufficient allocation of resources to training an adequate supply of psychiatrists, especially child psychiatrists, to meet the current and future needs of the population.

(Substitute Resolution 6-2003, adopted 11/16/03)
(revised, Report R-2007, Item 3-28, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-43, adopted 10/27/2012)
(technical corrections, Board Report-2018, Item 59, adopted 11/3/2018)

Postpartum Depression

RESOLVED, That the North Carolina Medical Society supports awareness of physicians and other allied health professionals regarding screening, diagnosis, and management of postpartum depression.

(Substitute Resolution 10-2003, adopted as amended 11/16/03)
(revised, Report N-2008, Item 3-36, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 26, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 60, adopted 11/3/2018)

Child and Adolescent Psychiatric Inpatient Beds

RESOLVED, That the North Carolina Medical Society supports development of public child and adolescent inpatient psychiatric beds and facilities necessary to ensure adequate and sufficient services are available in the community; and be it further

RESOLVED, That the North Carolina Medical Society opposes the use of hospital emergency rooms as a substitute for adequate mental health treatment facilities.

(Substitute Resolution 19-2003, adopted 11/16/03)
(revised, Report R-2007, Item 3-30, adopted 10/21/2007)
(reafffirmed, Report F-2012, Item 3-44, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 61, adopted 11/3/2018)

Suicide Prevention Education for Health Professionals

RESOLVED, That the North Carolina Medical Society supports curriculum and continuing education requirements addressing depression and suicide for all health professionals.

(Resolution 20-2003, adopted as amended 11/16/03)
(revised, Report N-2008, Item 3-40, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 8, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 62, adopted 11/3/2018)

Mental Health Carve-Outs

RESOLVED, That the North Carolina Medical Society opposes efforts by third-party payers to subcontract or "carve out" the benefits for mental health and chemical dependency to ensure that these benefits are managed and administered like other health care services.

(Resolution 20-2001, adopted 11/11/2001)
(revised, Report R-2007, Item 3-44, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-45, adopted 10/27/2012)
(technical corrections, Board Report-2018), Item 63, adopted 11/3/2018)

Insurance Coverage – Psychiatric Services

RESOLVED, That the North Carolina Medical Society supports the provision of benefits for emotional and mental illness under all governmental and private insurance programs that are equivalent in scope and duration to those benefits provided for other medical or physical illnesses.

(Resolutions 10, 16, 19, 23-1983, adopted 5/7/83)
(reaffirmed, Report FF-1993, Item 10, adopted 11/7/93, and by Substitute Resolution 8-1999, adopted as amended 11/14/99)
(revised, Report C-2005, Item 50, adopted 10/16/2005)
(revised, Report J-2010, Item 3-5, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 58, adopted 10/24/2015)

Funding of Public Mental Health Programs

RESOLVED, That the North Carolina Medical Society supports adequate funding for high-quality mental health programs at the state and local level for all citizens.

(Resolution 9-1999, adopted as amended 11/14/99)
(revised, Report C-2005, Item 4, adopted 10/16/2005)
(revised, Report R-2007, Item 3-29, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-46, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 64, adopted 11/3/2018)

Mental Health Coverage for Youth

RESOLVED, That the North Carolina Medical Society supports provision of adequate mental health care access and reimbursement for children and youth.

(Resolution 14-1999, adopted as amended 11/14/99)
(revised, Report C-2005, Item 44, adopted 10/16/2005)
(reaffirmed, Report R-2007, Item 2-6, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-47, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 65, adopted 11/3/2018)

Early Psychiatric Discharge

RESOLVED, That the North Carolina Medical Society opposes early discharge of psychiatric patients who have been inadequately treated.

(Report I-1996, adopted 11/17/96)
(revised, Report L2-2004, Item 25, adopted 11/14/2004)
(reaffirmed, Report R-2007, Item 2-7, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-48, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 66, adopted 11/3/2018)

Suicide Prevention

RESOLVED, That the North Carolina Medical Society supports suicide prevention initiatives recognized by the National Suicide Prevention Resource Center as promising or evidence-based practices and promotes physician involvement in local initiatives; and be it further

RESOLVED, That the North Carolina Medical Society supports physician and public awareness of the resources available to identify and treat at-risk patients in order to prevent suicides and to assist families who have suffered losses due to suicide.

(Substitute Resolution 6-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-39, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 9, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 67, adopted 11/3/2018)

Payment for Psychiatric Treatment

RESOLVED, That the North Carolina Medical Society opposes the refusal by health plans to pay qualified physicians for treating patients with psychiatric diagnoses including but not limited to anxiety, depression, bipolar disorder, and attention deficit disorders without an authorization from the behavioral health management organizations; and be it further

RESOLVED, That the North Carolina Medical Society supports efforts to eliminate mandatory requirements for psychiatric referrals and to permit qualified physicians to evaluate and treat patients and be paid for psychiatric services.

(Substitute Resolution 10-2007, adopted in lieu of Resolution 10 10/21/2007)
(reaffirmed, Report F-2012, Item 3-39, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 68, adopted 11/3/2018)

Mental Health System Reform Principles — New Freedom Commission Report

That the North Carolina Medical Society supports consideration of the following principles in mental health reform efforts:

1. Focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.
2. Focus on community-level models of care that effectively coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.
3. Focus on those policies that maximize the utility of existing resources by increasing cost-effectiveness and reducing the unnecessary and burdensome regulatory barriers.
4. Consider how mental health research findings can be used most effectively to influence the delivery of services.
5. Follow the principles of Federalism, and ensure that recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of the States and Indian tribes.

(Report G-2009, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 73, adopted 10/25/2014)

Boarding of Individuals with Psychiatric Disorders

RESOLVED, That the North Carolina Medical Society opposes the prolonged emergency department admission, also known as boarding, of individuals with psychiatric disorders. Furthermore, the North Carolina Medical Society encourages the development of observation and crisis beds along with increased use of Telemedicine to evaluate patients more efficiently to obtain appropriate care. Patients who are being boarded should receive all appropriate care related to their condition(s).

(Resolution 6-2014, adopted 10/25/2014)
(technical correction, Board Report-2019, Page 5, Item 2-3, adopted 7/27/2019)

OPTOMETRY

Optometry Practice

RESOLVED, That the North Carolina Medical Society opposes inappropriate expansion of the scope of practice of optometrists.

(Resolution 18-1996, adopted as amended 11/17/96)
(revised, Report L3-2004, Item 39, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-67, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 77, adopted 10/25/2014)

ORGAN DONOR PROGRAMS

Organ Donation Awareness

RESOLVED, That the North Carolina Medical Society supports efforts of all businesses, organizations, and agencies to join the United States Department of Health and Human Services "Workplace Partnership for Life" program to create awareness among their employees of the need for voluntary organ, tissue, bone marrow, and blood donations; and be it further

RESOLVED, That the North Carolina Medical Society supports the North Carolina Donate for Life registry program and public and private efforts to encourage citizens to consider becoming organ, tissue, bone marrow, and blood donors.

(Resolution 2-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-27, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 10, adopted 10/26/2013)
(technical correction, Board Report-2018, Item 72, adopted 11/3/2018)

Human Tissue Donation

RESOLVED, That the North Carolina Medical Society supports public education concerning the need of making anatomical gifts to medical science; and be it further

RESOLVED, That the North Carolina Medical Society supports efforts to achieve maximal organ recovery; and be it further

RESOLVED, That the North Carolina Medical Society supports availability of organ donation registry methods and educational information in health care facilities; and be it further

RESOLVED, That the North Carolina Medical Society supports the efforts of appropriately accredited organ procurement agencies to recover human tissues, organs, and bodies to be used by transplanting surgeons, hospitals, and medical schools of the State.

(Report M-1973, adopted 5/22/73)
(revised, Report II-1988, Item 25, adopted 5/7/88)
(revised, Report MM-1998, Item 30, adopted 11/15/98)
(revised, Report L3-2004, Item 40, adopted 11/14/2004)
(revised, Report I-2009, Item 3-3, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 63, adopted 10/24/2015)

PATIENT CENTERED

TEAM-BASED CARE

The North Carolina Medical Society supports the following principles and actions to promote the adoption
and implementation of an effective and enhanced team-based care ecosystem:

I. Development of a Statement of Intent and Purpose
♦ Define the roles and responsibilities to meet the health needs and goals of people and populations to optimize performance through the collective training and competencies of team members
♦ Determination of team leadership that is versatile and accounts for the environment of care and the specific needs and goals of each patient or population
♦ Identify shared values and ethics among the interprofessional care team members
♦ Keep the patient at the center of the care team
♦ Develop a collaborative and coordinated process strategy that promotes patient success

II. Promotion of Interprofessional, Multidisciplinary Care
♦ Include shared decision-making with the patient and family/caregiver(s)
♦ Integrate behavioral, physical, oral, and social health
♦ Cultivate a collaborative environment with shared accountability
♦ Promote interoperability across sectors and geography

III. Workforce Preparation
♦ Incorporate the IPEC core competencies and NCICLE Focus Areas into workforce education and training
♦ Utilize a common language to foster universal understanding and effective communication among the interprofessional team
♦ Identify objective and reasonable metrics that translate across sectors for data consistency and efficacy
♦ Recruit and retain a diverse team that reflects the community in which the practice or organization serves

IV. Support Advanced Payment and Care Delivery Models
♦ Advocate for an equitable payment model that rewards high value, patient-centered care delivered and coordinated by a diverse team of care providers
♦ Encourage flexible coverage and access to care such as telehealth, remote patient monitoring, and other social and health innovations
♦ Amplify support and recommendations for administrative simplification to reduce patient barriers to timely coverage and care

V. Promote Public Awareness
♦ Provide public education that defines team-based care and introduces the various members and roles that may make up a team for health
♦ Uphold a common and consistent language

♦ Create a communication strategy that incorporates interpretative services and multiple outreach methods to ensure equitable and broad outreach
♦ Engage community partners
♦ Advocate for technology advancement to drive access and opportunity

(Approved by NCMS Board of Directors; Board Report 11/5/22)

PATIENT EDUCATION

Health Care Literacy

RESOLVED, That the North Carolina Medical Society supports efforts to improve health care literacy that improves patient understanding of treatment and health care plans.

(Resolution 10-2000, adopted as amended 11/12/00)
(revised, Report R-2006, Item 6, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-8, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 73, adopted 11/3/2018)

Patient Education

RESOLVED, That the North Carolina Medical Society supports incorporating appropriate patient medical education as an integral part of medical services, and that such services should be provided by or under the supervision of a physician and adequately documented in the medical record.

(Resolution 14-1975, adopted 5/3/75)
(revised, Report II-1988, Item 27, adopted 5/7/88)
(revised, Report MM-1998, Item 23, adopted 11/15/98)
(revised, Report L1-2004, Item 48, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-14, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 64, adopted 10/24/2015)

PHYSICIAN HEALTH

Physicians Health Program

RESOLVED, That the North Carolina Medical Society supports the efforts of the NC Physicians Health Program; and be it further

RESOLVED, That the North Carolina Medical Society supports the reporting of suspected impaired physicians to the North Carolina Physicians Health Program as being in the best interest of such physicians and the ethical responsibility of every physician.

(Report U-1988, adopted 5/7/88)
(revised Report MM-1998, Item 28, adopted 11/15/98)
(revised, Report L1-2004, Item 38, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-10, adopted 11/01/2009) (reaffirmed, NCMS Policy Review Report, Item 9, adopted 10/24/2015)

Physician Health and Wellness

RESOLVED, That the North Carolina Medical Society supports efforts that allow physicians to address their personal physical and mental health, including wellness issues.

(Report O-1992, adopted 11/8/92)
(revised Report H-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-31, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 11, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 74, adopted 11/3/2018)

Educating Medical Students about the North Carolina Physicians Health Program

RESOLVED, That the North Carolina Medical Society supports programs by the North Carolina Physician Health Program to educate medical students about the NC Physicians Health Program.

(Report K-1994, adopted 11/6/94)
(revised, Report L1-2004, Item 70, adopted 11/14/2004)
(reaffirmed, Reaffirmation Report-2013, Item 12, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 75, adopted 11/3/2018)

PHYSICIAN-HOSPITAL ISSUES

Conversion of Hospital or Medical Service Corporation

RESOLVED, That the North Carolina Medical Society opposes the conversion of any hospital service corporation or medical service corporation from not-for-profit status unless the corporation is required to transfer the fair market value of the ownership interest of that corporation to an irrevocable trusts held for the benefit of the health needs of the public.

(Emergency Resolution 1-1997, adopted as amended 11/16/97)
(revised, Report L3-2004, Item 15, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-68, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 65, adopted 10/24/2015)

Physician Background Checks

RESOLVED, That the North Carolina Medical Society supports the inclusion in the medical staff credentialing process of only those aspects of an applicant's personal background that relate to professional competence or to professional, criminal, or ethical misconduct, and be it further

RESOLVED, That the North Carolina Medical Society opposes any requirement that an applicant for medical staff privileges release credentialing bodies or background search firms from liability for negligent or intentional misuse of information attributed to the applicant, for failure to take reasonable steps to verify the accuracy of the findings, or for failure to safeguard the confidentiality of the information obtained.

(Report H-2010, adopted as amended 10/24/2010)
(technical corrections, Board Report-2018, Item 76, adopted 11/3/2018)

Hospital Diagnostic Related Group (DRG) Rates

RESOLVED, That the North Carolina Medical Society supports appropriate payment to hospitals under the federal DRG system.

(Resolution 18-1984, adopted 5/5/84)
(revised, Report CC-1994, Item 27, adopted 11/6/94)
(revised, Report L2-2004, Item 32, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-25, adopted 11/01/2009)
(reaffirmed, Board Report-2018, Item 77, adopted 11/3/2018)

Diagnostic Related Group (DRG) Certification Statement

RESOLVED, That the North Carolina Medical Society opposes the requirement that a medical doctor complete DRG certification statements.

(Resolution 32-1984, adopted 5/5/84)
(revised, Report CC-1994, Item 33, adopted 11/6/94)
(revised, Report L2-2004, Item 44, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-24, adopted 11/01/2009)
(reaffirmed, Board Report-2018, Item 78, adopted 11/3/2018)

Admitting Officer and Hospitalist Programs

RESOLVED, That the North Carolina Medical Society supports the following:

1. Patients should receive prior notification regarding the implementation and use of "admitting officer" or "hospitalist" programs, and
2. Participating in "admitting officer" or "hospitalist programs" should be at the discretion of the patient and the patient's physician, and
3. Hospitalist systems should be developed consistent with AMA policy on medical staff bylaws and implemented with approval of the organized medical staff to assure that the principles and structure of the autonomous and self-governing medical staff are retained,

> and hospitals and other health care organizations should not compel physicians by contractual obligation to assign their patients to “hospitalists” and no punitive measure should be imposed on physicians or patients who decline participation in “hospitalist programs,”

and be it further

RESOLVED, That the North Carolina Medical Society opposes any hospitalist model that disrupts the patient/physician relationship or the continuity of patient care and jeopardizes the integrity of inpatient privileges of attending physicians and physician consultants.

(Resolution 18-1999, adopted as amended 11/14/99)
(revised, Report L2-2004, Item 36, adopted 11/14/2004)
(revised, Report I-2009, Item 3-11, adopted 11/01/2009)

Full Medical Staff Membership

RESOLVED, That the North Carolina Medical Society supports appropriate medical training and clinical experience as a prerequisite for full hospital medical staff membership.

(Report A-1988, adopted 5/7/88)
(revised, Report MM-1998, Item 48, adopted 11/15/98)
(revised, Report L1-2004, Item 36, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-11, adopted 11/01/2009)
(reaffirmed, Board Report-2018, Item 79, adopted 11/3/2018)
(reaffirmed, NCMS Board Report- Hospital Medical Staff Task Force Recommendations, adopted 8/24/2020)

Economic Credentialing

RESOLVED, That the North Carolina Medical Society opposes the practice of economic credentialing, defined as the use of economic criteria unrelated to quality of care or professional competency, in determining an individual’s qualifications for initial or continuing hospital medical staff membership or privileges.

(Report LL-1996, adopted as amended 11/17/96)
(revised, Report L2-2004, Item 39, adopted 11/14/2004)
(revised, Report I-2009, Item 3-9, adopted 11/01/2009)
(reaffirmed, Board Report-2018, Item 80, adopted 11/3/2018)

Exclusive Contracts

RESOLVED, That the North Carolina Medical Society opposes the practice of hospital organizations executing exclusive contracts with physicians without prior consultation and approval of the medical staff of each contract; and be it further

RESOLVED, That the North Carolina Medical Society supports model medical staff bylaws defining the proper scope of medical staff involvement in exclusive contracting; and be it further

RESOLVED, That the North Carolina Medical Society supports initiatives to ensure opportunity for full participation of medical staff and due process in all hospital decisions to contract exclusively with physicians and other providers of care.

(Resolution 43-1996, adopted as amended 11/17/96)
(revised, Report L2-2004, Item 38, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-12, adopted 11/01/2009)
(reaffirmed, Board Report-2018, Item 81, adopted 11/3/2018)

Hospital Fair Credentialing and Peer Review

RESOLVED, That the North Carolina Medical Society supports the following guidelines and encourages other affected organizations to support them as well:

1. Peer review functions are distinguishable and separate from risk management functions within a hospital. Peer review is a process of the medical staff, governed by the medical staff bylaws and applicable federal and state law. Risk management is a function that would normally involve hospital administration and may involve medical staff.
2. The process of choosing “indicators” or “monitors” of physician performance should be overseen by a quality committee at the medical staff level, provided, however, that all metrics should be thoroughly vetted at the department or specialty level. The composition of this committee should represent the diversity of the medical staff, including “economic diversity.” This diversity requirement should be clearly explained in the medical staff’s policies. Oversight of this process should lie within the Medical Executive Committee, which should approve the variance criteria (indicators/monitors) chosen.
3. Physicians whose cases are chosen for peer review should be notified of this occurrence. They should have an opportunity to provide written input that can be considered by any peer review committee and that becomes part of the peer review file. The physician under review should also be informed of any decisions that may lead to recommendations for individual remedial action or corrective action, and the physician should have an opportunity to respond, in person or in writing, to the underlying quality concerns before the recommendations are implemented.
4. When data is traced for trends, threshold criteria should be established for defining where a trend exists that needs further evaluation. This responsibility should lie with a medical staff quality committee. Peer review should be based on objective process and outcome metrics as monitored by the local institution and as defined by the department in question.
5. The North Carolina Medical Society recommends that medical staffs use care in labeling certain aspects of their peer review activities. The term “investigation” should be reserved for a formal review of data that is anticipated to lead to corrective action, since this term has implications for reporting to the NPDB (National Practitioner Data Bank). Initial reviews of data should be labeled using other terminology, e.g., “quality review,” “focused study,” “peer review evaluation,” etc. The purpose is to avoid unnecessary or

inappropriate reporting to the NPDB, which may harm physicians who have no reportable quality concerns.

6. The North Carolina Medical Society recognizes the important value of External Peer Review (EPR). Where EPR occurs, selection of external peer reviewers should be submitted in advance to the physician under review, and he or she should have an opportunity to object to any particular individual. Such objections should not rise to the level of veto power, which could obstruct the process. In general, EPR should be reserved for circumstances in which internal review has raised the possibility of a restriction or reduction of privileges or where objectivity of internal peer review may have the appearance of being compromised because of medical staff demographics. A physician under review always has the option to request external peer review prior to a final decision implementing corrective action.
7. Medical staffs should adopt a mechanism that affords protection to physicians who, acting in good faith and the best interest of quality of care concerns, report concerns to the peer review committee, under the protection of a medical staff policy.
8. Fair hearing panels should be selected with good faith effort where practical to include representation similar to that of the physician under review (i.e., with regard to race, gender, ethnicity, training, etc.). Physicians under review should have an opportunity to voice good faith objections to inclusion of any members of a Fair Hearing Panel. Such objections should not rise to the level of veto power, which would obstruct the process.
9. Medical staffs should be informed about the uses of mediation and arbitration in resolving disputes around credentials and privileges.
10. The North Carolina Medical Society should facilitate educational programs to help ensure that members of hospital boards, medical executive committee, credentials committees, and quality committees are knowledgeable about proper practices regarding peer review, performance improvement and appropriate credentialing and privileging. To maximize availability, a variety of tools may be used to promote this education (e.g., video tapes, Internet tools, retreats, grand rounds, computer education tools, continuing medical education, etc.).
11. Approaches should be developed to promote the sharing of successful practices that exist in member hospitals and medical staffs with regard to peer review/performance improvement activities.

(Report G-2002, adopted as amended 11/17/2002)
(Report J-2010, Item 3-7, adopted 10/24/2010)
(technical corrections, Board Report-2018, Item 82, adopted 11/3/2018)

Peer Review Committees

RESOLVED, That the North Carolina Medical Society supports organizing peer review committees that are free of conflicts of interest whenever possible. Since conflicts of interest in the peer review process are sometimes inevitable, medical staffs should develop a process for resolving conflicts of interest that centers on the best interests of patients, includes full disclosure of conflicts and potential conflicts, and makes available a fair external review option in appropriate situations.

(Report D-1972, adopted 5/23/72)
(revised, Report II-1988, Item 31, adopted 5/7/88)
(revised, Report MM-1998, Item 4, adopted 11/15/98)
(revised, Report C-2005, Item 8, adopted 10/16/2005)
(revised, Report J-2010, Item 3-6, adopted 10/24/2010)
(technical corrections, Board Report-2018, Item 83, adopted 11/3/2018)

Hospital Utilization Data

The North Carolina Medical Society supports physician efforts to work with their hospital boards and administrators to develop appropriate educational uses of physician hospital utilization and related financial data and that any such data should be reviewed by professional peers and shared with the individual physicians from or about whom it was collected.

(Report F-2009, adopted 11/01/2009)
(reaffirmed, Board Report-2018, Item 84, adopted 11/3/2018)

Emergency Department Unassigned Call Coverage

1. The North Carolina Medical Society supports the provision by hospitals of adequate staffing, facilities, equipment, and other resources for emergency departments;

2. The North Carolina Medical Society supports the availability of appropriate financial and other resources by hospitals for physicians who staff emergency departments;
3. The North Carolina Medical Society opposes the development of additional emergency departments unless it can be shown that adequate staffing, including specialty coverage; equipment; and other resources will be provided to handle all cases in a timely manner;
4. The North Carolina Medical Society supports the provision by hospitals of adequate operating room availability and adequate staffing to take care of emergency and urgent surgical cases in a timely fashion;
5. The North Carolina Medical Society supports payment by hospitals to physicians who take unassigned call coverage;
6. The North Carolina Medical Society supports the development of core credentials for each specialty, approved by the medical staff, in an attempt to balance the need for general call coverage and specialization, and to ensure a clear understanding of what is expected of credentialed physicians;
7. The North Carolina Medical Society supports the right of organized medical staffs to make best efforts to schedule physician members to take unassigned call in their core-privilege areas; however, the North Carolina Medical Society opposes any requirement for care beyond stabilization and appropriate referral of patients requiring care that is beyond the normal practice parameters of physicians who have limited their practice to a subspecialty;
8. The North Carolina Medical Society supports measures that would allow rural hospitals to expedite transfers of patients to appropriate referral centers when deemed necessary by the physician on call;

9. The North Carolina Medical Society supports the development of specialty specific call coverage arrangements coordinated among physicians, hospitals, and EMS providers in a given region, especially in those regions where some hospitals are unable to provide 24/7 call coverage for that specialty, to expedite appropriate care for patients.

(Report K-2008, Resolution 13-2007, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 74, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 85, adopted 11/3/2018)

Emergency Department Crowding

RESOLVED, That the North Carolina Medical Society supports hospitals developing institution-wide solutions to alleviate emergency department crowding, including but not limited to development of hospital-wide protocols for addressing capacity issues in the emergency department, use of streamlined admission and discharge policies; and be it further

RESOLVED, That the North Carolina Medical Society supports the development of hospital policies regarding the coordination of the scheduling of elective admissions and procedures with respect to volumes of admitted patients in the emergency department.

(Resolution 15-2009, adopted as amended, 11/01/2009)
(reaffirmed, Board Report-2018, Item 86, adopted 11/3/2018)

Medical Staff Executive Committee Voting Privileges

The North Carolina Medical Society supports the ability of each medical staff to self-determine the composition of the medical executive committee, voting rights and structure to promote the highest quality patient care and well-being based on the unique needs of the facility and specific local circumstances.

The NCMS supports that a majority of voting power on medical staff executive committees should reside with licensed physicians on the active medical staff.

(NCMS Board Report – Hospital Medical Staff Task Force Recommendations, adopted 8/24/2020)

PHYSICIAN-PATIENT RELATIONSHIP

Physicians' Roles as Patient Advocates

RESOLVED, That the North Carolina Medical Society opposes any measure, from government or the private sector, that compromises the physician's role as patient advocate.

(Resolution 26-1998, adopted 11/15/1998)
(revised, Report L3-2004, Item 41, adopted 11/14/2004)

(reaffirmed, Report I-2009, Item 2-9, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 66, adopted 10/24/2015)

Self-Regulation of Medicine

RESOLVED, That the North Carolina Medical Society supports the self-regulation of medicine and an effective state medical board that adequately and appropriately polices the medical profession; and be it further

RESOLVED, That the North Carolina Medical Society supports the position statement of the North Carolina Medical Board entitled, "The Physician-Patient Relationship" as updated and adopted in September 2016.

(Resolution 11-1995, adopted 11/12/1995)
(revised, Report R-2007, Item 3-7, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-5, adopted 10/27/2012)
(technical correction, Board Report-2018, Item 87, adopted 11/3/2018)

Physician-Patient Relationship and Cost Containment Efforts

RESOLVED, That the North Carolina Medical Society supports every effort to reduce the cost of medical care in every way practical and possible without impairing the quality of care received.

(Resolution 15-1984, adopted 5/5/84)
(revised, Report CC-1994, Item 25, adopted 11/6/94)
(revised, Report L3-2004, Item 42, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-16, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 78, adopted 10/25/2014)

Physician Refusal To Treat

RESOLVED, That the North Carolina Medical Society opposes physician refusal to treat a patient whose condition is within the physician's current realm of competence solely because the patient has a specific health condition.

(Report F-2006, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-45, adopted 10/23/2011)
(technical corrections, Board Report-2018, Item 88, adopted 11/3/2018)

POLITICAL ACTION

Political Action by Physicians

RESOLVED,That the North Carolina Medical Society supports the active personal and financial involvement of all physicians in the political process for the purpose of promoting responsible health policy decisions.

(Resolution 4 – 2004, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-59, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 79, adopted 10/25/2014)

PRESCRIPTION DRUGS

Drug Enforcement Administration

RESOLVED, That the North Carolina Medical Society oppose: (1) the practice of requiring use of the Drug Enforcement Administration (DEA) license number for any purpose other than for verification to the dispenser that the prescriber is authorized by federal law to prescribe a controlled substance; (2) the sale or release of DEA number data to non-governmental entities; and (3) the use of DEA number data to track prescription histories of physicians for commercial use.

(Substitute Report X-1999, adopted 11/14/99)
(revised, Report R-2006, Item 42, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-36, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 89, adopted 11/3/2018)

Cannabis

The North Carolina Medical Society supports efforts to research the potential health benefits and adverse health effects of cannabis and cannabidiol products, including the pediatric population, and supports the education of its members regarding these issues.

The NCMS supports efforts to increase funding for education, prevention, and treatment of substance use disorders, particularly cannabis use disorder.

The NCMS supports increasing state and federal funding for cannabis research, easing regulatory restrictions that impede approval for cannabis and cannabinoid research, and encouraging ongoing collection of individual and population data on patients using cannabis.

The NCMS supports rescheduling cannabis from a Schedule I to a Schedule II drug to enable clinical research and developing standardization and prescribing guidelines for cannabinoids congruent with the FDA drug development process.

The NCMS supports further pharmacological research to develop potency limits for cannabis and cannabidiol products.

The NCMS supports the identification, monitoring, and publicizing of health care and social costs associated with cannabis and cannabidiol use.

The NCMS supports improved cannabidiol product testing, regulation, and public information about contaminated cannabidiol products.

The NCMS supports dissemination of scientifically sound information about the efficacy, as well as short and long-term adverse health effects, of cannabis and cannabidiol products to the medical community and the public.

The NCMS recognizes that there are significant differences between states and the federal government in the legal status of cannabis use.

(Report D-2011, Resolution 7-2010, adopted, 10/23/2011) (Revised and adopted, NCMS Board Report 1/28/2023)

Opposition to Automatic Refill Programs

RESOLVED, That the North Carolina Medical Society supports efforts to educate physicians, patients, employers, and pharmacies about potential problems related to automated refill systems so that unnecessary or erroneous refills can be minimized; and be it further

RESOLVED, That the North Carolina Medical Society opposes automated prescription refill systems that do not explicitly require patients to opt-in to or opt-out of the service.

(Substitute Resolution 2-2010, adopted by the NCMS Board of Directors, 9/10/11)
(reaffirmed, Board Report-2018, Item 90, adopted 11/3/2018)

Opioid Medication

RESOLVED, That the North Carolina Medical Society opposes any current or future regulation of the prescribing of opioid medications that limit their use to selected medical specialties as these exclusionary strategies may complicate the delivery of care and can prolong the pain and suffering of patients

(Resolution 8-2010, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 67, adopted 10/24/2015)

Chronic Pain Management

RESOLVED, That the North Carolina Medical Society supports the North Carolina Medical Board position statement “Policy for the Use of Controlled Substances for the Treatment of Pain,” as amended in July 2005.

(Resolution 27-1996, adopted as amended 11/17/96)
(revised, Report L1-2004, Item 11, adopted 11/14/2004)
(revised, Report I-2009, Item 3-6, adopted 11/01/2009)

Prescription Privileges

RESOLVED, That the North Carolina Medical Society supports the prescription of medications for the treatment of mental illnesses be limited to allopathic physicians, osteopathic physicians, and physician assistants, and nurse practitioners under the supervision of a physician.

(Substitute Resolution 17-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-35, adopted 10/19/2008)
(revised, Report G-2013, Item 1-7, adopted 10/26/2013)

Prior Authorizations for Medications

RESOLVED, That the North Carolina Medical Society supports alternatives to prior authorization programs, which have a detrimental effect on the health of patients; and be it further

RESOLVED, That the North Carolina Medical Society supports legislation that prohibits prior authorization programs for prescription drugs that unduly restrict a patient's timely access to those prescribed drugs.

(Resolution 12-2001, adopted as amended 11/11/01)
(revised, Report R-2007, Item 3-47, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-21, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 91, adopted 11/3/2018)

Overly Restrictive Prescription Plans

RESOLVED, That the North Carolina Medical Society supports legislation that would require insurance companies, managed care organizations, pharmacy benefit management plans and utilization review organizations to describe pharmaceutical or drug plans in insurance policies or contracts in language understandable to the average layperson including:

- The inclusion of any drug formularies and the process of selecting drugs to be used on such formularies,
- The inclusion of any "tiered" formulary programs requiring higher co-payments for certain drugs and the process for selecting drugs to be used in such tiers,
- The inclusion of any "step" programs requiring use of one drug prior to the use of another subsequent drug and the process for selection of drugs in the step program, and
- An explicit list of drugs requiring preauthorization and the process for enrollees to use to obtain such preauthorization.

(Report J-2000, adopted 11/12/00)
(revised, Report R-2006, Item 60, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-3, 10/23/2011)
(reaffirmed, Board Report-2018, Item 92, adopted 11/3/2018)

Prescribing of Drugs by Non-Qualified Healthcare Providers

RESOLVED, That the North Carolina Medical Society opposes drug prescribing privileges for any healthcare provider who lacks the appropriate background, education, and training.

(Report D-1990, adopted 11/10/90)
(reaffirmed, Report Q-2000, Item 8, adopted 11/12/00)
(revised, Report R-2006, Item 9, adopted 10/29/2006)
(reaffirmed, Reaffirmation Report-2013, Item 28, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 93, adopted 11/3/2018)

Internet and Telephone Prescribing and Dispensing

RESOLVED, That the North Carolina Medical Society opposes the practice of prescribing drugs to individuals the physician has not personally examined based solely on answers to a set of questions, as is common in Internet or toll-free telephone prescribing, except in certain circumstances such as admission orders for a newly hospitalized patient, prescribing for a patient of another physician for whom the prescriber is taking call, or continuing medication on a short-term basis for a new patient prior to the patient's first appointment.

(Substitute Resolution 18-2000, adopted 11/12/00)
(revised, Report R-2006, Item 10, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-49, adopted 10/23/2011)

Illegal Diversion of Prescription Drugs

RESOLVED, That the North Carolina Medical Society supports efficient and cost effective measures to stop diversion of prescription drugs and that will not impede 1) the appropriate prescribing of pain killing and other prescription drugs, and 2) will ensure the full protection of patients' interests, and 3) preserve the confidentiality of sensitive medical information.

(Report J-1999, adopted 11/14/1999)
(revised, Report R-2006, Item 55, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-57, adopted 10/23/2011)
(technical corrections, Board Report-2018, Item 94, adopted 11/3/2018)

Drug Substitution

RESOLVED, That the North Carolina Medical Society opposes blanket substitution authorization by physicians to pharmacists, and encourages dialogue between pharmacists and physicians regarding choice of brands; and be it further

RESOLVED, That the North Carolina Medical Society opposes any measure requiring or allowing generic drug substitution without prior consent of the prescribing physicians.

(Report F-1979, adopted 5/5/79)
(revised, Report II-1989, Item 15, adopted 11/11/89)
(revised, Report L-1999, Item 31, adopted 11/14/99)
(revised, Report R-2006, Item 56, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-15, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 95, adopted 11/3/2018)

Dispensing of Drugs from Physician's Office

RESOLVED, That the North Carolina Medical Society supports the dispensing of drugs by physicians from their offices whenever patient care factors deem it appropriate.

(Report AA-1987, adopted 5/2/87)
(reaffirmed, Report OO-1997, Item 30, adopted 11/16/97)
(revised, Report C-2005, Item 16, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-18, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 68, adopted 10/24/2015)

Therapeutic Drug Substitution

RESOLVED, That the North Carolina Medical Society opposes any law or directive that allows therapeutic drug substitution except in an institutional setting in which a pharmacy and therapeutics committee oversee the process.

(Report BB-1987, adopted 5/2/87)
(amended, Report OO-1997, Item 31, adopted 11/16/97)
(revised, Report L3-2004, Item 44, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-34, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 80, adopted 10/25/2014)
(reaffirmed, NCMS Board Report-2019, Page 3, Item 1-23, adopted 7/26/2019)

Mandatory Restrictive Drug Formularies

RESOLVED, That the North Carolina Medical Society opposes the use of restricted or closed drug formularies by health plans; and be it further

RESOLVED, That the North Carolina Medical Society supports efforts to eliminate the inappropriate implementation and enforcement of restricted or closed drug formularies; and be it further

RESOLVED, That the North Carolina Medical Society opposes any use of restricted or closed formularies or formulary tiers unless supported by scientific evidence and reviewed by a pharmacy and therapeutics committee composed of pharmacists and physicians.

(Resolution 28-1997, adopted as amended 11/16/97)
(revised, Report L2-2004, Item 23, adopted 11/14/2004)
(revised, Report I-2009, Item 3-19, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 81, adopted 10/25/2014)

Privacy of Physician Prescribing Data

RESOLVED, That the North Carolina Medical Society opposes the sale or distribution of individual physician prescribing data to any entity, except as required by law; and be it further

RESOLVED, That the North Carolina Medical Society supports state and federal efforts to prohibit the pharmacies or other entities from selling or distributing individual physician prescribing data to any entity, except as required by law, without the express written consent of the prescribing physician.

(Substitute Resolution 19 – 2004, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-42, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 82, adopted 10/25/2014)
(reaffirmed, NCMS Board Report-2019, Page 4, Item 1-1, adopted 7/26/2019)

Prescribing of Drugs for Off-Label Uses

RESOLVED, That the North Carolina Medical Society supports efforts to ensure coverage for medications for off-label use when the prescribing physician deems it to be in the best interest of the patient.

(Substitute Resolution 12-2005, adopted as amended 10/16/2005)
(revised, Report I-2009, Item 3-22, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 69, adopted 10/24/2015)

Disposal of Medication

RESOLVED, That the North Carolina Medical Society supports drug “take back” events, when managed within the Federal DEA guidelines, for the purpose of safely disposing of unneeded medications, including opioids and other controlled substances.

(Report A2-2012, adopted 10/27/2012)
(revised, Resolution 11-2013, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 96, adopted 11/3/2018)

Increased Availability of Opioid Antagonists

RESOLVED, That the North Carolina Medical Society supports the prescribing of opioid antagonists to patients at risk of opioid overdose as well as to family members, community agencies, or other persons in a position to assist patients in the event of an opioid overdose.

(Resolution 13-2013, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 97, adopted 11/3/2018)

The Electronic Discontinuation of Medications

RESOLVED, That the North Carolina Medical Society supports the development of a standardized, electronic method for the communication of the allergies to medications and/or the discontinuation of medications between the provider and the patient's pharmacy to improve medication reconciliation and patient safety.

(Resolution 1-2014, adopted 10/25/2014)
(reaffirmed, NCMS Board Report-2019, Page 4, Item 1-12, adopted 7/26/2019)

PROFESSIONAL LIABILITY

Medical Liability Reform Priority

RESOLVED, That the North Carolina Medical Society supports improving the integrity and fairness of the medical liability system as a long term priority of its lobbying program.

(Substitute Resolution 6-1993, adopted 11/7/93)
(revised, Report H-2003, Item 3 #22, adopted as amended 11/16/03)
(reaffirmed, Report N-2008, Item 2-10, adopted 10/19/2008)
(reaffirmed, Report I-2009, Item 2-71, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 83, adopted 10/25/2014)

Professional Liability Task Force Report

RESOLVED,

1. That the North Carolina Medical Society supports existing North Carolina law to ensure patients are fully compensated for economic damages and to cap non-economic damages in professional liability actions.
2. That the North Carolina Medical Society supports legislation to require that plaintiffs accept periodic payments of judgments in professional liability cases so that resources will be available throughout the injured patient's lifetime.
3. That the North Carolina Medical Society supports legislation to limit attorney contingency fees in professional liability cases in order to ensure that injured parties receive adequate compensation and to eliminate excessive fees that serve as an incentive for the filing of frivolous cases.

(Report I-2002, adopted as amended 11/17/02)
(revised, Report N-2008, Item 3-48, adopted 10/19/2008)
(revised, Report G-2013, Item 1-8, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 98, adopted 11/3/2018)

Medical Liability Premiums

RESOLVED, That the North Carolina Medical Society supports the calculation of medical liability insurance premiums based, as much as possible, on the actual underwriting cost of providing insurance, and opposes a system that would place all physicians in one insurance class without any demographic or experience-based difference among all insureds.

(Resolution 14-1980, adopted 5/3/1980)
(reaffirmed, Report M-1990, Item 4, adopted 11/10/1990)
(reaffirmed, Report Q-2000, Item 1, adopted 11/12/2000)
(revised, Report R-2006, Item 52, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-53, adopted 10/23/2011)
(technical corrections, Board Report-2018, Item 99, adopted 11/3/2018)

Limited Immunity for Volunteer Care

RESOLVED, That the North Carolina Medical Society supports limited immunity for physicians rendering care under the following circumstances:

- While rendering first aid or emergency health treatment at a local health department, nonprofit community health center, as a rescue squad member, or for athletic teams;
- While rendering care at a local health department facility or nonprofit community health center;
- While serving as medical director of emergency medical services (EMS) agency;
- While providing care as a retired physician holding "Limited Volunteer License;" or
- While rendering care at a free clinic.

(Substitute Resolution 13-1990, adopted as amended 11/10/90)
(revised, Report Q-2000, Item 53, adopted 11/12/00)
(revised, Report R-2006, Item 14, adopted 10/29/2006)
(revised, Report H-2011, Item 1-5, adopted 10/23/2011)
(technical correction, Board Report-2018, Item 100, adopted 11/3/2018)

Mediation of Medical Malpractice Claims

RESOLVED, That the North Carolina Medical Society supports mandatory pre-litigation review of medical liability claims by clinically qualified medical experts; and be it further

RESOLVED, That the North Carolina Medical Society supports mediation programs that include medical liability claims to the extent such programs reduce the filing of non-meritorious medical liability claims, reduce the volume of litigation, and increase the portion of any settlement payment received by the patient.

(Report W-1999, adopted 11/14/1999)
(revised, Report R-2006, Item 48, adopted 10/29/2006)

(reaffirmed, Report H-2011, Item 3-54, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 101, adopted 11/3/2018)

Medical Liability Reform

RESOLVED, That the North Carolina Medical Society supports a cap on civil non-economic damages in medical liability actions; and be it further

RESOLVED, That the North Carolina Medical Society supports efforts to reform the collateral source evidence rule so that juries are informed of collateral sources of compensation provided to the plaintiff for the losses in question; and be it further

RESOLVED, That the North Carolina Medical Society supports merit selection of judges, outside the context of tort reform, to reform the judicial selection process in North Carolina in a way that reduces or eliminates the political pressure on judges, and allows judges to be selected based on objective quality criteria; and be it further

RESOLVED, That the North Carolina Medical Society supports the confidentiality of peer review activities and documents, particularly addressing the effects of Virmani v. Presbyterian Health Services Corp; and be it further

RESOLVED, That the North Carolina Medical Society supports calculation of the statutory interest rate on judgments from the date of the final judgment, rather than the date the action is filed; and be it further

RESOLVED, That the North Carolina Medical Society supports modification of the requirement that physician defendants secure a bond for the full amount of a judgment prior to appeal so there is a reasonable correlation between the amount of the bond and the physician's net worth; and be it further

RESOLVED, That the North Carolina Medical Society supports permitting defendants to opt for periodic payments of judgments in medical liability cases; and be it further

RESOLVED, That the North Carolina Medical Society supports modification of the statute governing the use of expert witnesses in medical liability actions to assure that the defense can learn the identity and qualifications of the expert who conducts the pre-filing review of the record to determine the case has merit; and be it further

RESOLVED, That the North Carolina Medical Society supports shortening the statute of limitations that applies to minors who have a cause of action for medical liability; and be it further

RESOLVED, That the North Carolina Medical Society supports modifying North Carolina Rule of Civil Procedure 41(a) to prevent a plaintiff from unilaterally dismissing their case without court order and without prejudice any time after the filing of the first responsive pleading; and be it further

RESOLVED, That the North Carolina Medical Society supports making statements, writings or benevolent gestures expressing sympathy or a general sense of benevolence relating to pain, suffering or death of a person involved in an accident inadmissible as evidence of an admission of liability in a civil action; and be it further

RESOLVED, That the North Carolina Medical Society supports the efforts of its members in political education and action committee activities related to medical liability reform and provide operational advice and assistance regarding these activities.

(Report W-1998, adopted 11/15/98)
(revised, Report L3-2004, Item 48, adopted 11/14/2004)
(reaffirmed, Report J-2010, Item 2-39, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 70, adopted 10/24/2015)

Good Samaritan Law Immunity

RESOLVED, That the North Carolina Medical Society supports Good Samaritan immunity for physicians who serve voluntarily and without compensation to care for indigent, uninsured and underinsured patients, regardless of the setting or source of referral; and be it further

RESOLVED, That the North Carolina Medical Society supports Good Samaritan immunity for physicians serving voluntarily and without compensation as medical directors for emergency medical services (EMS) agencies; and be it further

RESOLVED, That the North Carolina Medical Society supports Good Samaritan immunity for physicians serving voluntarily and without compensation at athletic events.

(Report JJ-1998, adopted 11/15/98)
(revised, Report L3-2004, Item 45, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-60, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 71, adopted 10/24/2015)

Access to Liability Insurance Coverage

RESOLVED, That the North Carolina Medical Society supports medical malpractice immunity for physicians serving as nursing home medical directors except where allegations involve a patient under their direct care, or where allegations involve willful or intentional misconduct, recklessness, or gross negligence in the performance of their medical director responsibilities.

(Report E-2004, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-61, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 72, adopted 10/24/2015)

No-Fault Medical Liability

RESOLVED, That the North Carolina Medical Society supports the development of no-fault systems to identify and reduce medical errors.

(Substitute Report B-2006, adopted as amended 10/29/2006)
(reaffirmed, Report H-2011, Item 3-55, adopted 10/23/2011)
(technical correction, Board Report-2018, Item 102, adopted 11/3/2018)

Limited Medical Liability for Safety Net Providers

RESOLVED, That the North Carolina Medical Society supports limiting medical liability for all safety net providers.

(Report 0-2006, adopted 10/29/2006)
(revised, Report H-2011, Item 1-6, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 103, adopted 11/3/2018)

PUBLIC HEALTH

Occupational Injuries and Illnesses

RESOLVED, That the North Carolina Medical Society supports efforts to collect information on all serious and preventable occupational injuries, diseases and illnesses designated by the Health Services Commission.

(Report N-1996, adopted 11/17/96)
(revised, Report L1-2004, Item 71, adopted 11/14/2004)
(revised, Report I-2009, Item 3-44, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 86, adopted 10/25/2014)

Public Health in North Carolina

In order to achieve the desired results outlined in HNC2030, the North Carolina Medical Society recognizes the importance of a strong, well-funded state and local public health infrastructure as codified by law. Therefore, the North Carolina Medical Society supports:

1. Efforts to ensure public health in North Carolina has the resources needed to ensure health and well-being for all people in North Carolina across geographic, demographic, and social sectors. [1]
2. Efforts to promote public health's critical role of assessing health outcomes and investigating root causes to identify appropriate policy solutions and needed system change to create a healthier state. [2]
3. Efforts to ensure public health can engage in strong policy response and development in areas including communications, communities and partnerships, policies and laws, and legal and regulatory actions to drive improvements in population health, well-being, and equity. [2] [3]

4. Efforts to organize diverse cross-sector collaboration to build communities where all individuals and families have equitable access to opportunities and the means to pursue healthy lifestyles. [1] [3] [4]
5. Efforts to make health a shared value considered by public and private entities during decision-making. [1] [3]
6. Efforts designed to guarantee public health has the resources, workforce, and capacity needed to effectively address disparities and respond to current and future health needs, including sustained long-term funding and increased investments in policies and programs. [2] [3] [4]
7. Efforts to build value into health care delivery by addressing public health and social drivers of health in partnership with state and local public health agencies and local community-based organizations. As physicians and physician assistants, we have an ethical responsibility to serve as agents of health in our communities and support policies, programs, and practices to improve health. [5] [4]
8. Efforts to support achieving the broad and ambitious vision for a healthier North Carolina with less health inequity by addressing a broad range of health drivers . [6]
9.

[1] https://www.rwjf.org/en/cultureofhealth/about/how-we-got-here.html
[2] https://phnci.org/uploads/resource-files/EPHS-English.pdf
[3] https://www.rwjf.org/en/cultureofhealth/taking-action.html
[4] https://nam.edu/wp-content/uploads/2017/09/Public-Health-3.0.pdf
[5] https://nciom.org/wp-content/uploads/2019/05/ACC-Guide-for-Communities_5.30.19.pdf
[6] https://nciom.org/wp-content/uploads/2020/01/HNC-REPORT-FINAL-Spread2.pdf

(NCMS Board Report, adopted 11/5/2022)

Qualifications for State Health Director and Medical Director, NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services

RESOLVED, That the North Carolina Medical Society supports qualifications for State Health Director and Medical Director of the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services that include a doctoral degree in medicine, public health training or experience, and adequate academic or experiential preparation for the management of a multifaceted public health and wellness agency.

(Resolution 5-1991, adopted 11/9/1991)
(revised, Report U-2001, Item 38, adopted 11/11/2001)
(revised, Report R-2007, Item 3-10, adopted 10/21/2007) (revised, Report F-2012, Item 1-4, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 106, adopted 11/3/2018)

Response to Biological, Chemical and Radiation Attack

RESOLVED, That the North Carolina Medical Society supports local public health infrastructure for rapid detection of and response to biological, chemical, and radiation attacks; and be it further

RESOLVED, That the North Carolina Medical Society supports the role of the North Carolina Health Care Information and Communications Alliance (NCHICA) as a facilitator of health care providers, public health departments, hospitals, health care systems, universities, biotechnology companies, and appropriate local, state, and federal government agencies so that they may cooperate quickly and effectively in response to such attacks.

(Resolution 32-2001, adopted as amended 11/11/2001)
(revised, Report R-2007, Item 3-23, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-7, adopted 10/27/2012)
(technical corrections, Board Report-2018, Item 108, adopted 11/3/2018)

Support Expansion of Data Gathering Activities by the North Carolina Behavioral Risk Factor Surveillance System

RESOLVED, That the North Carolina Medical Society supports data gathering expansion of the NC Behavioral Risk Factor Surveillance System (BRFSS) by:

1. Increasing the number of interviews conducted by program staff;
2. Increasing the number of North Carolina-specific issues addressed in the program questionnaire; and
3. Obtaining the additional information needed to permit the program staff to compare North Carolina data by region or county.

(Report D-1999, adopted 11/14/99)
(revised, Report R-2007, Item 3-24, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-50, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 113, adopted 11/3/2018)

PUBLIC HEALTH - CHILDREN'S ISSUES

Athletic Trainers in High Schools

That the North Carolina Medical Society supports the use of licensed athletic trainers in middle and high schools.

(Report H-2009, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 91, adopted 10/25/2014)

Expanded School Health Curriculum

RESOLVED, That the North Carolina Medical Society supports the use of a required health curriculum within the school system that addresses such issues as accidents, homicides, suicides, obesity, physical fitness, nutrition, self-esteem, tobacco and substance abuse, pregnancy, child, elder, and spouse abuse, sexually transmitted infection, and other sexual issues in a comprehensive and age-appropriate fashion, and supports efforts to include parents in the

teaching about these subject areas so that the environment at home will support the choice of a healthy lifestyle.

(Resolution 12-1993, adopted as amended 11/7/1993)
(revised, Report H-2003, Item 3 #5, adopted as amended 11/16/2003)
(reaffirmed, Report R-2007, Item 2-9, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-24, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 124, adopted 11/3/2018)

Pre-Kindergarten Health Assessment

RESOLVED, That the North Carolina Medical Society supports mandatory health assessments for children no more than twelve months prior to the date of school entry.

(Substitute Report BB-1992, adopted 11/8/92)
(revised Report H-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-34, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 32, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 125, adopted 11/3/2018)

NC Child Fatality Task Force

RESOLVED, That the North Carolina Medical Society supports the North Carolina Child Fatality Task Force and its work to prevent child deaths and to promote child well being by recommending law and policy changes that will increase the protection of children.

(Report Z-1992, adopted 11/8/92)
(revised, Report H-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-25, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 33, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 126, adopted 11/3/2018)

Anti-Bullying in Schools

RESOLVED, That the North Carolina Medical Society supports policies and programs that enable students to attend school in a peaceful manner without fear of harassment, harm or criminal acts to themselves or others.

(Substitute Resolution 7-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-6, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 34, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 127, adopted 11/3/2018)

Medical Evaluation of Preschool Children Prior to Placement for Special Education Services

RESOLVED, That the North Carolina Medical Society supports medical evaluations of preschool children prior to placement for special education services.

(Report S-1991, adopted 11/9/1991)
(revised, Report U-2001, Item 26, adopted 11/11/2001)
(revised, Report R-2007, Item 3-12, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-51, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 128, adopted 11/3/2018)

Accidental Poisoning in Day Care Settings

RESOLVED, That the North Carolina Medical Society supports regulations requiring all day care centers to develop and maintain a poison action plan that includes state and national poison control center and physician telephone numbers; and be it further

RESOLVED, That the North Carolina Medical Society supports having all day care employees be knowledgeable of the proper procedures to follow should a poisoning occur, comply with the facility's action plan and administer activated charcoal or other appropriate remedies as directed by poison control centers and physicians.

(Report V-1991, adopted 11/9/1991)
(revised, Report U-2001, Item 27, adopted 11/11/2001)
(revised, Report R-2007, Item 3-13, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-25, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 129, adopted 11/3/2018)

Adequate School Breaks and Lunch Times

RESOLVED, That the North Carolina Medical Society supports physical activity and adequate lunch breaks for all students in North Carolina schools.

(Resolution 28-2001, adopted as amended 11/11/01)
(revised, Report R-2007, Item 3-14, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-26, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 130, adopted 11/3/2018)

Volunteer Vision and Hearing Screeners in Schools

RESOLVED, That the North Carolina Medical Society supports the use of appropriately trained volunteer vision and hearing screeners in NC schools.

(Resolution 4-1994, adopted as amended 11/6/94)
(revised, Report L1-2004, Item 28, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-86, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 92, adopted 10/25/2014)

Child Maltreatment

RESOLVED, That the North Carolina Medical Society supports a comprehensive, statewide program of specialized medical and mental health evaluation services for victims of child abuse or neglect through the Division of Public Health and Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

(Resolution 34-2000, adopted 11/12/00)
(revised, Report R-2006, Item 19, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-34, adopted 10/23/2011)
(technical correction, Board Report-2018, Item 131, adopted 11/3/2018)

Improving Child Health Care

RESOLVED, That the North Carolina Medical Society supports programs under physician direction for universal coverage of Children with Special Health Care Needs; and be it further

RESOLVED, That the North Carolina Medical Society supports a mandatory health screening for children prior to entering kindergarten; and be it further

RESOLVED, That the North Carolina Medical Society supports public programs for children and youth with special needs that require these children to undergo a comprehensive evaluation as part of the eligibility determination process for the categories of specific learning disabled and speech/language impaired and requiring that medical and psychological evaluations or screening be performed by qualified practitioners licensed or approved to practice in NC; and be it further

RESOLVED, That the North Carolina Medical Society supports lead poisoning screening for children and youth in North Carolina.

(Report H-1998, adopted as amended 11/15/98)
(revised, Report L2-2004, Item 3, adopted 11/14/2004)
(revised, Report I-2009, Item 3-28, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 93, adopted 10/25/2014)

Services for Minors

RESOLVED, That the North Carolina Medical Society supports the parental consent exception and minor's consent only for prevention, diagnosis, and treatment of pregnancy, sexually transmitted diseases, abuse of controlled substances or alcohol, and emotional disturbances.

(Resolution 14-1983, adopted 5/7/83)
(reaffirmed, Report FF-1993, Item 2, adopted 11/4/93)
(revised, Report H-2003, Item 3-29, adopted as amended 11/16/03)
(revised, Report N-2008, item 3-11, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 13, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 132, adopted 11/3/2018)

Corporal Punishment

RESOLVED, That the North Carolina Medical Society opposes corporal punishment in any educational setting.

(Resolution 9-1986, adopted 5/3/86)
(Report KK-1991, Item 10, adopted as amended 11/9/91)
(revised, Report U-2001, Item 29, adopted 11/11/01)
(revised, Report R-2007, Item 3-15, adopted 10/21/2007)
(revised, Report C-2008, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 35, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 133, adopted 11/3/2018)

Child Abuse

RESOLVED, That the North Carolina Medical Society recognizes child abuse and neglect as a significant health problem, and be it further

RESOLVED, That the North Carolina Medical Society supports cooperation between physicians and state and local child protection agencies in reporting suspected child abuse cases.

(Resolution 4-2000, adopted as amended 11/12/00)
(revised, Report R-2006, Item 20, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-35, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 134, adopted 11/3/2018)

Child Maltreatment Prevention

RESOLVED, That the North Carolina Medical Society supports comprehensive efforts to prevent the physical, psychological, sexual abuse, neglect, and death of juveniles; and be it further

RESOLVED, That the North Carolina Medical Society supports the use of medically appropriate investigative methods for victims of suspected physical, psychological, sexual abuse, neglect, and death of juveniles; and be it further

RESOLVED, That the North Carolina Medical Society supports evidence-based home visitation programs to prevent physical, psychological, sexual abuse, neglect, and death of juveniles.

(Report D-1995, adopted as amended 11/12/95)
(revised, Report L3-2004, Item 7, adopted 11/14/2004)
(revised, Report I-2009, Item 3-27, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 78, adopted 10/24/2015)

Age-Appropriate School Health and Physical Education Programs

RESOLVED, That the North Carolina Medical Society supports efforts of the Department of Public Instruction in strengthening and expanding age-appropriate school health and physical education programs throughout all of our K-12 school systems and that satisfactory completion of these programs be a requirement of graduation from North Carolina public schools.

(Substitute Resolution 32-1990, adopted as amended 11/10/90)
(reaffirmed, Report Q-2000, Item 2, adopted 11/12/00)
(revised, Report R-2006, Item 23, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-38, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 136, adopted 11/3/2018)

High-Quality Physical Education in North Carolina Public Schools

RESOLVED, That the North Carolina Medical Society supports the efforts of the Department of Public Instruction, superintendents, and local school boards to provide adequate funding to develop and maintain quality curriculum and high-quality physical education specialists to provide safe and appropriate equipment, quality staff development, and high-quality physical education programs for all children K-12 as one part of a coordinated school health program.

(Resolution 3-1989, adopted 11/11/1989)
(revised, Report Q-2000, Item 48, adopted 11/12/2000)
(revised, Report R-2006, Item 24, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-39, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 137, adopted 11/3/2018)

Health Education

RESOLVED, That the North Carolina Medical Society supports comprehensive health education including behavioral health provided by qualified health educators as a major course in all schools, beginning at the elementary level; and be it further

RESOLVED, that the North Carolina Medical Society supports a statewide comprehensive sexual education curriculum in all schools that emphasizes abstinence and will provide information about measures to prevent STDs and teenage pregnancy; and be it further

RESOLVED, That the North Carolina Medical Society supports behavioral health and substance abuse education in all schools beginning at the elementary level including alcohol, tobacco, prescription and non-prescription drug, and illegal substance abuse education.

(Resolution 22-1986, adopted 5/3/86)
(revised, Report Y-1996, Item 4, adopted 11/17/96)
(revised, Report L1-2004, Item 56, adopted 11/14/2004)
(revised, Report I-2009, Item 3-35, adopted 11/01/2009)
(reaffirmed, Board Report-2018, Item 138, adopted 11/3/2018)

School Health Education

RESOLVED, That the North Carolina Medical Society supports qualified health educators within the North Carolina School system to provide a program of instruction to include basic health care, preventive health care, first-aid, and cardiopulmonary resuscitation.

(Resolution 11-1984, adopted 5/5/84)
(reaffirmed, Report CC-1994, Item 22, adopted 11/6/94)
(revised, Report L3-2004, Item 16, adopted 11/24/2004)
(reaffirmed, Report I-2009, Item 2-1, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 79, adopted 10/24/2015)

Minors' Consent for Certain Medical Health Services

RESOLVED, That the North Carolina Medical Society supports the authority of minors to give effective consent to receive health services for the prevention, diagnosis and treatment of venereal disease; other diseases reportable under NCGS 130A-135, or any successor statute; pregnancy; abuse of controlled substances or alcohol, and emotional disturbance.

(Report B-2000, adopted 11/12/2000)
(revised, Report R-2006, Item 57, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-40, adopted 10/23/2011)
(Technical correction, Board Report-2018, Item 139, adopted 11/3/2018)

Newborn Screenings

RESOLVED, That the North Carolina Medical Society supports continued newborn screening by the NC Department of Health and Human Services that are based on the most current and best medical evidence.

(Report KK-1997, adopted 11/16/97)
(revised, Report L1-2004, Item 46, adopted 11/14/2004)
(reaffirmed, Report N-2008, Item 2-6, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 37, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 140, adopted 11/3/2018)

Early Childhood Programs

RESOLVED, That the North Carolina Medical Society supports continuation of state-sponsored early childhood programs in all one hundred North Carolina counties.

(Report G-1997, adopted as amended 11/16/97)
(revised, Report L3-2004, Item 53, adopted 11/14/2004)
(revised, Report I-2009, Item 29, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 45, adopted 10/25/2014)

Protect Children from Second-Hand Smoke

RESOLVED, That the North Carolina Medical Society supports protection of all children from secondhand smoke exposure.

(Resolution 33-1991, adopted 11/9/1991)
(reaffirmed, Report U-2001, Item 8, adopted 11/11/2001)
(revised, Report R-2007, Item 3-52, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-28, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 141, adopted 11/3/2018)

Public School Employees

RESOLVED, That the NCMS supports pre-employment health certification and criminal background checks for all public school employees.

(Report S-1984, Item 9, adopted 5/5/1984)
(reaffirmed, Report CC-1994, Item 14, adopted 11/6/1994)
(revised, Report L1-2004, Item 69, adopted 11/14/2004)
(revised, Report I-2009, Item 3-41, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 80, adopted 10/24/2015)

Pediatric Psychiatric Co-Morbidities

RESOLVED, That the North Carolina Medical Society supports the development of educational programs to assist physicians who care for children and adolescents to identify and initiate appropriate psychiatric support.

(Resolution 9-2005, adopted as amended 10/16/2005)
(reaffirmed, Report J-2010, Item 2-44, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 81, adopted 10/24/2015)

Vision Screening for Children

RESOLVED, That the North Carolina Medical Society supports age-appropriate vision screening using evidence-informed guidelines for all children. Comprehensive examinations should be provided for those who are referred for follow-up care due to concerns identified by the vision screening or who are unable to be screened.

(Substitute Resolution 22-2005, adopted as amended 10/16/2005)
(revised, Report J-2010, Item 3-19, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 82, adopted 10/24/2015)

Automatic External Defibrillator (AED) Placement in Middle and High Schools

That the North Carolina Medical Society supports the implementation of automatic external defibrillators (AEDs) in all middle and high schools in North Carolina, training of school staff to

operate the AED devices, and the adoption by each school of an emergency action plan for the use of AED devices; and

That the North Carolina Medical Society supports the widespread availability of automated external defibrillators (AEDs).

(Report C-2009, adopted as amended, 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 44, adopted 10/25/2014)

Foster Care

That the North Carolina Medical Society supports policies and programs to optimize the health and well-being of children in foster care including promotion of medical homes.

(Report E-2009, adopted, 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 83, adopted 10/24/2015)

Support for Statewide Pediatric Growth Chart Registry

RESOLVED, That the North Carolina Medical Society supports utilization of an accessible statewide pediatric growth chart registry for pediatric patients.

(Resolution 14-2013, adopted 10/26/2013)
(Technical correction, Board Report-2018, Item 142, adopted 11/3/2018)

QUALITY IMPROVEMENT

Performance Measurement and Implementation by Third Party Payers

1. The North Carolina Medical Society supports health care cost and quality improvement efforts that are transparent and aimed at improving the patient decision-making process;
2. The North Carolina Medical Society supports efforts to assure that the following minimum standards are met when a third party payer uses a performance measurement program:

   Criteria and Methodology

   - Criteria used must be objective, reasonable, and must disclose all known flaws in methodology used.
   - Payer performance programs should incorporate the use of non-claims based data when available, such as national registry data and physician recognition programs, that rely on practice-collected all-payer data. Current examples include NCQA Provider Recognition Programs and Maintenance of Certification Part IV practice improvement modules. Soon, Health Information Exchange has the potential to provide this sort of clinical data for performance measurement purposes.

Economic profiling unrelated to quality should not occur; however any supplemental data used must be clearly defined and explained.

- Established criteria and methodology must be evidence-based and nationally recognized by the National Quality Forum, the Ambulatory Care Quality Alliance or the National Committee on Quality Assurance.
- Basis for criteria and methodology should be made available to the public in an understandable manner, providing a disclaimer that economic efficiencies as determined by the third party payer may not equate to inefficiencies in practitioner quality.
- Measures must be risk adjusted when necessary and specialty-specific severity adjustments must be made when appropriate.
- Methodology for determining and addressing outlier scenarios must be clearly explained by a third party payer prior to measuring practitioners.
- Methodology used to attribute episodes of care to specific practitioners must be fully explained by a payer and and look-back period specifically defined.

Certification of Data

- The data and methodologies used in a third party payer's performance measurement program should be audited and certified by an independent quality assessment organization.
- The North Carolina Department of Insurance must hold the authority and responsibility for ensuring that performance measurement programs adequately protect practitioners and patients.
- Any penalties imposed on a practitioner for failure to report on measures, or for other violations of a performance measurement program agreement or policy must be reasonable and clearly identified by the third party payer.
  Implementation
- Practitioners must be given proper notice of a performance measurement program prior to its implementation, ample time to review data to be analyzed, and the opportunity to appeal prior to publication of any designation.
- A practitioner must be allowed to discuss details of his/her assessment with a peer clinician representative of the third party payer. The peer clinician should have access to the practitioner's data, applicable metrics, the assessment, and should hold the authority to make appropriate adjustment to the practitioner's assessment.
- An appeal process must be clearly defined and available to all practitioners.
- All costs associated with the creation and certification of data in a performance measurement program must be the sole responsibility of the third party payer.
- Any contract provision requiring a practitioner to submit data to a third party payer for performance measurement must also allow for adequate payment to the practitioner for that data reporting.
- Practitioners must be clearly informed regarding how their information will be used and how designations will be made available to patients or the public.

- Third party payers must avoid performance measurement programs that may adversely impact a patient's ability to access primary care or specialty care in their geographic area, which may occur through limitations on coverage or increased co-pays or co-insurance.

(Report E-2011, adopted, 10/23/2011)

Quality Improvement Organizations

RESOLVED, That the North Carolina Medical Society supports the communication of current health care policies and review guidelines of organizations such as Carolinas Center for Medical excellence to each physician involved in the care of patients and that changes in these policies and guidelines be communicated as soon as possible; and be it further

RESOLVED, That the North Carolina Medical Society supports adequate funding for quality improvement initiatives; and be it further

RESOLVED, That the North Carolina Medical Society supports working with quality improvement organizations and encouraging physicians and hospitals to define quality in medical care; and be it further

RESOLVED, That the North Carolina Medical Society supports the continued efforts of Carolinas Center for Medical Excellence as a statewide quality improvement organization with physician oversight for North Carolina.

(Resolution 3-1986, adopted 5/3/86)
(revised, Report Y-1996, Item 24, adopted 11/17/96)
(revised, Report L1-2004, Item 15, adopted 11/14/2004)
(revised, Report I-2009, Item 3-14, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 35, adopted 10/25/2014)

Data Collection and Dissemination

RESOLVED, That the North Carolina Medical Society supports data collection and dissemination for the purpose of education of physicians, of providers, and in selected circumstances, patients. Such support shall incorporate the following principles: (1) protection of privacy and confidentiality, (2) appropriate consent obtained for the process, (3) careful attention to data collection and analysis methodologies in order to avoid misinterpretation and to insure fairness, and (4) due process to allow physicians reasonable opportunity to review their own data in relationship to the standard against which they are being compared.

(Report M-1987, adopted 5/2/87)
(amended, Report OO-1997, Item 32, adopted 11/16/97)
(revised, Report L2-2004, Item 30, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-17, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 36, adopted 10/25/2014)

Quality of Care and Performance Improvement

RESOLVED, That the North Carolina Medical Society supports efforts to improve the effectiveness of care and practice in North Carolina that are voluntary, cost-effective, efficient, and practical to implement.

(Report K – 2004, adopted as amended 11/14/2004)
(reaffirmed, Report I-2009, Item 2-15, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 37, adopted 10/25/2014)

Pay for Performance

RESOLVED, That the North Carolina Medical Society supports Pay for Performance programs provided the following principles are incorporated:

1. The program design focuses on improved quality and safety, using evidence-based, broadly accepted, clinically relevant, continually updated, quality of care measures, particularly those developed by the AMA Physician Consortium, and allows for, without penalty, variations in individual patient care regimens based on a physician's sound clinical judgment;
2. The program adequately adjusts for patient mix so that physicians are encouraged to accept, treat, and retain all patients regardless of health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns (fosters the physician-patient relationship and supports continuity of care);
3. Physicians and physician professional organizations have meaningful input into the program design and enhancements;
4. The program is voluntary and will not adversely affect physicians who elect not participate;
5. The program uses accurate and reliable data (preferably the use of encounter data instead of claims data), and scientifically valid analytical reporting methods, and provides physicians with an opportunity to review, comment, and appeal results prior to the use of results for program incentives and reporting; and
6. Clear and positive incentives are employed that are not budget neutral or "zero-sum" but rather provide new funds from expected savings that are adequate to offset needed infrastructure changes and enhancements and reward quality care; the incentives must be clearly and accurately explained; and be it further

RESOLVED, That the North Carolina Medical Society supports uniform evidence-based performance measures across all Pay for Performance programs.

(Report I-2006, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-17, adopted 10/23/2011)

REGULATORY ISSUES

Antitrust Protection for Physicians

RESOLVED, That the North Carolina Medical Society supports antitrust protection for joint and collective efforts and activities organized by individuals or groups of physicians for the purposes of (1) maintaining high quality medical care, (2) assuring access to medical care, and (3) achieving reductions in the cost of medical care.

(Resolution 16-1993, adopted as amended 11/7/93) (revised, Report H-2003, Item 3 #14, adopted as amended 11/16/03)
(revised, Report L3-2004, Item 4, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-56, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 38, adopted 10/25/2014)

Certificate of Need

RESOLVED, That the North Carolina Medical Society supports a fair and transparent CON process that includes the thorough evaluation and consideration of the following factors in any application for a CON to provide regulated health care services:

1. the availability of health care services to all patients;
2. timely access to needed health care services and treatments;
3. the harm caused to patients when health care treatments are unduly delayed;
4. the additional expense incurred by patients and society when access to services is restricted;
5. the accountability of the applicant for the delivery of quality care and continuous performance improvement; and
6. the clinical appropriateness of the setting for the proposed services;and be it further

RESOLVED, That the North Carolina Medical Society supports operational, administrative, and legislative changes to assure that all applicants for certificates of need are treated equitably; and be it further

RESOLVED, That the North Carolina Medical Society supports measures that ensure physician interests are appropriately represented before the Department of Health and Human Services, including the development of the State Medical Facilities Plan and the administration of the Certificate of Need program.

(Report N-1999, adopted 11/14/99)
(revised, Report R-2006, Item 41, adopted 10/29/2006)
(revised, Report I-2009, Item 10, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 53, adopted 10/25/2014)

Cost Containment

RESOLVED, That the North Carolina Medical Society supports efforts of physicians to contain medical costs.

(Resolution 6-1979, adopted 5/5/1979)
(reaffirmed, Report II-1989, Item 8, adopted 11/11/1989)
(Report L-1999, Item 2, adopted 11/14/1999)
(revised, Report R-2007, Item 3-39, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-12, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 143, adopted 11/3/2018)

Cost Containment Activities

RESOLVED, That the North Carolina Medical Society supports the use of hospital utilization data to develop programs for cost containment; and be it further

RESOLVED, That the North Carolina Medical Society supports cost containment activities between organized medicine and strategic segments of the community; and be it further

RESOLVED, That the North Carolina Medical Society supports cost containment activities be pursued through appropriate Society mechanisms as may be required; and be it further

RESOLVED, That the North Carolina Medical Society supports cost containment activities at the local level.

(Report T-1984, adopted 5/5/84)
(revised, Report CC-1994, Item 15, adopted 11/6/94)
(revised, Report L2-2004, Item 11, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-13, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 54, adopted 10/25/2014)

Legislation Requiring All Health Care Providers To Wear Standardized Photo IDs

RESOLVED, That the North Carolina Medical Society supports legislation standardizing medical provider name tags to include photo identification and credentials in large block letters legible at a conversational distance.

(Resolution 3-2011, adopted as amended, 10/23/2011)

Physician Representation on Government Entities

RESOLVED, That the North Carolina Medical Society supports physician representation on all North Carolina government entities that have a direct effect on the practice of medicine.

(Resolution 7-1985, adopted 5/4/85)
(reaffirmed, Report II-1995, Item 14, adopted 11/12/95)
(revised, Report L3-2004, Item 60, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-62, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 39, adopted 10/25/2014)

The Joint Commission

RESOLVED, That the North Carolina Medical Society opposes any changes in the Joint Commission standards concerning medical staff composition and responsibilities that would result in a lowering of the standard of care.

(Resolutions 5, 7, 9 and 21-1983, adopted 5/7/1983)
(revised, Report FF-1993, Item 7, adopted as amended 5/7/1993)
(revised, Report H-2003, Item 3-13, adopted as amended 11/16/2003)
(revised, Report N-2008, Item 3-53, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 75, adopted 10/26/2013)
(Technical correction, Board Report-2018, Item 144, adopted 11/3/2018)

Reports by Professional Accreditation or Certification Organizations

RESOLVED, That the North Carolina Medical Society supports exclusion from discovery in any civil or criminal action of the proceedings of a medical or peer review committee, the records and materials it produces and the materials it considers, that provided by the institution to a professional standards review organization that performs any accreditation or certification, including the Joint Commission, and patient safety organizations.

(Resolution 43-1998, adopted 11/15/98)
(revised, Report L3-2004, Item 28, adopted 11/14/2004)
(revised, Report I-2009, Item 3-12, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 40, adopted 10/25/2014)

Licensing Boards for New Professions

RESOLVED, That the North Carolina Medical Society opposes the establishment of new health care licensing boards unless the proponents convincingly demonstrate that it is necessary for the protection of the public health, safety, or welfare, and be it further

RESOLVED, That the North Carolina Medical Society supports certification or registration as a mechanism to show an allied health professional has demonstrated a particular level of competency in his/her field.

(Report JJ-1989, adopted 11/11/89)
(reaffirmed, Report L-1999, Item 29, adopted 11/14/99)
(revised, Report R-2006, Item 46, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-20, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 145, adopted 11/3/2018)

Cost Accounting Requirement

RESOLVED, That the North Carolina Medical Society support efforts to require all governmental agencies to properly cost account their activities before raising registration fees.

(Substitute Report G-1994, adopted 11/6/94)
(revised, Report L3-2004, Item 23, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-69, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 41, adopted 10/25/2014)

Pluralistic System of Health Care

RESOLVED, That the North Carolina Medical Society supports a pluralistic health care delivery system, and the right of both patients and physicians to choose the system within which services are delivered so long as that system exploits neither patient nor physician. The North Carolina Medical Society opposes governmental intervention on behalf of any one method of practice over all others, or any unfair competitive advantage. However, the North Carolina Medical Society is not opposed to experimental, demonstration, or pilot model projects in new systems of health care (including medical care) delivery.

(Report B-1972, adopted 5/23/72)
(reaffirmed, Report D-1986, Item 3, adopted 5/3/86)
(reaffirmed, Report Y-1996, Item 23, adopted 11/17/96)
(revised, Report L2-2004, Item 31, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-70, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 42, adopted 10/25/2014)

Clinical Competence of Practicing Physicians

RESOLVED, That the North Carolina Medical Society supports reasonable efforts to ensure the continued clinical competence of physicians practicing in North Carolina.

(Report CC-1998, adopted as amended 11/15/98)
(revised, Report L3-2004, Item 32, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-20, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 43, adopted 10/25/2014)

Licensure Standards

RESOLVED, That the North Carolina Medical Society supports medical licensure standards based solely on professional competence, conduct, character, and ethics.

(Resolutions 5, 16-1986, adopted 5/3/86)
(revised, Report Y-1996, Item 20, adopted 11/17/96)
(revised, Report L1-2004, Item 10, adopted 11/1/4/2004)
(reaffirmed, Report I-2009, Item 2-21, adopted 11/01/2009)
(reaffirmed, Board Report-2018, Item 147, adopted 11/3/2018)

Inpatient Rehabilitation Facilities

RESOLVED, That the North Carolina Medical Society supports reasonable safety and quality standards for inpatient rehabilitation facilities.

(Report GG-1989, adopted 11/11/89)
(reaffirmed, Report Q-2000, Item 5, adopted 11/12/00)
(revised, Report R-2006, Item 11, adopted 10/29/2006)
(reaffirmed, Reaffirmation Report-2013, Item 39, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 148, adopted 11/3/2018)

Healthcare Provider Taxes

RESOLVED, That the North Carolina Medical Society opposes taxes levied solely on healthcare providers by the state and federal governments.

(Resolution 16-2003, adopted 11/16/03)
(reaffirmed, Report N-2008, Item 2-11, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 38, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 149, adopted 11/3/2018)

Telemedicine

RESOLVED, That the North Carolina Medical Society supports a full and unrestricted medical licensure requirement for physicians, with no differentiation by specialty, who wish to regularly practice telemedicine in North Carolina.

(Report JJ-1996, adopted as amended 11/17/96)
(revised, Report L3-2004, Item 70, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-64, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 32, adopted 10/25/2014)

Unlicensed Practice of Medicine

RESOLVED, That the North Carolina Medical Society opposes the unlicensed practice of medicine and supports the prosecution of offenders.

(Report P-2001, adopted 11/11/2001)
(revised, Report R-2007, Item 3-8, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-29, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 150, adopted 11/3/2018)

Re-Entry Training

RESOLVED, That the North Carolina Medical Society supports individualized re-entry training programs in cooperation with the North Carolina Medical Board, the medical schools in North Carolina, the North Carolina Area Health Education System, medical liability insurers, and individual physicians.

(Resolution 10-2006, substitute resolution adopted 10/28/2006)
(reaffirmed, Report H-2011, Item 3-47, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 151, adopted 11/3/2018)

Opposition to Linking Licensure to Participation in Specialty Maintenance of Certification Processes

RESOLVED, That the North Carolina Medical Society opposes linking state medical license issuance or renewal to the Maintenance of Certification processes of the specialty medical boards.

(Resolution 17-2012, adopted as amended 10/27/2012)
(reaffirmed, Board Report-2018, Item 152, adopted 11/3/2018)

Opposition to Linking Licensure to Mandatory Participation in Insurance Programs

RESOLVED, That the North Carolina Medical Society opposes linking state licensure to obligatory participation in any private or government third-party payer program.

(Resolution 18-2012, adopted as amended 10/27/2012)
(reaffirmed, Board Report-2018, Item 153, adopted 11/3/2018)

Medical Interpreter Certification

RESOLVED, That the North Carolina Medical Society supports the development of a medical interpreter certification process.

(Resolution 23-2012, adopted as amended 10/27/2012)
(reaffirmed, Board Report-2018, Item 154, adopted 11/3/2018)

Surprise Billing

The North Carolina Medical Society supports protecting patients from unanticipated bills due to non-network medical services through up-front, equitable financial arrangements.

The North Carolina Medical Society supports the following actions to protect patients:

- Discontinue attempts to fix surprise bills on a case-by-case basis through any post-service reconciliation process for insured patients.
- Require robust network adequacy standards and up-front arbitration of contracts between physicians/providers and insurers before services are rendered to prevent non-network medical bills for insured patients.
- Maintain the existing shared principles of holding the patient harmless, providing fair compensation for medical services, and protecting access to care for patients.
- Study ways to address similar concerns for the uninsured.

NCMS Board Report, Adopted 11/9/2019

REPRODUCTIVE HEALTH CARE

Access to Comprehensive Reproductive Health Care

The North Carolina Medical Society supports access to comprehensive, safe, equitable, and evidence-based quality reproductive care for every individual of reproductive age, regardless of gender or gender identity, sexual orientation, race, creed, culture, disability, geography, or financial status.

Therefore, the North Carolina Medical Society:

❖ Supports abortion as an essential part of comprehensive reproductive medical care.

❖ Supports access to comprehensive family planning, pregnancy, and post-natal services.

❖ Supports the preservation and protection of the relationship between patients and qualified health professionals and shared-decision making among available options for care that best meet patients' medical needs and goals.

❖ Supports promoting access to a qualified health professional for guidance and evidence-based care for all reproductive health services, regardless of location.

❖ Supports medical science as the best source of evidence-based care.

❖ Supports a qualified health professional's medical judgment, based on a holistic assessment of the pregnant patient's condition, for determining the presence of an emergent or potentially emergent situation and determining the appropriate course of action and care.

❖ Supports the AMA's Principles of Medical Ethics, including the obligation to ensure that patients have access to needed emergency services.

❖ Supports qualified health professionals not being required to perform or assist in an abortion if their personal beliefs conflict with the interruption of a pregnancy by such means.

❖ Supports that the decision to continue or end a pregnancy is influenced by an individual's cultural, ethical, philosophical, and religious values and beliefs.

❖ Opposes regulations that impose undue burdens that supplant pregnant people's values, beliefs, and circumstances or impede the ability of qualified health professionals to support their patients.

❖ Supports health care providers and trainees in North Carolina receiving medical education in fair and equitable principles and procedures in reproduction and childbearing, including core competency in comprehensive family planning, contraception, and pregnancy termination.

❖ Opposes government, institutional, or corporate interference in individuals' ability or right to access reproductive health and support services.

❖ Supports correcting inequities in reproductive health care and health outcomes for people disadvantaged by socioeconomic status and people of color.

❖ Supports the prevention of restrictions that heighten medical risks for individuals with high-risk conditions during pregnancy or have pre-existing conditions that may be exacerbated during pregnancy.

❖ Opposes any attempt to impose legal or regulatory penalties or retaliation against health care professionals, patients, advocates, and organizations that aid in providing medically appropriate reproductive health services.

The North Carolina Medical Society fundamentally values compassion and respect for human dignity and rights, empowering patient self-determination and bodily autonomy with respect to reproductive health.

Key Resources Referenced:
1. The American College of Obstetricians and Gynecologists (ACOG)
2. Society for Maternal and Fetal Medicine (SMFM)
3. American Medical Association (AMA)

(Adopted, NCMS BOD Report 1/28/2023)

SAFETY

Drivers Impaired by Alcohol or Drugs

RESOLVED, That the North Carolina Medical Society supports strict enforcement of impaired driving laws; and be it further

RESOLVED, That the North Carolina Medical Society supports a maximum blood alcohol level for operators of motor vehicles and boats that is supported by current medical evidence; and be it further

RESOLVED, That the North Carolina Medical Society supports efforts to guard against the operation of motor vehicles and boats by persons who are impaired by alcohol or drugs; and be it further

RESOLVED, That the North Carolina Medical Society supports making impaired driving with a child passenger under the age of 16 years an aggravating factor in the sentencing of that defendant; and be it further

RESOLVED, That the North Carolina Medical Society supports a two-year follow-up treatment requirement for offenders convicted of driving while impaired in an alcohol and drug education traffic school or a substance abuse treatment programs; and be it further

RESOLVED, That the North Carolina Medical Society supports requiring drivers, who have lost their licenses as a result of a conviction for DWI, to be medically reviewed before their license privileges are restored.

(Substitute Report K-1998, adopted 11/15/98)
(revised, Report L1-2004, Item 25, adopted 11/14/2004)
(revised, Report N-2008, Item 3-21, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 40, adopted 10/26/2013)
(technical correction, Board Report-2018, Item 155, adopted 11/3/2018)

All-Terrain Vehicles

RESOLVED, That the North Carolina Medical Society supports limiting the operation of all-terrain vehicles (ATV) to persons 16 years of age and older, with a current driver's license who have completed a safety course in ATV operation and wear a safety helmet.

(Substitute Report K-1993, adopted 11/7/93) (revised, Report H-2003, Item 3-11, adopted as amended 11/16/03)
(revised, Report N-2008, Item 3-5,adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 41, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 156, adopted 11/3/2018)

All-Terrain Vehicles Safety

RESOLVED, That the North Carolina Medical Society supports mandatory minimum age requirements, personal protective equipment, and safety training and application of motor vehicle safety laws for users of all-terrain vehicles (ATVs).

1. Vehicles should be sturdy and stable;
2. Riders should receive instruction from an experienced rider;
3. Riders should wear approved helmets and protective clothing (trousers, boots, gloves, etc.);
4. Roadway and nighttime riding should not be permitted;
5. Riders should be required to hold licenses based on demonstrated competence.

(Report P-1988, adopted as amended 5/7/88) (revised, Report MM-1998, Item 21, adopted 11/15/98)
(revised, Report L1-2004, Item 53, adopted 11/14/2004)

(revised, Report I-2009, Item 3-51, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 33, adopted 10/25/2014)

Boxing

RESOLVED, That the North Carolina Medical Society supports the universal use of protective equipment and the measures advocated by the World Medical Boxing Congress designed to reduce the incidence of brain and eye injuries inflicted during boxing, and be it further;

RESOLVED, That the North Carolina Medical Society supports the principle that the professional responsibility of a physician who serves in a medical capacity at a boxing contest is to protect the health and safety of the contestants, and that the physician's judgment should be governed only by medical considerations and not the desire of spectators, promoters of the event, or even injured athletes that they not be removed from the contest.

(Resolution 3-1997, adopted 11/16/97)
(revised, Report L2-2004, Item 15, adopted 11/14/2004)
(revised, Report I-2009, Item 3-56, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 34, adopted 10/25/2014)

Mobile Infant Walkers Ban

RESOLVED, That the North Carolina Medical Society supports banning the manufacture and sale of mobile infant walkers.

(Resolution 9-2003, adopted as amended 11/16/03)
(revised, Report N-2008, Item 3-23, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 42, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 157, adopted 11/3/2018)

Encouraging Further Research Into How to Distinguish the Impaired Driver

RESOLVED, That the North Carolina Medical Society supports continued research by highway safety organizations addressing identification of drivers with drinking or chemical dependency problems; and be it further

RESOLVED, That the North Carolina Medical Society supports groups involved in preventing impaired drivers from operating motor vehicles.

(Substitute Report JJ-1991, adopted 11/9/1991)
(revised, Report U-2001, Item 31, adopted 11/11/2001)
(revised, Report R-2007, Item 3-17, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-9, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 159, adopted 11/3/2018)

Law Enforcement Investigations

RESOLVED, That the North Carolina Medical Society supports comprehensive immunity for physicians who disclose evidence of the chemical impairment of a patient, including the professional opinion of the physician, at the request of a law enforcement officer investigating an incident in which the chemical impairment of the patient is a relevant consideration.

(Report U-1999, adopted 11/14/99)
(revised, Report R-2006, Item 54, adopted 10/29/2006)
(reaffirmed, Reaffirmation Report-2013, Item 14, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 160, adopted 11/3/2018)

Medical Evaluation Program

RESOLVED, That the North Carolina Medical Society supports the Medical Evaluation Program, which provides, limited immunity for physicians and psychologists providing medical information to the NC Commissioner of Motor Vehicles on drivers who the physician or psychologist believe have a mental or physical disability that will adversely affect the patient's ability to safely operate a motor vehicle.

(Report O-1997, adopted 11/16/97)
(revised, Report L3-2004, Item 25, adopted 11/14/2004)
(revised, Report I-2009, Item 3-52, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 84, adopted 10/24/2015)

Statewide Injury Surveillance and Prevention System

RESOLVED, That the North Carolina Medical Society supports the integration of statewide injury surveillance systems to provide for data query, program evaluation, and interagency collaboration.

(Report G-1989, adopted 11/11/89)
(reaffirmed, Report L-1999, Item 19, adopted 11/14/99)
(revised, Report C-2005, Item 22, adopted 10/16/2005)
(revised, Report M-2008, Item 26, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 44, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 162, adopted 11/3/2018)

Law Enforcement Methods to Subdue Persons

RESOLVED, That the North Carolina Medical Society supports educational efforts for law enforcement personnel about the safe use and dangers of capsaicin spray (also known as "OC spray" or "pepper spray"), tasers, and other non-lethal methods to subdue persons and how to respond should an adverse reaction occur.

(Report N-1997, adopted 11/16/97)
(revised, Report L1-2004, Item 47, adopted 11/14/2004)

(revised, Report I-2009, Item 3-59, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 85, adopted 10/24/2015)

Horseback Riding Safety

RESOLVED, That the North Carolina Medical Society supports horseback riding educational programs for parents, riding instructors, show organizers, and managers outlining the risks in horseback riding and methods to minimize them; and be it further

RESOLVED, That the North Carolina Medical Society supports universal use of satisfactory headgear for all horseback riding activities.

(Report H-1983, adopted 5/7/83)
(reaffirmed, Report FF-1993, Item 16, adopted 11/7/93)
(revised, Report H-2003, Item 3-8, adopted as amended 11/16/03)
(reaffirmed, Report N-2008, Item 2-4, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 45, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 163, adopted 11/3/2018)

Safety for Bicycle, Skateboard, and Similar Devices

RESOLVED, That the North Carolina Medical Society supports the safe operation of bicycles, skateboards, and similar devices through communication to the public about the need to use proper helmets and appropriate safety equipment.

(Report R-1989, adopted 11/11/89)
(reaffirmed, Report L-1999, Item 21, adopted 11/14/99)
(revised, Report C-2005, Item 26, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-5, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 86, adopted 10/24/2015)

Skateboards and In-Line Skates

RESOLVED, That the North Carolina Medical Society supports the use of proper helmets and pads by persons using skateboards and in-line skates.

(Report O-1989, adopted 11/11/89)
(revised, Report L-1999, Item 23, adopted 11/14/99)
(revised, Report L1-2004, Item 67, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-75, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 22, adopted 10/25/2014)

Playground Safety

RESOLVED, That the North Carolina Medical Society supports sensible and cost-effective regulation of playground safety.

(Substitute Report D-1998, adopted 11/15/98)
(revised, Report L3-2004, Item 61, adopted 11/14/2004)
(revised, Report I-2009, Item 3-30, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 23, adopted 10/25/2014)

Smoke Detectors

RESOLVED, That the North Carolina Medical Society supports mandating the use of properly functioning smoke detectors in all rental property.

(Report CC-1995, adopted 11/12/95)
(revised, Report L3-2004, Item 58, adopted 11/14/2004)
(revised, Report I-2009, Item 3-45, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 24, adopted 10/25/2014)

Swimming Pool Safety

RESOLVED, That the North Carolina Medical Society supports standards requiring isolation pool fencing for new and existing residential pools.

(Substitute Report DD-1992, adopted as amended 11/8/92)
(revised, Report H-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-42, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 46, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 164, adopted 11/3/2018)

Medically Impaired Drivers

RESOLVED, That the North Carolina Medical Society supports cooperation between physicians, attorneys, courts, and state agencies to identify and treat medically impaired drivers.

(Report F-1993, adopted as amended 11/7/93)
(revised, Report H-2003, Item 3-9, adopted as amended 11/16/03)
(revised, Report N-2008, Item 3-22, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 47, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 165, adopted 11/3/2018)

“Click It Or Ticket” Program

RESOLVED, That the North Carolina Medical Society supports the “Click It or Ticket” Program, which encourages the use of automotive restraint devices in North Carolina.

(Resolution 18-1993, adopted as amended 11/7/93)
(revised, Report H-2003, Item 3 #10, adopted as amended 11/16/03)
(reaffirmed, Report N-2008, Item 2-3, adopted 10/19/2008)

(reaffirmed, Reaffirmation Report-2013, Item 48, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 166, adopted 11/3/2018)

Drivers' Licenses

RESOLVED, That the North Carolina Medical Society supports limiting the opportunities for unsafe drivers to obtain a driver's license under false pretenses.

(Substitute Report G-1993, adopted 11/7/93)
(revised, Report H-2003, Item 3 #24, adopted as amended 11/16/03)
(revised, Report N-2008, Item 3-15, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 49, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 167, adopted 11/3/2018)

Motorcycle Helmets

RESOLVED, That the Medical Society opposes the repeal of mandatory motorcycle helmet use laws.

(Resolution 28-1983, adopted 5/7/83)
(reaffirmed, Report FF-1993, Item 18, adopted 11/7/93)
(revised, Report H-2003, Item 3 #25, adopted as amended 11/16/03)
(reaffirmed, Report N-2008, Item 2-5, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 50, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 168, adopted 11/3/2018)

Pickup Truck Passenger Safety

RESOLVED, That the North Carolina Medical Society supports prohibiting children under twelve years of age in an open bed or cargo area of a vehicle, repeal of county exemptions allowing children to ride with an adult in an open bed or cargo area of a vehicle, and making violations of these laws subject to the same penalties as other child passenger safety violations.

(Report FF-1992, adopted 11/8/92)
(revised, Report H-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-33, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 51, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 169, adopted 11/3/2018)

Bicycle Helmet Use

RESOLVED, That the North Carolina Medical Society supports all measures to increase helmet use among the bicycling population; and be it further

RESOLVED, That the North Carolina Medical Society supports increased enforcement of helmet use laws among the bicycling population.

(Report HH-1992, adopted 11/8/92)
(reaffirmed, Report H-2002, adopted 11/17/02)
(revised, Report N-2008, Item 3-7, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 52, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 170, adopted 11/3/2018)

Support Linkage of Databases Related to Highway Injuries for Research Purposes

RESOLVED, That the North Carolina Medical Society supports linkage of the State's Crash File, Administrative Office of the Courts, Emergency Department, Hospital Discharge, Death Certificate, Trauma Registry, and the Pre-Hospital Medical Information System (PreMIS)databases for highway safety research and quality improvement.

(Report II-1992, adopted 11/8/92)
(revised, Report H-2002, adopted 11/17/02
(revised, Report N-2008, Item 3-41, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 53, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 171, adopted 11/3/2018)

Mandatory Seat Belt Laws

RESOLVED, That the North Carolina Medical Society supports ongoing enforcement of laws regarding use of seat belts, child safety seats, and other approved safety devices.

(Substitute Report J-1991, adopted 11/9/1991)
(reaffirmed, Report U-2001, Item 9, adopted 11/11/2001)
(revised, Report R-2007, Item 3-25, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-30, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 172, adopted 11/3/2018)

Seat Belts and Shoulder Harnesses

RESOLVED, That the North Carolina Medical Society supports mandatory use of lap seat belts, shoulder harnesses, and age-appropriate restraints by all persons driving or riding in motor vehicles on the public roads of North Carolina.

(Resolution 8-1985, adopted 5/4/1985)
(revised, Report Q-2000, Item 36, adopted 11/12/2000)
(revised, Report R-2006, Item 34, adopted 10/29/2006)
(reaffirmed, Reaffirmation Report-2013, Item 54, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 173, adopted 11/3/2018)

School Buses

RESOLVED, That the North Carolina Medical Society supports the use of school buses equipped with appropriate passenger protective systems; and be it further

RESOLVED, That the North Carolina Medical Society supports the reduced school bus idling policy to reduce diesel emissions.

(Report J-1987, adopted 5/2/87)
(reaffirmed, Report OO-1997, Item 5, adopted 11/16/97)
(revised, Report L3-2004, Item 54, adopted 11/14/2004)
(revised, Report I-2009, Item 3-54, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 25, adopted 10/25/2014)

Helmet Use

RESOLVED, That the North Carolina Medical Society supports mandatory American National Standards Institute (ANSI) certified helmet use by all operators and passengers of bicycles, mopeds, all terrain vehicles, and other motorized vehicles.

(Report H-1987, adopted 5/2/87) (amended, Report OO-1997, Item 6, adopted 11/16/97)
(revised, Report L3-2004, Item 67, adopted 11/14/2004)
(revised, Report I-2009, Item 3-53, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 26, adopted 10/25/2014)

Bicycling Access

RESOLVED, That the North Carolina Medical Society supports efforts to improve bicycling access in North Carolina through construction of bicycle paths and modifications of existing roadways.

(Resolution 15-1997, adopted as amended 11/16/97)
(revised, Report L3-2004, Item 70, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-83, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 27, adopted 10/25/2014)

Graduated Drivers Licensing

RESOLVED, That the North Carolina Medical Society supports a fully graduated driver licensing system.

(Report J-1995, adopted as amended 11/12/95)
(revised, Report L3-2004, Item 56, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-82, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 28, adopted 10/25/2014)

Traffic Safety

RESOLVED, That the North Carolina Medical Society supports development of traffic policies that consider pedestrian and bicycle access and safety in addition to vehicular traffic flow.

(Report H-2006, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-19, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 174, adopted 11/3/2018)

Wheelchair Restraints

RESOLVED, That the North Carolina Medical Society supports legislation requiring the use of vehicle restraint systems for wheelchair occupants, based upon national standards.

(Resolution 5-2007, adopted in lieu of Resolution 5 10/21/2007)
(reaffirmed, Report F-2012, Item 3-31, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 175, adopted 11/3/2018)

Distracted Driver Awareness

RESOLVED, That the North Carolina Medical Society encourages its members to educate their patients about the dangers of distracting activities while driving.

(Resolution 11-2008, adopted as amended 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 55, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 176, adopted 11/3/2018)

Driving While Intoxicated Prevention

The North Carolina Medical Society supports policies and programs that prevent individuals from driving while intoxicated.

(Report D-2008, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 56, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 177, adopted 11/3/2018)

External Cause of Injury Coding

The North Carolina Medical Society supports recording of external cause of injury codes (e-codes) in the hospital discharge database (HDD) and emergency department database (NC DETECT) for each emergency department visit or hospital admission for which an injury is one of the diagnoses, and to ensure that the first-listed external cause code should be related directly to the principal injury diagnosis.

(Report E-2008, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 57, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 178, adopted 11/3/2018)

Falls Prevention

The North Carolina Medical Society supports policies and programs to reduce the number of falls, fall-related injuries, and seriousness of injuries resulting from falls.

Report F-2008, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 58, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 179, adopted 11/3/2018)

STORE-BASED CLINICS / URGENT CARE CENTERS

Free-Standing Emergency, Urgent Care, or Store-Based Clinics

RESOLVED, That the North Carolina Medical Society supports the use of appropriate criteria and guidelines for the establishment and operation of free-standing emergency, urgent care, or store-based clinics in North Carolina to ensure that the public is adequately informed of the limitations of their emergency care capabilities.

(Report S-1985, adopted 5/4/85)
(revised, Report II-1995, Item 10, adopted 11/12/95)
(revised, Report L3-2004, Item 19, adopted 11/14/2004)
(revised, Report I-2009, Item 3-13, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 29, adopted 10/25/2014)

Store-Based Health Clinics

RESOLVED, That the North Carolina Medical Society opposes the existence of store-based health clinics unless they meet the following principles:

PRINCIPLES:

1. Store-based health clinics must have a well-defined and limited scope of clinical services, consistent with state scope of practice laws.
2. Store-based health clinics must use standardized medical protocols derived from evidence-based practice guidelines to ensure patient safety and quality of care.
3. Store-based health clinics must establish arrangements by which their health care practitioners have direct access to and supervision by those with medical degrees (MD and DO) as consistent with state laws.
4. Store-based health clinics must establish protocols for ensuring continuity of care with practicing physicians within the local community.
5. Store-based health clinics must establish a referral system with physician practices or other facilities for appropriate treatment if the patient’s conditions or symptoms are beyond the scope of services provided by the clinic.

6. Store-based health clinics must clearly inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as any limitation in the types of illnesses that can be diagnosed and treated.
7. Store-based health clinics must establish appropriate sanitation and hygienic guidelines and facilities to ensure the safety of patients.
8. Store-based health clinics should be encouraged to use electronic health records as a means of communicating patient information and facilitating continuity of care.
9. Store-based health clinics should encourage patients to establish care with a primary care physician to ensure continuity of care.
10. Store-based health clinics must clearly display a) the name, location and telephone number of the supervising physician and b) notification as to whether there is a physician on site.
11. Store-based health clinics must ensure that all patients seen are referred back to their current primary care physician. If no primary care relationship exists for a patient seen at a store-based health clinic, then referral should be made to a primary care physician in the local community for follow-up, including private practices, public health clinics or other primary care offices.
12. Store-based health clinics must ensure that notification is clearly visible to all patients seen at store-based health clinics that they do not have to get prescriptions at the store-based health clinic where care is delivered. This notice should specifically include addresses and phone numbers of other nearby pharmacies where medications may be obtained at a lower price.

(Report N-2006, adopted 10/29/2006)(revised, Report D-2009, adopted in lieu of Resolution 12-2008, 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 30, adopted 10/25/2014)

SUBSTANCE ABUSE

Anabolic Steroids

RESOLVED, That the North Carolina Medical Society opposes the prescription and use of anabolic steroids for the enhancement of athletic ability.

(Resolution 36-1989, adopted 11/11/89)
(reaffirmed, Report L-1999, Item 25, adopted 11/14/99)
(revised, Report R-2006, Item 43, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-10, adopted 10/23/2011)
(reaffirmed, Board Report-2018, Item 180, adopted 11/3/2018)

Addictive Drug Prescribing Patterns

RESOLVED, That the North Carolina Medical Society supports educating health care professionals, including medical students, in North Carolina about the addiction process, including cross addiction, and supports the use of appropriate measures, such as the NC Controlled Substance Registry, to avoid inappropriate prescribing.

(Report S-1988, Item 2, adopted as amended 5/7/88)
(reaffirmed, Report MM-1998, Item 27, adopted 11/15/98)
(revised, Report L1-2004, Item 32, adopted 11/14/2004)
(revised, Report J-2010, Item 3-8, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 87, adopted 10/24/2015)

Substance Abuse Prevention

RESOLVED, That the North Carolina Medical Society supports developing comprehensive community-based programs to combat substance abuse and dependency including "drug treatment" courts; and be it further

RESOLVED, That the North Carolina Medical Society supports physician directed evaluation and appropriate treatment for incarcerated individuals for substance dependency; and be it further

RESOLVED, That the North Carolina Medical Society supports substance abuse education for medical students and physicians, especially in their community education programs, that includes information on the prevalence of and prevention of substance abuse in the medical practice setting.

(Report F-1972, adopted 5/23/72)
(revised, Report D-1986, Item 12, adopted 5/3/86)
(revised, Report Y-1996, Item 17, adopted 11/17/96)
(revised, Report L1-2004, Item 33, adopted 11/14/2004)
(revised, Report I-2009, Item 3-50, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 31, adopted 10/25/2014)

Adequate Coverage by State Employees Health Program for Adolescent Chemical Dependency Treatment

RESOLVED, That the North Carolina Medical Society supports adequate coverage by the State Employees Health Insurance Program for adolescent chemical dependency treatment.

(Resolution 7-1986, adopted 5/3/86)
(revised, Report Y-1996, Item 22, adopted 11/17/96)
(revised, Report C-2005, Item 35, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-11, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 88, adopted 10/24/2015)

Prescription Drug Abuse, Forgery, and Diversion

RESOLVED, That the North Carolina Medical Society supports increased state funding for drug abuse treatment services including reimbursement for buprenorphine as alternative to methadone maintenance for opioid dependence; and be it further

RESOLVED, That the North Carolina Medical Society supports an amendment to the Controlled Substances Reporting System (CSRS) Act confidentiality provisions providing civil and criminal immunity for all health care practitioners who access the CSRS system and communicate CSRS information to health care personnel involved in a patient's care and law enforcement; and be it further

RESOLVED, That the North Carolina Medical Society supports the North Carolina Medical Board's position statement "Policy for the Use of Opiates for the Treatment of Pain" as amended in June 2014.

(Report S-2006, adopted 10/29/2006)
(revised, Report H-2011, Item 1-7, adopted 10/23/2011)

Support Legislation Requiring Parity for the Treatment of Chemical Dependency

RESOLVED, That the North Carolina Medical Society support parity for the treatment of chemical, alcohol, drug, and nicotine dependency.

(Report I-1999, adopted as amended 11/14/99)
(revised, Report C-2005, Item 45, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-41, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 89, adopted 10/24/2015)

Use of Controlled Substances Reporting System (CSRS)

RESOLVED, That the North Carolina Medical Society supports adding a provision to patient narcotic or opioid informed consent documents stating that the Controlled Substances Reporting System database can be accessed and used in making decisions regarding treatment, referral, consultation, and continuing the physician-patient relationship.

(Resolution 2-2008, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 59, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 181, adopted 11/3/2018)

Manufacture and Sale of Synthetic Drug Products

RESOLVED, That the North Carolina Medical Society opposes the manufacture and sale of various synthetic drug products rapidly becoming substances of abuse and commonly know by such names as "bath salts, incense, spice, K-2, and Kush" among others; further, the North Carolina Medical Society supports the study of these chemical compounds for the purposes of testing for and regulation of these substances.

(Resolution 15-2012, adopted as amended 10/27/2012)

Controlled Substance Reporting System (CSRS) Enrollment

RESOLVED, That the North Carolina Medical Society supports the voluntary enrollment of physicians to access the Controlled Substance Reporting System.

(Report A1-2012, adopted 10/27/2012)

SURGERY

Postoperative Patient Care

RESOLVED, That the North Carolina Medical Society supports the provision of safe and readily available postoperative or post-procedure care by the physician who performed the surgery or procedure or by an appropriately licensed MD, DO, NP, or PA capable of providing the requisite postoperative or post-procedure care under a formal arrangement with the physician who performed the surgery or procedure; and be it further

RESOLVED, That the North Carolina Medical Society opposes actions by physicians performing surgery or procedures to avoid responsibility for postoperative care.

(Resolution 8-1986, adopted 5/3/86)
(revised, Report Q-2000, Item 52, adopted 11/12/00)
(revised, Report R-2006, Item 3, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-14, adopted 10/23/2011)
(technical correction, Board Report-2018, Item 182, adopted 11/3/2018)

Care of the Patient Undergoing Surgery or Other Invasive Procedure

RESOLVED, that the North Carolina Medical Society supports the North Carolina Medical Board position statement “Care of the Patient Undergoing Surgery or Other Invasive Procedure” as amended in June 2012.

(Report K-1988, adopted as amended 5/7/88)
(reaffirmed, Report MM-1998, Item 50, adopted 11/15/98)
(revised, Report L1-2004, Item 12, adopted 11/14/2004)
(revised, Report I-2009, Item 3-15, adopted 11/01/2009)
(technical correction, Board Report-2018, Item 183, adopted 11/3/2018)

Preoperative Care

RESOLVED, That the North Carolina Medical Society supports the provision of preoperative care, including the decision to recommend surgery, by or under the supervision of a licensed physician.

(Report K-1990, adopted 11/10/90)
(revised, Report Q-2000, Item 51, adopted 11/12/00)
(revised, Report R-2006, Item 12, adopted 10/29/2006)

(reaffirmed, Report H-2011, Item 3-4, 10/23/2011)
(reaffirmed, Board Report-2018, Item 184, adopted 11/3/2018)

Laser as Surgery

RESOLVED, That the North Carolina Medical Society supports a definition of surgery that includes the revision, destruction, incision or other structural alteration of human tissue using laser or other similar technology; and be it further

RESOLVED, That the North Carolina Medical Society opposes any efforts to define the therapeutic use of lasers as anything other than surgery; and be it further

RESOLVED, That the North Carolina Medical Society supports initiatives to define the medical therapeutic use of lasers as a type of surgery.

(Substitute Resolution 28-1996, adopted 11/17/96)
(revised, Report L3-2004, Item 52, adopted 11/14/2004) (reaffirmed, Report I-2009, Item 2-63, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 21, adopted 10/25/2014)

Second Opinion Surgery

RESOLVED, That the North Carolina Medical Society supports the rights of physicians and patients to seek a second opinion freely from any physician of his/her choice; and be it further

RESOLVED, That the North Carolina Medical Society supports the concept that second opinions should not be required by a third party.

(Report S-1984, Item 4, adopted 5/5/84)
(reaffirmed, Report CC-1994, Item 10, adopted 11/6/94)
(revised, Report L1-2004, Item 51, adopted 11/14/2004)
(revised, Report I-2009, Item 3-20, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 90, adopted 10/24/2015)

Surgical Patient Safety

RESOLVED, That the North Carolina Medical Society supports that any person who performs surgical procedures that present substantial risks of injury or complication should be qualified by appropriate education, training, and experience to evaluate, diagnose, and treat the underlying condition(s), provide postoperative care, and treat complications; and be it further

RESOLVED, That the North Carolina Medical Society supports a physician’s discussion with the patient of expected benefits, common risks, and alternative treatments should be discussed with all patients before the performance of any surgical procedure.

(Report K-2006, adopted 10/29/2006)
(reaffirmed, Report H-2011, Item 3-5, 10/23/2011)
(technical correction, Board Report-2018, Item 185, adopted 11/3/2018)

Definition of Surgery

RESOLVED, That the North Carolina Medical Society supports a definition of the term "surgery" as follows:

Surgery

> The diagnosis or therapeutic treatment of conditions or disease processes by any instrument causing localized alteration or transposition of live human tissue or organs, including, but not limited to: lasers, ultrasound, ionizing radiation, scalpels, probes and needles in which human tissue or organs are cut, burned, vaporized, frozen, sutured, probed, manipulated by closed reduction for major dislocations and fractures, or otherwise altered by any mechanical, thermal, light-based, electromagnetic, or chemical means.

(Report J-2006, adopted as amended 10/29/2006)
(reaffirmed, Report H-2011, Item 3-6, 10/23/2011)
(reaffirmed, Board Report-2018, Item 186, adopted 11/3/2018)

THIRD-PARTY PAYORS

Child Health Care Coverage

RESOLVED, That the North Carolina Medical Society supports coverage of well-baby and well-child services by health plans.

(Report N-1988, adopted 5/7/1988)
(revised Report MM-1998, Item 16, adopted 11/15/1998)
(revised, Report C-2005, Item 32, adopted 10/16/2005)
(reaffirmed, Reaffirmation Report-2013, Item 60, adopted 10/26/2013)
(technical correction, Board Report-2018, Item 187, adopted 11/3/2018)

Insurance Bureaucracy/Paperwork

RESOLVED, That the North Carolina Medical Society supports legislation that would require insurers to pay a fee of $20 to a practice or physician for each prior authorization or pre-authorization.

(Resolution 6-2009, adopted, 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 5, adopted 10/25/2014)

Disability Insurance Policies

RESOLVED, That the North Carolina Medical Society supports requiring all disability policies to state that insured individuals be considered disabled and thus eligible for benefits when they cannot work in their usual occupations or professional specialties due to public health concerns.

(Resolution 15-1993, adopted as amended 11/7/1993)
(revised, Report H-2003, Item 3 -7, adopted as amended 11/16/2003)
(revised, Report N-2008, Item 3-14, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 61, adopted 10/26/2013)
(technical correction, Board Report-2018, Item 188, adopted 11/3/2018)

Health Insurance

RESOLVED, That the North Carolina Medical Society supports health insurance programs including managed care programs and employer-sponsored plans structured to maintain appropriate quality and coverage for the citizens of North Carolina.

(Resolution 17-1990, adopted 11/10/1990)
(revised, Report Q-2000, Item 44, adopted 11/12/2000)
(revised, Report R-2006, Item 59, adopted 10/29/2006)
(reaffirmed, Reaffirmation Report-2013, Item 62, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 189, adopted 11/3/2018)

Health Insurance Coverage in the Free Enterprise System

RESOLVED, That the North Carolina Medical Society supports the American Medical Association-sponsored initiatives on health insurance, which incorporates a major role for the private sector and the free enterprise system.

(Resolution 15-1978, adopted 5/7/78)
(revised, Report II-1989, Item 12, adopted 11/11/89)
(title revised, Report L-1999, Item 28, adopted 11/14/99)
(revised, Report C-2005, Item 5, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-25, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 91, adopted 10/24/2015)

Consumer Protection in ERISA Plans

RESOLVED, That the North Carolina Medical Society supports meaningful consumer protections for enrollees of ERISA qualified health plans, similar to those applicable to state regulated plans.

(Report KK-1998, adopted 11/15/98)
(revised, Report L3-2004, Item 17, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-27, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 6, adopted 10/25/2014)

Managed Care Organizations’ Medical Necessity Criteria for Approval of Benefits

RESOLVED, That the North Carolina Medical Society supports policies requiring the managed care companies operating in North Carolina to make available to physicians, upon request, clinical guidelines and all medical and scientific reference sources used to validate clinical guidelines.

(Resolution 15-1992, adopted 11/8/1992)
(reaffirmed, Report H-2002, adopted 11/17/2002)
(revised, Report N-2008, Item 3-50, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 63, adopted 10/26/2013)
(technical correction, Board Report-2018, Item 190, adopted 11/3/2018)

North Carolina Medical Society Managed Care Organization Report Card

RESOLVED, That the North Carolina Medical Society supports periodic surveys of physician offices regarding their experience, attitudes, and opinions of the operation of Managed Care Organizations doing business in North Carolina.

(Report R-1999, adopted 11/14/99)
(revised, Report C, Item 41, adopted 10/16/2005)
(reaffirmed, Report I-2009, Item 2-43, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 7, adopted 10/25/2014)

Physician Advocacy with Managed Care Organizations

RESOLVED, That the North Carolina Medical Society supports efforts to represent organized medicine’s viewpoint to managed care organizations; and be it further

RESOLVED, That the North Carolina Medical Society supports efforts to continue and expand these efforts to promote the advocacy of physician interests in the health care arena, including monitoring and evaluating activities of health plans, provision of assistance to members, regulatory intervention, and legal action when necessary.

(Resolution 4-1999, adopted 11/14/99)
(revised, Report C-2005, Item 42, adopted 10/16/2005)
(revised, Report I-2009, Item 3-18, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 8, adopted 10/25/2014)

Physician Decision-Making in Health Plans

RESOLVED, That the North Carolina Medical Society opposes the preemption of treating physicians’ judgments by third party payors in responsibilities including, but not limited to, the following:

- Selection of diagnostic tests that are appropriate;
- When and to whom in-plan physician referral is indicated;
- When and to whom out-of-plan physician referral is indicated;
- When and with whom consultation is indicated;
- When non-emergency hospitalization is indicated;
- When hospitalization from the Emergency Department is indicated;
- Choice of in-plan service sites for specific services (office, out-patient department, home care, etc.);
- Hospital length of stay;
- Frequency and length of hospital out-patient visits or care;
- Use of out-of-formulary medications;
- When and what surgery is indicated;
- When termination of extraordinary heroic care is indicated;
- Recommendations to patients for other treatment options, including non-covered care;
- Scheduling of on-call coverage;
- Terminating a physician/patient relationship;
- Whether to work with and what responsibility should be delegated to mid level practitioners; and
- Determination of the most appropriate treatment methodology.

(Resolution 12-1997, adopted as amended 11/16/97)
(revised, Report L2-2004, Item 47, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-30, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 9, adopted 10/25/2014)

Ethics in Managed Care

RESOLVED, That the North Carolina Medical Society supports the 1996 Ethics in Managed Care Report. See Appendix A.

(Report QQ-1996, adopted 11/17/96)
(revised, Report L2-2004, Item 41, adopted 11/14/2004)
(reaffirmed, Report J-2010, Item 2-13, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 92, adopted 10/24/2015)

Health Care Coverage for Special Needs Children

RESOLVED, That the North Carolina Medical Society opposes the systematic denial of coverage to children with special needs by managed care organizations and indemnity insurance companies, and be it further

RESOLVED, That the North Carolina Medical Society supports the elimination of such systematic denial of coverage by the insurance industry.

(Substitute Resolution 2-1995, adopted 11/12/95)
(revised, Report C-2005, Item 36, adopted 10/16/2005)

(revised, Report J-2010, Item 3-21, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 93, adopted 10/24/2015)

Health Plan Financial Incentives

RESOLVED, That the North Carolina Medical Society supports measures to ensure that all health plans be required to disclose with a prominent statement on all policies and promotional materials the following to potential clients, customers, employers, and members:

1. Economic and other incentives given to providers to limit plan expenses.
2. Specific and detailed disclosure of restrictions in choice of physicians and limitations of services available.

(Resolution 13-1995, adopted as amended 11/12/95)
(revised, Report L2-2004, Item 28, adopted 11/14/2004)
(revised, Report I-2009, Item 3-17, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 10, adopted 10/25/2014)

Fairness Measures in Managed Care

RESOLVED, That the North Carolina Medical Society supports measures to assure fairness in the practice of managed care. Fairness measures for patients and physicians should address:

- certification of managed care plans based on compliance with standards regarding access of enrollees to providers, disclosure of plan limitations, solvency, physician input into medical decision making, opportunity for physicians to apply to managed care panels, and assurance of patient confidentiality;
- due process for physicians who are terminated from panels;
- appropriateness of utilization review standards, including clinical relevance of screening criteria, and qualifications of physicians involved in utilization review;
- opportunity for patients to select plans with a reasonable point of service option;
- allowing any willing physician provider access to practice within any plan or plans of the provider's choice; if the provider meets the criteria for all others in the provider's scope of practice, and if the provider agrees to accept the terms of contract offered by the managed care organization; and
- requiring annual public disclosure of the complete financial statement of the managed care organization to include annual revenues, expenditures by line items, salaries, bonuses and fringe benefits paid to officers, directors and stockholders of such organizations and public disclosure of the names of officers, directors and stockholders.

(Report AA-1994, adopted as amended 11/6/94)
(revised, Report L2-2004, Item 29, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-31, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 11, adopted 10/25/2014)

Prospective Review by Health Plans

RESOLVED, That the North Carolina Medical Society opposes prospective review programs by health plans, including preauthorization and precertification, that cause undue delay and impairment of appropriate patient care; and be it further

RESOLVED, That the North Carolina Medical Society opposes any prospective review programs in urgent or emergent circumstances.

(Resolution 8-1983, adopted 5/7/83)
(revised, Report FF-1993, Item 17, adopted 11/7/93)
(revised, Report H-2003, Item 3 #27, adopted as amended 11/16/03)
(reaffirmed, Report N-2008, Item 2-13, adopted 10/19/2008)
(revised, Report G-2013, Item 2-9, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 192, adopted 11/3/2018)

Physician Credentialing

RESOLVED, That the North Carolina Medical Society supports standardized and streamlined credentialing processes for state licensure, Medicare Carrier provider numbers, hospital privileges, and third-party payors.

(Report N-2001, adopted 11/11/2001)
(revised, Report R-2007, Item 3-34, adopted 10/21/2007)
(reaffirmed, Report I-2009, Item 2-41, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 12, adopted 10/25/2014)

Exclusivity of Hospital Emergency Use

RESOLVED, That the North Carolina Medical Society supports elimination of exclusive contracting between third-party payors and hospitals for rendering emergency medical care; and be it further

RESOLVED, That the North Carolina Medical Society oppose exclusive contracts between third-party payors and hospitals for provision of emergency medical care as inappropriate and not in the best interest of patient care.

(Report I-2000, adopted 11/12/2000)
(revised, Report R-2006, Item 61, adopted 10/29/2006)
(reaffirmed, Reaffirmation Report-2013, Item 65, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 193, adopted 11/3/2018)

Transplantation Services

RESOLVED, That the North Carolina Medical Society supports the requirement that the HMOs, PPOs, and other North Carolina third-party payors offer transplantation services to their enrollees at a transplant center near to the enrollee.

(Resolution 11-1999, adopted 11/14/99)
(revised, Report C-2005, Item 47, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-20, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 94, adopted 10/24/2015)

Dietary Instruction for Chronic Disease Patients

RESOLVED, That the North Carolina Medical Society supports third party reimbursement of nutritional instruction services for patients at risk of or who already have a chronic disease for which appropriate nutrition is important for prevention or treatment of the disease.

(Substitute Resolution 24-1998, adopted as amended 11/15/98)
(revised, Report C-2005, Item 39, adopted 10/15/2005)
(reaffirmed, Report J-2010, item 2-22, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 95, adopted 10/24/2015)

Direct Access to Physiatrists

RESOLVED, That the North Carolina Medical Society supports coverage by third party payors for direct access to specialists in Physical Medicine and Rehabilitation as principal physicians for individuals with severe disabilities such as spinal cord injuries or traumatic brain injuries.

(Substitute Resolution 27-1998, adopted as amended 11/15/98)
(revised, Report C-2005, Item 38, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-23, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 96, adopted 10/24/2015)

Assignment of Benefits

RESOLVED, That the North Carolina Medical Society supports (1) permitting patients to assign their benefits to physicians upon their written authorization to the appropriate third party payor and (2) requiring the third party payor to honor the assignment, regardless of the physician's participation in the patient's health plan network.

(Substitute Resolution 6 – 2004, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-36, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 13, adopted 10/25/2014)

Reimbursement for Specific Services or Benefits

RESOLVED, That the North Carolina Medical Society supports review of health care coverage and reimbursement requirements based on the following criteria:

1. The service or procedure is required in a life-threatening emergency, or
2. The service or procedure is required to prevent chronic disease, or

3. The service or procedure is cost-effective, i.e., will prevent or reduce future health care expenditures, or
4. The service or procedure would be considered by prudent laypersons to be a standard provision in a health insurance benefit package, or
5. The service or procedure is based on generally accepted standards of medical practice, based on credible scientific evidence published in peer-reviewed medical literature and generally recognized by the relevant medical community.

(Report F – 2004, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-28, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 14, adopted 10/25/2014)

Health Plan Profits

RESOLVED, That the North Carolina Medical Society opposes excessive profits and excessive CEO compensation by insurance companies and health plans in lieu of employer and individual premium decreases.

(Report G – 2004, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-40, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 15, adopted 10/25/2014)

Expert Testimony by Medical Directors for Managed Care Company

RESOLVED, That the North Carolina Medical Society opposes Medical Directors for managed care organizations serving as expert witnesses in cases involving physicians participating in that managed care organization's provider network.

(Resolution 2-2005, adopted as amended, 10/16/2005)
(reaffirmed, Report I-2009, Item 2-44, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 17, adopted 10/25/2014)

Assist Solo and Small Medical Practices with Contract Negotiations

RESOLVED, That the North Carolina Medical Society supports the vitality of solo and small practices, to the extent that physicians prefer that practice structure.

(Resolution 28-2006, adopted as amended 10/29/2006)
(reaffirmed, Report H-2011, Item 3-7, 10/23/2011)
(reaffirmed, Board Report-2018, Item 194, adopted 11/3/2018)

Standardized Contracting Agreements

RESOLVED, That the North Carolina Medical Society supports strategies to facilitate physician-health plan contracting reform.

(Resolution 8-2008, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 66, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 195, adopted 11/3/2018)

THIRD-PARTY PAYORS / REIMBURSEMENT

Reimbursement for Health Services Rendered to Children in School Health Centers

RESOLVED, That the North Carolina Medical Society supports adequate funding by private and public sources to allow health services to be rendered in school health centers by individuals who are licensed, certified, or otherwise authorized to provide them.

(Substitute Resolution 1-1998, adopted 11/15/1998)
(revised, Report L3-2004, Item 18, adopted 11/14/2004)
(revised, Report J-2010, Item 3-17, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 97, adopted 10/24/2015)

Timely Payment

RESOLVED, That the North Carolina Medical Society supports amending the current North Carolina General Statutes such that: any physician that does not receive payment within 30 days of filing a claim that is initially denied but later found to be accurate and legitimate be entitled to a commercially reasonable rate of interest per month beyond 30 days of the initial filing.

(Resolution 7-2009, adopted as amended, 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 18, adopted 10/25/2014)

Cognitive Services Reimbursement

RESOLVED, That the North Carolina Medical Society supports equitable reimbursement by third party payors for physicians' cognitive services in comparison with their procedural services.

(Resolution 26-1984, adopted 5/5/84)
(revised, Report CC-1994, Item 31, adopted 11/6/94)
(revised, Report C-2005, Item 33, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-10, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 98, adopted 10/24/2015)

Small Employer Purchasing Groups

RESOLVED, That the North Carolina Medical Society supports the right of small employers to form purchasing groups in order to obtain lower health insurance rates, thereby controlling their costs while increasing access.

(Resolution 7-1993, adopted 11/7/93)
(reaffirmed, Report H-2003, Item 2 #2, adopted as amended 11/16/03)
(reaffirmed, Report I-2009, Item 2-39, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 19, adopted 10/25/2014)

Third-Party Reimbursement of Phase III Clinical Trials

RESOLVED, That the North Carolina Medical Society supports health insurance coverage for services provided in conjunction with Phase III trials sanctioned by the National Cancer Institute or Institute of Medicine, for all cancers and for life-threatening, degenerative, permanently disabling conditions.

(Report M-2000, adopted 11/12/00)
(revised, Report R-2006, Item 58, adopted 10/29/2006)
(reaffirmed, Reaffirmation Report-2013, Item 15, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 196, adopted 11/3/2018)

Continuation of Health Insurance Coverage for Students

RESOLVED, That the North Carolina Medical Society supports the provision of continuous coverage to students converting from parents' or institutional group coverage upon submission of proper application and payment of premiums.

(Report II-1998, adopted 11/15/98)
(revised, Report L2-2004, Item 18, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-26, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 20, adopted 10/25/2014)

Home Health Infusion Therapy Reimbursement

RESOLVED, That the North Carolina Medical Society support reimbursement of medically necessary medications delivered through home health infusion therapy.

(Substitute Resolution 12-2000, adopted 11/12/00)
(reaffirmed, Report C-2005, Item 8, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-11, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 99, adopted 10/24/2015)

All Products Clauses

RESOLVED, That the North Carolina Medical Society opposes the use of "all-products" clauses in physician managed care contracts; and be it further

RESOLVED, That the North Carolina Medical Society opposes any limitation on the ability of the physician to choose the plans in which he or she participates; and be it further

RESOLVED, That the North Carolina Medical Society educate its members on the potential risks of "all-products" clauses and the importance of identifying such clauses in contracts prior to their signing; and be it further

RESOLVED, That the North Carolina Medical Society supports both state legislation and regulations to prohibit the use of "all-products" clauses in physician managed care contracts.

(Report B-2001, adopted 11/11/2001)
(revised, Report R-2007, Item 3-43, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-32, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 197, adopted 11/3/2018)

Harnessing Market Forces in Medical Pricing

RESOLVED, That the North Carolina Medical Society supports the following principles for incorporation in any public or private insurance proposal for physician payment:

1. A Resource Based Relative Value Scale that is regularly updated and rigorously validated should form the basis for all physician fee schedules.
2. Government programs and private insurers may establish fee schedules based upon a dollar conversion factor but physicians should not be required to accept this as payment in full unless they have freely entered into a contract to do so.
3. Physicians should be free to set their own fees based upon a conversion factor determined solely by the physicians' assessment of their overhead costs and the value of their services in the marketplace.
4. The conversion factors of payors and physicians should be widely published and distributed so that consumers can choose physicians based upon economic factors and the perceived quality of a physician's services.

(Substitute Resolution 1-1992, adopted 11/8/1992)
(revised, Report H-2002, adopted 11/17/2002)
(revised, Report N-2008, Item 3-52, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 67, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 198, adopted 11/3/2018)

Reimbursement Policy for Visits and Procedures on Same Day

RESOLVED, That the North Carolina Medical Society supports requirements for payors to reimburse physicians for appropriate multiple services performed on the same day.

(Substitute Report Q-1991, adopted 11/9/1991)
(revised, Report U-2001, Item 37, adopted 11/11/2001)
(revised, Report R-2007, Item 3-45, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-33, adopted 10/27/2012)
(reaffirmed, Board Report-2018, Item 199, adopted 11/3/2018)

Reimbursement for Cardiac Physical Rehabilitation

RESOLVED, That the North Carolina Medical Society supports the use of and reimbursement for cardiac physical rehabilitation in post-myocardial infarction and post-cardiac surgery.

(Report K-1986, adopted 5/3/86)
(revised, Report Y-1996, Item 14, adopted 11/17/96)
(revised, Report C-2005, Item 37, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-16, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 100, adopted 10/24/2015)

Fee-for-Service Payment

RESOLVED, That the North Carolina Medical Society supports preservation of fee-for-service as an appropriate payment method; and be it further

RESOLVED, That the NCMS is actively engaged in developing and supporting new models of care that include payment based on value and quality measures. While fee-for-service remains a model of payment, other models are encouraged.

(Resolution 23-1986, adopted 5/3/86)
(revised, Report Y-1996, Item 27, adopted 11/17/96)
(revised, Report L2-2004, Item 21, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-37, adopted 11/01/2009) (revised, Report F-2014, Item 1, adopted 10/25/2014)

Professional Courtesy

RESOLVED, That the North Carolina Medical Society supports the right of physicians to offer professional courtesy to medical colleagues and their families.

(Resolution 31-1998, adopted as amended 11/15/98)
(revised, Report L3-2004, Item 47, adopted 11/14/2004)
(revised, Report I-2009, Item 3-4, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 101, adopted 10/24/2015)

Payment For Tests and Procedures

RESOLVED, That the North Carolina Medical Society support the concept that treating MDs/DOs who are qualified to perform a test, procedure, or treatment on their patients should be allowed to perform that test, procedure, or treatment and be reimbursed accordingly.

(Report B-2002, adopted 11/17/2002)
(reaffirmed, Report N-2008, Item 2-12, adopted 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 68, adopted 10/26/2013)

Unfair Health Plan Payment Policies

RESOLVED, that the North Carolina Medical Society supports appropriate remedies, including legislative or regulatory remedies, to address unfair payment policies that disadvantage physicians, and result in patient inconvenience and injustice. Such unfair payment policies include:

- Demands for Refunds of "Overpayments,"
- Payor Responsibility for Payment following Eligibility Verification,
- Suspended Payments Pending Receipt of Coordination of Benefits (COB) Information from Patients,
- Balance Billing for Services Later Not Deemed Medically Necessary or for Ineligible Patients,
- Bundling and Automatic Downcoding,
- Absence of Provision of Fee Schedule Information and Fee Schedule Updates,
- Payor Refusals to Honor Assignments of Benefits,
- Provision of Mandatory Clinical Guidelines to Physicians,
- Absence of Opportunity for Provider Initiation of Grievances and Appeals,
- Health Plan or Payor Communications which Give Providers a Negative Image,
- Excessive Requests for Medical Records and Lack of Adherence to Principles or Patient Confidentiality,
- Refusal to Permit Specialist Physicians to Act as a Direct Point of Entry for Patients with Diseases within their Area of Specialization; and be it further

RESOLVED, That the North Carolina Medical Society supports the use of an evaluation mechanism or "report card" on all third party payors measuring communications, medical review programs, payment efficiency and accuracy, and other attributes.

(Report K-2001, adopted as amended 11/11/01)
(revised, Report L2-2004, Item 40, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-38, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 2, adopted 10/25/2014)

On-Site Lab Work

RESOLVED, That the North Carolina Medical Society supports legislation that requires health care plans to pay for medically necessary on-site testing at a rate equal to the highest rate paid for the same service to off-site providers.

(Resolution 13-2001, adopted as amended 11/11/01)
(revised, Report R-2007, Item 3-38, adopted 10/21/2007)
(reaffirmed, Report F-2012, Item 3-34, adopted 10/27/2012)

Reporting of Claims Payment Data

RESOLVED, That the North Carolina Medical Society supports requirements mandating that all claims processing organizations in North Carolina, including health insurers and third-party administrators, submit annual reports to the North Carolina Department of Insurance. These reports shall include timeliness of payments, payment and rejection rates, and reasons for rejection. These reports shall be made available to the public.

(Resolution 30-2000, adopted as amended 11/12/2000)
(revised, Report R-2006, Item 62, adopted 10/29/2006)
(reaffirmed, Reaffirmation Report-2013, Item 69, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 200, adopted 11/3/2018)

Timely Payments of "Clean Claims"

RESOLVED, That the North Carolina Medical Society supports a definition of "clean claims" and measures requiring all third-party payors to adhere strictly to a prompt payment process. Penalties to third-party payors for delaying payment should include full payment plus interest, followed by fines on a per case basis.

(Resolution 12-1999, adopted as amended 11/14/99)
(revised, Report C-2005, Item 48, adopted 10/16/2005)
(reaffirmed, Report J-2010, Item 2-21, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 102, adopted 10/24/2015)

Prompt Claims Payment

RESOLVED, That the North Carolina Medical Society supports requiring health benefit plans to pay error free claims within 30 days of receipt, including self-insured plans.

(Resolution 28-1998, adopted 11/15/98)
(revised, Report L3-2004, Item 63, adopted 11/14/2004)
(revised, Report I-2009, Item 3-23, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 3, adopted 10/25/2014)

Tricare Payment

RESOLVED, That the North Carolina Medical Society supports increasing the CHAMPUS Maximum Allowable Charge schedule to a level that assures adequate access to care for CHAMPUS and Tricare beneficiaries.

(Resolution 8-1994, adopted as amended 11/6/94)
(revised, Report L2-2004, Item 34, adopted 11/14/2004)
(reaffirmed, Report I-2009, Item 2-32, adopted 11/01/2009) (reaffirmed, Reaffirmation Report-2014, Item 4, adopted 10/25/2014)

Administrative and Professional Services

RESOLVED, That the North Carolina Medical Society supports charging patients for services that typically are not reimbursed by third party payors, provided that the following conditions are met:

1. There are no third party payor or other applicable contractual prohibitions on billing the individual patient for such services;
2. The practice has a clear policy outlining what services will be billed to the patient and how much;
3. The patient is notified in writing of the practice's policy, either at the initial visit or at the first visit after the policy is adopted by the practice; updated versions of the policy are provided as necessary; and
4. The amount charged is reasonable under the circumstances and is limited to costs incurred by the practice in performing the service.

Examples of services that typically are not reimbursed by third party payors include, but are not limited to: copying medical records; filling out lengthy insurance and other forms; telephone, email, and telemedicine consultations and prescription refills; and be it further

RESOLVED, That the North Carolina Medical Society supports waiving charges to patients for services that typically are not reimbursed by third party payors if such charges would impede access to care; and be it further

RESOLVED, That the North Carolina Medical Society supports third party reimbursement for services that are not reimbursed by third party payors such as telephone, email, and telemedicine consultations and prescription refills.

(Report D – 2004, adopted 11/14/2004)
(reaffirmed, Report J-2010, Item 2-17, adopted 10/24/2010) (reaffirmed, NCMS Policy Review 2015 Report, Item 103, adopted 10/24/2015)

Vaccine Product and Administration Reimbursement

RESOLVED, That the North Carolina Medical Society supports vaccine product reimbursement levels of at least the physician's reasonable acquisition cost; and be it further

RESOLVED, That the North Carolina Medical Society supports vaccine administration reimbursement levels of at least the Medicare vaccine administration fee schedule for North Carolina; and be it further

RESOLVED, That the North Carolina Medical Society supports balance billing by physicians for the difference between the reasonable acquisition costs of the vaccine product and the reimbursement by the health insurance plan for the vaccine product.

(Resolution 21-2006, adopted as amended 10/29/2006)
(reaffirmed, Reaffirmation Report-2013, Item 70, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 201, adopted 11/3/2018)

Payment at Time of Service/Point of Service Payment Systems

RESOLVED, That the North Carolina Medical Society supports the development of payment systems that facilitate payment at the point of service.

(Resolution 7-2008, adopted as amended 10/19/2008)
(reaffirmed, Reaffirmation Report-2013, Item 71, adopted 10/26/2013)
(reaffirmed, Board Report-2018, Item 202, adopted 11/3/2018)

TOBACCO

Tobacco-Free NC

The North Carolina Medical Society supports a tobacco-free society where all public spaces are free of tobacco in all forms (including smoke and vapor).

The North Carolina Medical Society supports funding and access to initiatives and programs aimed at education, prevention, and cessation to aid in the reduction of tobacco use across North Carolina, especially in children/teens.

(NCMS Board Report, adopted 1/23/2021)

VIOLENCE PREVENTION

Domestic Violence Awareness

RESOLVED, That the North Carolina Medical Society supports increasing clinical awareness of suspected incidences of physical, sexual, or psychological abuse or other means of domestic violence; and be it further

Resolved, That the North Carolina Medical Society supports mandatory reporting of

1. Suspicion of abuse or neglect of a juvenile.
2. Every case of bullet wound, gunshot wound, powder burn, or any other injury arising from or caused by, or appearing to arise from or be caused by, the discharge of a gun or firearm.
3. Every case of illness caused by poisoning if it appears to the physician that a criminal act was involved.
4. Every case of a wound, injury caused or apparently caused by a knife or sharp or pointed instrument if it appears to the physician that a criminal act was involved.
5. Every case of a wound or injury or illness in which there is grave bodily harm or grave illness if it appears to the physician that it resulted from a criminal act of violence.

(Report J-1997, adopted 11/16/97)
(revised, Report L3-2004, Item 59, adopted 11/14/2004)

(revised, Report I-2009, Item 3-57, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 104, adopted 10/24/2015)

Domestic Violence/Abuse Education

RESOLVED, That the North Carolina Medical Society supports educational efforts for medical students and physicians aimed at improving diagnosis, treatment, and appropriate referral, of physical, sexual, psychological,and other abuse victims.

(Report F-1994, adopted as amended 11/6/94)
(revised, Report L1-2004, Item 30, adopted 11/14/2004)
(revised, Report I-2009, Item 3-58, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 105, adopted 10/24/2015)

School Violence Prevention

RESOLVED, That the North Carolina Medical Society supports educational programs that prevent school violence.

(Substitute Resolution 13-1998, adopted 11/15/98)
(revised, Report L1-2004, Item 73, adopted 11/14/2004)
(revised, Report I-2009, Item 3-55, adopted 11/01/2009) (reaffirmed, NCMS Policy Review 2015 Report, Item 106, adopted 10/24/2015)