



ALABAMA State Board of Medical Examiners Medical Licensure Commission

Newsletter and Report

www.albme.org

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Testosterone replacement from an endocrinologist's perspective

by Robert C. Osburne, MD, Endocrinology,
Simon Williamson Clinic, Birmingham, Alabama

In the past two newsletters, the Board has featured articles concerning testosterone replacement therapy from a reproductive endocrinologist's perspective and from a urologist's perspective. The following article is the last in this series and includes a more detailed, technical discussion of testosterone replacement.

Testosterone replacement is appropriate to treat the clinical symptoms of male hypogonadism unless a contraindication is present. Proper use requires an understanding of the physiology of the hypothalamic-pituitary-gonadal axis.

See Testosterone replacement, page 4

After peaking in adolescent and young adult males, testosterone gradually declines

over a lifetime.

This is considered a normal part of aging.

The term “andropause”

is used to describe the hypogonadism in older males. Its

manifestations are less dramatic than the symptoms that



Robert C. Osburne, MD



Continuing Medical Education Notice of Rule Amendments Effective May 25, 2012

Alabama Board of Medical Examiners and Medical Licensure Commission Rules concerning Continuing Medical Education were amended to:

- Eliminate the “grace period” of Jan. 1 through Jan. 31 for obtaining CME
- CME (25 Category 1 or equivalent credits annually) must be obtained by Dec. 31
- Having obtained CME is no longer a condition precedent to renewing license (see example below)
- CME certification on renewal application reflects that CME requirement has been met or will be met by Dec. 31

Physicians may now renew licenses before obtaining all the required credits. For example, physician renews license on Nov. 1 but does not obtain 25th credit until Dec. 10. As long as 25 **valid** credits are earned by Dec. 31, the requirement is met.

The grace period for renewing the license (with a late fee) remains in effect. It is the physician's responsibility to ensure that courses are accredited to confer *AMA PRA Category 1 Credit™* or equivalent.

Please see www.albme.org/cme.html for more information. All physicians are required to read and be familiar with the content of the rules.

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A Message from the Executive Director Proposed CME Change: Elimination of Grace Period

by Larry Dixon, Executive Director

At its April 18, 2012, meeting, the Board proposed amending the continuing medical education (CME) rules to eliminate the grace period (Jan. 1 - Jan. 31) for obtaining CME credits. Now, all CME credits must be obtained by Dec. 31. The grace period for renewing your license is unaffected; you can renew between Jan. 1 and Jan. 31 with a \$100 late fee. But now you don't have to wait to renew your license until you have obtained the CME as the Commission previously required. On the CME certification portion of the renewal application, you will now state that the requirement has been met **or will be met** by Dec. 31. The Medical Licensure Commission also approved the rule amendments at its May 23, 2012, meeting. The rules will be published for public comment and also adopted as emergency rules, effective May 25, 2012. The text of the rule amendments is available at our website, www.albme.org. The number of Category 1 or equivalent credits required annually remains 25.

The rule changes were proposed because of confusion about attesting in the renewal application to having obtained the CME as of the date of renewal. Many physicians have conferences scheduled for the last few months of the year but would like to renew their licenses earlier. It was not clear to some physicians that they were certifying on their renewal applications that they had already obtained all of their required credits for the year. The Board began discussions and proposed eliminating the grace period and modifying the attestation on the license renewal application to allow physicians to renew their licenses before they have obtained all of the required credits. The Board is hopeful these amendments will assist those physicians who would like to renew their licenses before they have obtained that 25th credit of CME scheduled for November or December.

To recap:

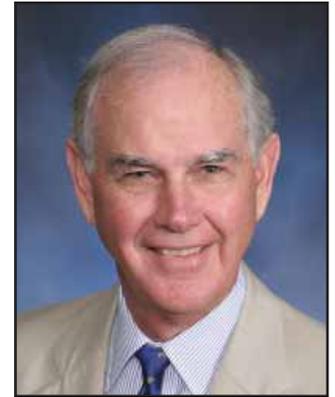
- 25 Category 1 or equivalent CME credits must be obtained by Dec. 31;
- The grace period of Jan. 1 - Jan. 31 for obtaining CME is eliminated;
- It is no longer required that all CME be obtained before renewing license; and
- CME certification on renewal application reflects CME requirement has been met or will be met by Dec. 31.

There has also been discussion about licensees' confusion about what constitutes acceptable CME credits. We continue to see physicians who have attended a basic or advanced life support class and later discovered it was not accredited to confer Category 1 credits. There are also physicians who obtain Category 2 credits with the mistaken impression that they will count toward the requirement, when in fact they do not. Below is a brief recap of what CME activities are acceptable. You are strongly encouraged to review the Board's web page and the rules concerning CME at www.albme.org/cme.

Acceptable:

- *AMA PRA Category 1 Credits*TM

see CME changes, page 3



Larry Dixon

Welcome new Board member



Michael Flanagan, MD

Michael T. Flanagan, MD, was elected to the Board in April 2012. He is a board certified anesthesiologist and pain management physician specializing in the diagnosis and treatment of acute and chronic pain syndromes. Dr. Flanagan received his Bachelor of Arts degree in chemistry and his medical degree from Wake Forest University. He completed his anesthesiology residency and pain manage-

ment fellowship at North Carolina Baptist Hospital. During that time, Dr. Flanagan was named a Glaxo-Wellcome Resident Scholar and Wyeth-Ayerst Pain Fellow Scholar. Dr. Flanagan has practiced pain management in Dothan since 1998. In 2008, the AMA Foundation recognized Dr. Flanagan with the Excellence in Medicine award. Outside of medicine, Dr. Flanagan enjoys spending time with his family, swimming, sailing, and serving on his church pastoral council.

*"Wherever the art of medicine is loved,
there is also a love of humanity"*
– Hippocrates

CME changes, cont.

- AOA Category 1-A credits
- Prescribed hours (AAFP)
- Cognates (ACOG)
- Documented attendance at grand rounds

Acceptable but must be claimed from AMA:

- Teaching at a live activity accredited to confer Category 1 credits
- Publishing as lead author a peer reviewed article in MEDLINE database
- Preparing poster presentation as first author which is included in the published abstracts at an accredited activity
- Obtaining a medically related advanced degree such as masters in public health
- Successfully completing an ABMS board certification or MoC process
- Successfully participating in an ACGME accredited residency or fellowship program

Not acceptable (when in doubt, check with the activity provider):

- **Non-accredited** basic life support classes (PALS, ATLS, ACLS, etc.) (These courses are acceptable through **accredited** providers.)
- Teaching medical students
- Precepting nurses or other healthcare providers
- Some board certification exam review courses
- Journal quizzes that are not turned in for credit
- Many Botox, laser and aesthetic procedure workshops are not accredited



Steven P. Furr, MD, (center) is recognized for eleven years of dedicated service to the Board of Medical Examiners.

In recognition of eleven years of service, the Board of Medical Examiners recognized Steven P. Furr, MD, with a commemorative plaque at its April meeting. Dr. Furr, a family practice physician in private practice in Jackson, became a member of the Board of Medical Examiners in 2001 and was elected vice chairman in May 2008. He completed his term on the Board in 2012. He also served as president of the Medical Association of the State of Alabama for 2010-2011. He received his bachelor's and medical degrees at the University of South Alabama College of Medicine. After completing post-graduate training at Huntsville Hospital, Dr. Furr established a group practice with Dr. Sid Crosby that now has four family physicians and two nurse practitioners. He is certified by the American Board of Family Medicine. In addition to being a trustee and vice chairman of the Board of the University of South Alabama, he is also active in the United Methodist Church. He is the conference lay leader for the Alabama West Florida Conference and recently gave the Laity Address at the United Methodist Church's General Conference. He was selected as a member of the Alabama Healthcare Hall of Fame, Class of 2012. His wife Lisa works with gifted students in the public schools.

Testosterone replacement, cont.

occur at menopause in women. Testosterone levels below the lower laboratory limit are seen in 20 percent of men over 60 years and 40 percent of men over 80 years. Comprehensive screening will reveal symptoms attributable to hypogonadism in many males below the age of 60 when the total serum testosterone is below 400 mcg/dl (provided that the sex hormone binding globulin is not low, and the bioavailable testosterone is also low). Generally the frequency of symptoms increases as the serum level of testosterone declines, although the correlation is far from perfect.

Testosterone is secreted from the Leydig cells in the testicles in response to the secretion of leutinizing hormone (LH) from the pituitary. In turn, testosterone inhibits secretion of LH from the pituitary. The presence and degree of LH secretion depend on pulsatile secretion of the LH releasing hormone (LHRH) from the hypothalamus. Hypogonadism may result from dysfunction at any point in the system. LHRH release can be inhibited by illness, stress, or depression, among other conditions.

The evaluation of male hypogonadism is usually straight forward. Symptoms include loss of libido, erectile dysfunction (a separate but related problem), fatigue and depression. Physical signs include muscle atrophy and weight gain, and complications include deterioration in control of diabetes mellitus and osteoporosis. A physical exam should include confrontation visual fields, breast exam, and inspection of genital development and testicular size and consistency. A determination of serum levels of total and bioavailable testosterone is necessary. If the bioavailable testosterone is normal, a low total testosterone has no clinical impact. The LH should be measured. If it is above the normal range the problem is with the testicles. If it is below the normal range a pituitary problem is likely. LH levels will also be low during therapy with testosterone therapy and will remain low for some time after it is stopped. "Inappropriately" normal LH levels are common in functional hypothalamic hypogonadism, but are consistent with hypothalamic or pituitary disease as well. A prolactin level should be obtained. If it is elevated, a central problem exists and if it is above 100 ng/dl a tumor should be strongly suspected. A number of medications can elevate the prolactin as can hypothyroidism. Pituitary imaging is indicated if a tumor (pituitary or supra-sellar) is suspected.

If the testosterone is mildly to moderately decreased (200-400 ng/dl) and there are no symptoms, treatment is not necessary. Osteoporosis is a significant concern especially when levels are chronically below 100. For a man with no present or future interest in fertility with a low testosterone (below 350 ng/dl in most labs) replacement with parenteral testosterone in some form is first line for most patients.

There are no oral forms of testosterone proven to be both effective and safe. Gels, solutions, or patches (cutaneous, scrotal and buccal) are the most common forms for initial therapy. Intramuscular testosterone esters in oil (cottonseed or sesame) are the oldest safe and effective therapy for male hypogonadism. Implantation of subcutaneous testosterone pellets has emerged as a viable option as well.

Complications of testosterone replacement include: infertility (reversible), testicular atrophy (reversible), prostatic hypertrophy, progression of prostate cancer (particularly undiagnosed and or more aggressive forms of prostate cancer), polycythemia, sleep apnea, hepatitis, breast tenderness or hypertrophy (due to aromatization), venous thrombosis, and hypertension.

Using testosterone or other hormones (including HCG) to build muscle mass and strength or to improve athletic performance should be discouraged. Problems associated with testosterone abuse with supra-physiologic serum levels may include irritable mood, anger management issues, increased aggression, acne and gynecomastia. Medical conditions including hypertension and hyperlipidemia may worsen, possibly increasing the long term risk for coronary artery disease. Testicular atrophy is common. With prolonged, continuous parenteral testosterone (usually more than 3-6 months) the central gonadal axis may be suppressed in the same manner that the adrenal axis is suppressed with prolonged use of glucocorticoids. Axis recovery may take 6 to 12 months or longer. The resulting hypogonadism is often severe with hot flashes, extreme fatigue and depression being common. The problem is best avoided by not abusing testosterone; but, should it occur, it is recommended that the patient be referred to a physician experienced with managing this problem. Medical or hormonal performance enhancement is prohibited by the NCAA, Professional Football, Professional Baseball, the Olympics and other sports associations. Most of these organizations have screening programs to detect the use of these medications/hormones and exclude athletes who use them. It is considered a form of cheating.

In summary, parenteral testosterone when used properly is valuable for the treatment of male hypogonadism, while use for body building has significant long term health risks and is discouraged.

Bibliography

- ¹ Jones, T Hugh (Ed). Testosterone Deficiency in Men. New York. Oxford University Press, 2011
- ² Rhoden, EL and Morgentaler A. Risks of Testosterone-Replacement Therapy and Recommendations for Monitoring. *N Engl J Med* 2004;350:482-92
- ⁴ Snyder, PJ. Testosterone treatment of male hypogonadism. In: UpToDate, Matsumoto, AM (Ed), UpToDate, Waltham, MA, 2012

Providing records of other physicians

There is no clear cut precedent to provide guidance concerning the appropriateness of including copies of medical records not generated by the physician, and there is a difference of opinion on this. The majority view is a physician should transfer any medical information in the patient's record which is pertinent to the patient's medical history and/or to any ongoing course of treatment. Some types of records should not be routinely forwarded, such as confidential financial information concerning the patient or records concerning sexually transmitted or other notifiable diseases, or drug/alcohol or psychiatric treatment. Except for those categories mentioned, there is no reason why a physician should not transfer medical records of other treatment providers. On the other hand, there is no statute or regulation which requires the forwarding of this information. In most circumstances, including the records of other treatment providers is a benefit to the patient who does not have to arrange for the transfer of records from past providers which may or may not be available.

Source: Paraphrased from Medical Association of the State of Alabama's Medical Records Policy (http://www.masalink.org/uploadedFiles/Practice_Management/policy_medicalrecords.pdf) (members only access).

Notice regarding e-mail addresses

The Board and Commission collect e-mail addresses for licensees through the online license renewal system. This is the e-mail address the Board and Commission will use for official business.

If applicable, please add @albme.org to your safe senders list to ensure you will receive official correspondence. The Board and Commission do not sell e-mail address lists.

MASA/BME

Educational Opportunities for 2012

August 10-12

Prescribing and Pharmacology of Controlled Drugs: Critical Issues and Common Pitfalls

November 17-18

Prescribing and Pharmacology of Controlled Drugs: Critical Issues and Common Pitfalls

November 29

Ensuring Quality in the Collaborative Practice

December 15

Ethics Education



Visit www.masalink.org for more information.

Reminder PA Controlled Substances Prescribing

Before a P.A. may obtain a QACSC, the following requirements must be met:

1. Must hold a current, unrestricted license and be registered to perform medical services under the supervision of a physician who holds a valid, current, unrestricted ACSC.
2. Complete 12 hours of continuing medical education in the area of prescribing controlled drugs (8 credits) and in the area of advanced pharmacology and prescribing trends (4 credits).
3. Complete the 12 credits within one year preceding the filing of an application.
4. Document a minimum of 12 months of active clinical employment with physician supervision.

This is an excerpt from the QACSC rules and is not intended to be comprehensive; please review the entire chapter of rules available at <http://www.albme.org/cscapp.html#qacsc>.

Your Medical License

As a physician, your license to practice medicine in the State of Alabama is one of your most important assets. It allows you to apply what you learned during years of school and post-graduate training to earn a livelihood to support your family.

Exercise care to protect this asset.

Reminder - Collaborative Practice Fees

All collaborative practice agreements that have not been terminated expire annually on Dec. 31. If our records indicate you are in a collaborative practice as a supervising physician, it will be listed on the license renewal postcard. The collaborative practice can be renewed online along with your license and ACSC. If you think you are not in a collaborative practice and your postcard notice indicates that you are, you should immediately contact our office.

Collaborative practices remain in effect until the Board has received a termination notice from the physician. Simply ending an employment rela-

tionship does not terminate the collaborative practice. There is a form to effect the termination of a collaborative practice available at our website, <http://www.albme.org/collpracapp.html>.

If a collaborative practice is neither renewed nor terminated by Dec. 31, then the physician will receive a letter to either send a termination notification or cease and desist collaboration with the advanced practice nurse(s) until the fee is paid. If these notices are simply ignored and neither action is taken, then the physician will receive a letter of concern from the Board.

Ensuring Quality in the Collaborative Practice

Working together to deliver quality healthcare

November 29, 2012

4 p.m. to 7 p.m.

Embassy Suites,
Montgomery

Registration Fee: **\$100**

[visit www.masalink.org/
CollaborativePractice](http://www.masalink.org/CollaborativePractice)

The Medical Association of the State of Alabama and the Alabama Board of Medical Examiners present...

Prescribing and Pharmacology of Controlled Drugs: Critical Issues and Common Pitfalls

2012 Series

August 10-12, 2012
Perdido Beach Resort
Orange Beach
27200 Perdido Beach
Boulevard

Registration Fee: \$375
Registration Deadline: Aug. 1

November 17-18, 2012
Embassy Suites | Hoover
2300 Woodcrest Place

Registration Fee: \$375
Registration Deadline: Nov. 7

How can the practitioner more effectively understand the pharmacologic profiles for controlled drugs, identify diagnostic criteria for appropriate prescribing and consider the therapeutic implications of specific substance use by individual patients? This special intensive course has been developed to enhance the practitioner's ability to effectively prescribe controlled medications, while minimizing their misuse whenever possible.

The Intensive Course in Prescribing Controlled Drugs is designed for physicians, dentists, and physician assistants in all specialties who need or wish to increase their knowledge and ability to effectively prescribe medications while minimizing the potential for abuse.

**For more information about the course, call MASA's Education Department
at (334) 954-2500 or visit www.masalink.org/Prescribing.**

Report of Public Actions of the Medical Licensure Commission and Board of Medical Examiners

BME – March 2012

◆ On March 21, the Board denied the application for a certificate of qualification to practice medicine in Alabama of **Pedro N. Capote, MD**, Miami, FL.

MLC – April 2012

◆ On April 6, the Commission entered an Order approving the practice plan of **Oscar V. Fadul, MD**, license number MD.9585, Huntsville, AL.

◆ On April 6, the Commission entered an Order approving the practice plan of **Lloyd Andrew Manchikes, MD**, license number MD.13075, Mobile, AL.

◆ On April 6, the Commission entered an Order denying the request to remove all restrictions on the license to practice medicine in Alabama of **Ervin Wells, MD**, license number MD.28241, Tuscaloosa, AL.

◆ Effective April 20, the license to practice medicine in Alabama of **Mark Koch, DO**, license number DO.322, Monroeville, AL, is summarily suspended until such time as the Administrative Complaint of the Board is heard and a decision rendered thereon.

◆ On April 27, the Commission entered an Order reinstating to full, unrestricted status the license to practice medicine in Alabama of **Paul Allen Brundage, DO**, license number DO.699, Cleveland, TN.

◆ On April 27, the Commission entered an Order reinstating to full, unrestricted status the license to practice medicine in Alabama of **Gilberto Sanchez, MD**, license number MD.17969, Montgomery, AL.

BME – April 2012

◆ On April 19, the Board entered an Order temporarily suspending the Alabama Controlled Substances Certificate of **Rodolfo M. Veluz, MD**, ACSC number ACSC.9246, Irondale, AL, until such time as a hearing shall be held and a decision rendered thereon.

MLC – May 2012

◆ On May 29, the Commission issued an Order placing on probation the license to practice medicine in Alabama of **Mary C. Murphy, MD**, license number MD.17707, San Diego, CA.

◆ On May 29, the Commission entered an Order suspending the license to practice medicine in Alabama of **Gladwyn L. Murray, MD**, license number MD.25986, Mobile, AL. A hearing has been scheduled for June 20, 2012, at which time the Commission may make such other, further and different orders in this matter as it may deem appropriate.

BME – May 2012

◆ On May 23, **William T. Hall, Jr., MD**, license number MD.8930, Birmingham, AL, voluntarily surrendered his Alabama Controlled Substances Certificate and controlled substances prescribing authority in all schedules.

◆ On May 24, the Board issued an Order denying the application of **John J. Villaverde, MD**, license number MD.11177, Birmingham, AL, for removal of voluntary restrictions.

Actions taken regarding failure to comply with CME requirements

Joint Petition, Stipulation and Consent Orders dated April 18:

- **Suzanne Tormoen, MD**, MD.20114, Fairhope, AL
- **Larry E. Thorne, MD**, MD.18478, Auburn, AL
- **Armando J. R. Quizon, MD**, MD.22028, Gadsden, AL
- **Christopher D. Mullenix, MD**, MD.23582, Mobile AL
- **Fred A. McLeod, MD**, MD.16702, Alexander City, AL
- **Steven J. King, MD**, MD.20022, Birmingham, AL
- **John M. Jinks, MD**, MD.19183, Anniston, AL
- **Michael K. Han, MD**, MD.20019, Birmingham, AL
- **Wendy R. Gomez, MD**, MD.23474, Boaz, AL
- **John W. Boyer, MD**, MD.22702, Mobile AL
- **Robert C. Bondurant, MD**, MD.19294, Daphne, AL

Joint Petition, Stipulation and Consent Orders dated April 24:

- **Chad J. Gilliam, PA**, PA.670, Madison, AL
- **James K. Knight, AA**, AA.840, Madison, AL

- **Arthur S. McAdams, PA**, PA.81, Birmingham, AL

Voluntary surrender

- **Elizabeth Anne Ellis, PA**, PA. 13, Birmingham, AL

Joint Petition, Stipulation and Consent Orders dated May 23, 2012:

- **Stephen J. Andrews, MD**, license number MD.19279, Mobile AL
- **Randall C. Boudreaux, MD**, license number MD.16510, Mobile AL
- **Gary M. Bullock, DO**, license number DO.729, Hoover AL
- **Amjad I. Butt, MD**, license number MD.29003, Selma AL
- **David Clyde Call, DO**, license number DO.1009, Birmingham AL
- **Britton B. Carter, MD**, license number MD.18205, Birmingham AL
- **Jeffrey M. Constantine, MD**, license number MD.20922, Huntsville, AL
- **David W. Cosgrove, MD**, license number MD.19927, Birmingham, AL
- **Percy V. Crocker, MD**, license number MD.6625, Mobile, AL
- **Anjanetta L. Foster, MD**, license number MD.18217, Birmingham, AL
- **Sher M. Ghori, MD**, license number MD.23730, Dothan, AL
- **Traci G. Hackett, MD**, license number MD.23561, Hoover, AL
- **Ascension P. Hilado, MD**, license number MD.24182, Samson, AL
- **Robert S. Hodson, MD**, license number MD.17344, Birmingham, AL
- **Rebecca Kirk Lockhart, MD**, license number MD.20191, Birmingham, AL
- **Norma M. Mobley, MD**, license number MD.23492, Mobile, AL
- **Brendella T. Montgomery, MD**, license number MD.17420, Madison, AL
- **Christopher B. Nester, MD**, license number MD.20694, Sheffield, AL
- **Jerry E. Robbins, II, MD**, license number MD.21372, Decatur, AL
- **David W. Sanford, MD**, license number MD.18394, Foley, AL
- **Robert A. Schuster, MD**, license number MD.16847, Dadeville, AL
- **Mark A. Sweeny, MD**, license number MD.23078, Decatur, AL
- **Robert A. Ward, MD**, license number MD.23890, Cullman, AL



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for important news
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Examiners that pertains to
your license
to practice medicine
in Alabama.**

All current licensees receive the Board of Medical Examiners *Newsletter and Report* at their address of record at no charge. Licensees may also choose to receive the newsletter by e-mail. Non-licensee subscriptions to the newsletter are by e-mail only.

If you would like to receive the newsletter by e-mail, please send a request to masa@masalink.org.

Change of Address

Alabama law requires that every licensed physician notify the Board of Medical Examiners in writing within 15 days of a change of the physician's practice location address and/or mailing address.