



# ALABAMA State Board of Medical Examiners Medical Licensure Commission

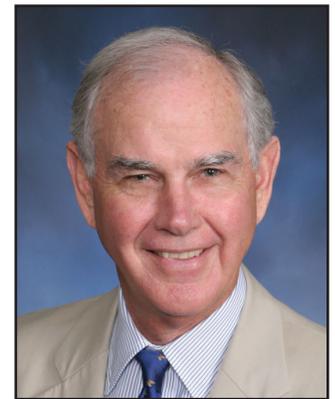
## Newsletter and Report

www.albme.org

July 2015

### *A Message from the Executive Director* **Alabama joins Interstate Medical Licensure Compact**

On May 19, 2015, Governor Robert Bentley signed Act No. 2015-197 (Senate Bill 125), sponsored by: Senators Reed, Waggoner, Dial and Marsh; physician Senators Melson and Stutts; and dentist Senator Bussman. This Act approved Alabama’s participation in the Interstate Medical Licensure Compact, which will provide a streamlined process for board-certified physicians to become licensed in multiple states. A physician currently licensed in a state participating in the Compact will be able to obtain expedited licensure in another Compact state. Only physicians who meet the highest standards of all states will be eligible. The Compact will not affect current Alabama laws concerning the qualifications to practice medicine, the current cost necessary for physicians to become licensed in Alabama or the current methods of regulation of the practice of medicine.



Larry Dixon

The framework of the Compact was developed by the Federation of State Medical Boards (FSMB) in response to a push for enhanced license portability through a national medical license that would be valid in all states. Such a national license would, for example, make it easier to practice via telemedicine all over the country. A major drawback of a federally issued license is the loss of state jurisdiction over the quality and standard of care of medicine being practiced in each state.

The Compact provides expedited licensure to enhance portability without compromising state regulation. Each state retains licensing and regulatory authority over the practice of medicine, which is defined to occur where the patient is located at the time of the physician-patient encounter. Compact state medical boards retain the jurisdiction to impose an adverse action against a licensee in that state.

Additionally, the Compact states are authorized to share derogatory information on fellow licensees and are required to report to the other Compact states any public action or complaints against a licensed physician who has applied for or received an expedited license through the Compact. Member boards may participate with other member boards in joint investigations of physicians licensed by member boards. These provisions prevent a physician sanctioned in one state from moving to another state in an attempt to “escape” sanctions.

The Compact was activated following the legislation’s passage in seven states, Alabama being the seventh state to enact it. The Act provides that a member of the Medical Licensure Commission of Alabama and a member of the Board of Medical Examiners each have one delegate on the governing body of the Compact. The Board of

*see Interstate Compact, page 4*

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## Patients, pain and physicians

by James A.C. Harrow, MD, PhD, Medical Director, APHP

We continue to find ourselves in the midst of an opioid epidemic. As an addiction medicine specialist, I have become very concerned regarding the mounting death toll as a result of opioid overdose. The questions that beg to be asked are how did this happen and who is responsible? It would be rather simplistic to point the finger at Government or Big Pharma. The reality is that physicians are given the privilege of prescribing controlled substances; and, therefore, we must bear some of the responsibility.

### **Studies have shown that the United States, with less than 5% of the world's population, uses 80% of the global supply of opioid drugs.**

Alabama has the dubious distinction of leading the nation in the use of prescription opioids and has the 26th highest drug overdose mortality rate in the United States, with 11.8 per 100,000 people suffering drug overdose fatalities, according to a new report, Prescription Drug Abuse: Strategies to Stop the Epidemic.

### **In the 1990s chronic nonmalignant pain became a political issue.**

The federal government made it clear to the medical community that we were not doing a very good job of treating patients with chronic pain. Estimates as high as one hundred million people in this country were affected and the media began to paint a picture that we as a profession were ignoring the problem. Pain became the "Fifth Vital Sign" and physicians were urged to address the concerns of their patients. The answer seemed rather simple: prescribe opioids. During training we were taught the appropriate use of opioids for the management of

acute traumatic, surgical or malignant pain. I would suggest that few, if any, physicians were taught the principles of addiction; and, therefore, we started to prescribe large amounts of high dose, euphorogenic opioids to an at-risk population.

### **Approximately 40% or more of chronic pain patients harbor the disease of addiction.**

In addition, there are no well-designed studies supporting the efficacy for the long-term use of opioids for the management of nonmalignant pain. It was assumed by many that addiction would not be an issue, and yet we find ourselves with a marked increase in patient overdose admissions to emergency rooms and hospitals. To further aggravate the problem, only one in ten patients receives treatment for addiction. Concurrently, the mortality rate from opioid overdose in the 17 to 45-year-old population has escalated and now is the leading cause of death in this cohort.

### **In response to this growing problem, government and organized medicine responded with the need to treat opioid addicts with opioids.**

Prior to the introduction of methadone for the treatment of opioid addiction, the Harrison Narcotic Act of 1914 made it a felony for a physician to treat an opioid addict with an opioid; and physicians at the time were literally arrested, charged and incarcerated. The introduction of methadone was approved by the United States Congress and Federal Drug Administration in the late 1960s. Clinics were licensed by the federal government and the regulations have become rather formidable. In 2000, the Drug Addiction Treatment Act gave authority to the Secretary of Health and Human Services to grant physicians with certain training

to prescribe buprenorphine for the treatment of opioid addiction.

### **It is necessary to appreciate the pharmacology of methadone and buprenorphine.**

Both drugs are synthetic opioids with high affinity for the mu receptor. Methadone is a pure agonist binding tightly to the receptor and the drug's half-life is on average 24 to 36 hours and longer in certain clinical conditions. The drug is highly lipid soluble, does not have a ceiling effect and is eliminated by first order kinetics. Buprenorphine is a partial agonist-antagonist. The drug has a ceiling effect and, therefore, is considerably safer owing to its unique pharmacokinetics. The advantages of buprenorphine are its safety profile and it can be prescribed as office-based treatment for opioid dependence.

As governmental authorities attempt to restrict the prescription of opioids, heroin use has escalated as have heroin-related overdose deaths.

### **There is, however, a rather dark side to the epidemic.**

Recent events in Mobile involved physicians engaged in criminal activity; and three Birmingham physicians have been charged as part of the DEA's Operation Pilluted. These news stories lend publicity to the involvement of our profession in the epidemic.

The majority of physicians provide care to their patients thoughtfully and make every reasonable effort to do no harm. We need to recognize that pain is a complex medical problem. The appropriate treatment of chronic nonmalignant pain requires a multidisciplinary approach and not simply prescribing large amounts of opioids for an indefinite period of time. It is imperative that we reflect on our own prescribing habits and become part of the solution, not the problem.

## Communication between physicians and patients

by Arthur F. Toole III, MD  
(Reprinted from the Alabama BME Newsletter and Report Volume 21, Number 4)

In the years that I spent on the Alabama Board of Medical Examiners it was clear that a large number of complaints filed against physicians were because of poor interpersonal communication rather than medical mismanagement. The communication problems to which I refer are not the difficulty that two persons find when each has a different native language. It is the need for the speaker to make certain that the message is fully and accurately received by the listener.

**I do not hold myself to be an authority on the art of communication, but I hope to stimulate introspection about your own medical practice.** Our goal as physicians is the comfort of our patients; the means to this goal is the cure, management, prevention, emotional support or other treatment of the person's disease. In this increasingly technological world it is easy to focus on the technical steps of disease management, assuming that this will produce patient satisfaction; frequently, additional care toward patient comfort is needed.

I will list some of the types of communication problems that I saw while serving on the Board and some that I have experienced myself. The list is not comprehensive but it may generate reflection on the general issue. It is difficult to form confident patient-physician relationships without sincere, open and trusting communication.

Try to put yourself in the patient's position and **answer your patient's questions**; have empathy. One of our greatest fears is the unknown. If the physician takes the time to explain the condition, with basic anatomical, physiological and pathological lessons in non-medical language the patient is

relieved and the physician's therapy may be more efficient because of an educated patient.

Recently, I read about an Irishman, discussing communications with others, who said, "Never underestimate their intelligence, always underestimate their knowledge."<sup>1</sup> This concept is pertinent for each of us as we talk to our patients. It does not insult your patient to review fundamental and basic facts; and, the patient is often capable of grasping ideas far more complex than we may assume.

I found that **using verbal similes and visual graphics** to amplify my explanation of a complicated medical thought helped.

Verbally, I tried to use a metaphor that related to the patient's work or life style so that he or she could more easily grasp the concept. When trying to explain muscle fascicles, one could use the simile of orange pulp being separated by tissue into slices. While technically this is not an exact comparison, it reveals the concept.

Visually, sketches or preprinted drawings, on which you mark the pertinent information, further amplify understanding.

One of my professors told me to **choose words carefully: to comfort, not cause concern.** Many words that physicians use routinely have a different connotation in the "outside" world. Some expressions conjure discomfort: when we want some one to draw a blood sample we frequently tell the technician to "stick" the patient. When we use the words "we are going to put you to sleep" we may, especially in a child, bring the thoughts of having a pet put down; using "we are going to give you medicine to let you go to sleep like at night" may be less fearsome. With CT, MRI and other new imaging modalities we often talk of "slices;"

to the non-medically informed person this sounds surgical.

Frequently, **family members have questions** about their relative's condition, treatment or prognosis. If they are not aware of important facts when they discuss your patient's illness among themselves they may make incorrect assumptions leading to incorrect conclusions. You may give information to your patient and expect the patient to relay it to the family, but, because the patient does not understand completely or forgets some of the pertinent facts, inadvertent misinformation can be spread.

Logistics often prevent you and the family being present at the same time when you make rounds on your hospitalized patient. You can relate to this if you have had a confined family member. Informing the family directly or through the nurses about when you usually make rounds lets them know when to be at the bedside instead of having to wait all day or having a "hit or miss" approach to speaking with you.

**Spend quality time with your hospitalized or otherwise confined patients.** I remember many times that I was rushed on morning rounds, trying to get to surgery and very tired after a long office day during evening rounds. Regrettably, my visits with my patients sometimes were hurried. Having had several experiences of hospitalizations for family members and for myself in the past few years, I understand how important the doctor's visit is for the patient. During the day there is time for the patient to wonder about the results of the tests that he or she has undergone and to wonder about his or her progress. The doctor's visit(s) is one of the highlights of the day. You can provide remarkable support for your patients by giving

*see Communication, page 5*

## Important Reminder for Collaborative Practice Physicians!

A Collaborative Practice Registration Fee of \$100 and a Commencement Form are required when beginning a new Collaborative Practice Agreement. This \$100.00 fee is the **responsibility of the physician** and must be paid before the application for Collaborative Practice can be considered for final approval, which is crucial for the future credentialing of the CRNP or CNM.

If you have questions or need assistance, contact one of the following:

### Collaborative Practice Nurse Inspectors

- Pat Ward, [pward@albme.org](mailto:pward@albme.org)
- Amy Wybenga, [awybenga@albme.org](mailto:awybenga@albme.org)

### Collaborative Practice Administrative Assistant

- Linda Stripling, [lstripling@albme.org](mailto:lstripling@albme.org)

## Internet drug sellers: What providers need to know

### FSMB and ASPO offer free continuing education course on illegal online drug sales

The Internet has had a profound impact on the practice of medicine and offers potential opportunities for improving the delivery and accessibility of health care. However, as more and more patients turn to the Internet to purchase their prescription drugs, whether for lifesaving medicines, antibiotics or drugs for cancer, diabetes and infertility, healthcare providers must play a key role in patient protection.

It has been reported that 97% of Internet pharmacies are illegal, selling prescription drugs without a valid prescription, offering unregulated and potentially unsafe pharmaceuticals and/or lacking the required licenses.

The goal of this activity is to increase awareness of illegitimate online pharmacies and to educate providers on how rogue online pharmacies operate, as well as the dangers they post to patients.

The Federation of State Medical Boards (FSMB) and the Alliance for Sale Online Pharmacies (ASOP) is offering a free online continuing education course (CME/CPE) for physicians and pharmacists focused on the growing problem of illegal online drug sales.

To access this FREE online CME/CPE activity, go to [www.fsmb.org/free-online-cme-cpe-activity](http://www.fsmb.org/free-online-cme-cpe-activity).

*see Free CME, page 8*

***“First, the patient, second the patient, third the patient, fourth the patient, fifth the patient and then maybe comes science. We first do everything for the patient.”***

– Bela Schick (1877-1967), renowned Hungarian pediatrician/ bacteriologist

## Interstate Compact, cont.

Medical Examiners has appointed **William E. Goetter, MD - Fairhope**, as its delegate; and the Medical Licensure Commission appointed **George C. Smith, Sr., MD – Lineville**, as its delegate. These two physicians will participate in the formation of the administrative structure of the Compact, including the adoption of bylaws.

This legislation not only enhances the provision of telemedicine, but also provides an expedited process for board-certified physicians to be recruited to the state of Alabama by existing groups or communities in underserved areas that need physicians. Those existing groups and communities, who have experienced the problems with recruiting new partners or physicians, know very well the amount of time it takes the process to work.

The Compact will retain all of the medical school, residency training and background information for every physician who applies. This means the time spent by the Board gathering that information, which can be months, will be dramatically shortened for Compact licensure applicants.

It is the Board's hope that the Compact will bring more board-certified physicians into the state of Alabama, as well as ensure that those physicians who utilize telemedicine to treat Alabama patients, but who do not reside here, will also meet the quality of care standards in Alabama.

## Notice: Limited Purpose Schedule II (LPSP)

If at a future date your supervising/collaborating physician feels it is appropriate to request approval for additional Schedule II medications, a supplemental formulary may be submitted at that time.

Please refer to page 2 of the current LPSP formulary for additional information and instructions regarding the medications listed. The formulary can be found on the BME's website at [www.albme.org/Documents/Forms/LPSP%20application.pdf](http://www.albme.org/Documents/Forms/LPSP%20application.pdf).

If you have questions concerning the Limited Purpose Schedule II Permit, please contact one of the following:

### PA LPSP

- Deana Bozeman, (334) 833-0166 or [dbozeman@albme.org](mailto:dbozeman@albme.org)

### CRNP LPSP

- Pat Ward, (334) 833-0186 or [pward@albme.org](mailto:pward@albme.org)
- Amy Wybenga, (334) 956-0307 or [awybenga@albme.org](mailto:awybenga@albme.org)

## Communication, cont.

them quality time on your rounds.

When you order laboratory tests or imaging studies you have a need for the results. The patient understands this need and is anxious to learn the results as soon as possible. **Relate reports of the results of laboratory and imaging tests promptly; if there are adverse or unexpected findings provide them personally.** Contact your patient with the results promptly, either through a planned, timely follow-up appointment or by telephone. If the tests are adverse or confusing, the patient appreciates hearing from the physician personally.

There are times when you discuss a patient's condition and you may sense that the patient is uncomfortable or unsure. Even if you are fully confident of your diagnosis, treatment plan, etc., **consider a consultation.** A second opinion can ease the patient's mind and such a referral may earn you the patient's respect and gratitude, leading to a better future relationship.

Many, if not most, of your patients now have Internet access. They use it as a resource for information about a diagnosis you have made or about a symptom before seeing you. We know that many sites contain erroneous information but there are reliable sites for the layperson. **Review and suggest specific Internet sites** to your patient as a place to educate themselves about

their disease. One such site is [www.medlineplus.gov](http://www.medlineplus.gov); the National Library of Medicine runs it.

**Non-verbal communication counts.** You can convey a significant amount of communication with your demeanor. A ready smile, a compassionate touch, a handshake or other gesture that indicates a sincere understanding of the patient's problem creates a level of communication. Personal touching must be done carefully, especially if you are a "hugger," so that you do not fall into sexual boundary violations. There are ways that you can make physical contact with your patient without incurring these types of accusations. [Read the administrative rules addressing sexual misconduct at [www.albme.org/sexualmisconduct.html](http://www.albme.org/sexualmisconduct.html).]

**Communicate with colleagues, especially those who may be covering for you.** In current medical practice most physicians have coverage arrangements for call. Communication with your covering physician about patients who have or may develop complex problems brings your coverage "up to speed" if an urgent problem develops.

### Summary

The essence of communication is to talk with your patients and with your colleagues. Don't be afraid of starting with the basics when explaining a medical condition or procedure. Don't

assume that your patient does not have the capacity to understand a concept.

Have empathy; understand your patients' anxieties. Answer their questions until they say that they understand fully and, when appropriate, include family members in the discussion. Use common, non-medical language as much as possible to assure understanding.

Realize that your patients worry about laboratory and imaging results. Provide them to the patient as soon as possible and answer the patient's questions about them. If you anticipate being out when the results arrive, make arrangement for a colleague to follow-up on them and answer questions as needed.

Remember, it is difficult to form confident patient/physician relationships without sincere, open and trusting communication.

**All of the above can be summarized with the concept of placing yourself in the position of your patient and treating your patient as you would wish to be treated if your roles were reversed.**

## PA Corner: Are you “covered” with covering physicians?

by Sheryll Coleman, PA

Physician Assistants are reminded that when the primary supervising physician is not immediately available to respond to patients’ needs, physician assistants are not authorized to practice without having an approved covering physician. A covering physician is defined below.

### **Rule: 540-X-7-.24 Covering Physicians for Physician Assistants (P.A.)**

(1) When the primary supervising physician is off duty, out of town, or not on call and not immediately available to respond to patients’ medical needs, the physician assistant is not authorized to perform any act or render any treatments unless another qualified physician in the same partnership, group, medical professional corporation or physician practice foundation or with whom the primary supervising physician shares call is on call and is immediately available to supervise the physician assistant and has previously filed with the Board a letter stating that he or she assumes all responsibility for the actions of the physician assistant during the temporary absence of the primary supervising physician.

(2) The covering physician providing the supervision shall also affirm in the letter that he or she is familiar with the current rules regarding physician assistants and the job description filed by the supervising physician and

the physician assistant, that he or she is accountable for adequately supervising the medical care rendered pursuant to the job description, and the he or she approves the drug type, dosage, quantity and number of refills of legend drugs which the physician assistant is authorized to prescribe in the job description.

The covering physician letter can be found at [www.albme.org/Documents/Forms/PA\\_coverltr.pdf](http://www.albme.org/Documents/Forms/PA_coverltr.pdf). If you have questions, contact Deana Bozeman at (334) 833-0166 or [dbozeman@albme.org](mailto:dbozeman@albme.org).

### **ASPA**

If you are not a member of the Alabama Society for Physician Assistants (ASPA), please consider joining to stay up-to-date with PA practice matters in Alabama. ASPA serves as the voice for PAs and is here to help you. Members of the Board meet quarterly with the Alabama Board of Medical Examiners to discuss issues that impact PA practice and the care of your patients. Board members also work on reimbursement issues on your behalf. For membership information, please contact Christi Long at (334) 954-2575 or go to [www.myaspa.org](http://www.myaspa.org).

## The Medical Association of the State of Alabama, the Alabama Board of Medical Examiners and the Alabama Board of Nursing present: **Medical Ethics, Prescribing of Controlled Drugs and ER/LA Opioid REMS**

November 20-22, 2015 | The Westin Huntsville

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

### MLC – March 2015

◆ On March 25, the Commission entered a Consent Order restricting the license to practice medicine in Alabama of **Guy E. Blaudeau, MD**, lic. no. MD.7503, Hoover, AL.

◆ On March 25, the Commission entered a Consent Order placing on probation the license to practice medicine in Alabama of **Joseph F. Sejud, MD**, lic. no. MD.26914, New Orleans, LA.

### BME – March 2015

◆ On March 18, the Board issued a Consent Order revoking the Qualified Alabama Controlled Substances Certificate of **Thomas S. Clark, PA**, lic. no. PA.427, Ft. Payne, AL.

◆ On March 18, the Board accepted the voluntary surrender of the Alabama Controlled Substances Certificate of **Peter A. Lodewick, MD**, lic. no. MD.15124, Birmingham, AL.

◆ On March 18, the Board accepted the voluntary surrender of the certificate of qualification and license to practice medicine in Alabama of **Paul Stephen Raphael, MD**, lic. no. MD.28915, Birmingham, AL.

### MLC – April 2015

◆ On April 1, the Commission entered an Order reinstating to full, unrestricted status the license to practice medicine in Alabama of **Eugene Evans, MD**, lic. no. MD.13574, Montgomery, AL.

### BME – April 2015

◆ On April 16, the Board accepted the Voluntary Surrender of the Alabama Controlled Substances Certificate of **Muhammad Wasim Sadiq Ali, MD**, lic. no. MD.22219, Jasper, AL.

◆ On April 16, the Board issued an Order amending the May 20, 2009, Order imposing conditions on the license to practice medicine in Alabama of **William S. Fleet, MD**, lic. no. MD.12869, Mobile, AL.

### MLC – May 2015

◆ On May 7, the Commission entered an Order removing all conditions on the license to practice medicine in Alabama of **Jose G. Zavaleta, MD**, lic. no. MD.22305, Pineville, LA.

◆ On May 20, the Commission entered a Consent Order revoking the license to practice medicine in Alabama of **Eric Lawrence Thomas, MD**, lic. no. MD.30286, Birmingham, AL, staying the revocation, and prohibiting him from practicing medicine in Alabama throughout the duration of the stayed revocation.

### BME – May 2015

◆ On May 5, **Nicholas C. Pantaleone, MD**, lic. no. MD.14539, Prattville, AL, voluntarily surrendered his Alabama Controlled Substances Certificate.

### MLC – June 2015

◆ On June 5, the Commission entered an Order denying the request of **Lasan Edward Davis, MD**, lic. no. MD.13059, Tuskegee, AL, to lift the suspension of his license to practice medicine in Alabama.

### Actions for CME (reprimand, fine, additional CME required):

- **James N. Byrd, Jr., MD**, lic. no. MD.27718, Mobile, AL
- **Lucy N. Culpepper, MD**, lic. no. MD.4535, Tuscaloosa, AL
- **Robert W. Eaton, DO**, lic. no. DO.441, Northport, AL
- **Christopher G. Enoe, MD**, lic. no. MD.30618, Athens, AL
- **Cheryl B. Gambrell, MD**, lic. no. MD.32371, Tuscaloosa, AL
- **Tiffany C. General, MD**, lic. no. MD.31756, Dothan, AL
- **Susan M. Gibson, MD**, lic. no. MD.21115, Scottsboro, AL
- **George Peter M. Gray, MD**, lic. no. MD.8645, Stevenson, AL
- **Brittney B. Laughlin, DO**, lic. no. DO.1115, Mobile, AL
- **Chad W. McElroy, MD**, lic. no. MD.27509, Moulton, AL
- **John H. McFarland, MD**, lic. no. MD.11404, Opelika, AL

- **Karin V. Straaton, MD**, lic. no. MD.13050, Tuscaloosa, AL
- **Hector T. Toledo, MD**, lic. no. MD.8448, Jasper, AL
- **Brittney K. Burdick, PA**, lic. no. PA.910, Birmingham, AL
- **Darcy M. Mosley, PA**, lic. no. PA.450, Jasper, AL

## News Briefs

### Alabama Supreme Court rules only dentists can perform teeth whitening services

A ruling on June 5 upheld a lower court's ruling that limits teeth whitening procedures in Alabama to dentists only will undoubtedly have repercussions. For the complete article that appeared in *Yellowhammer*, go to [www.yellowhammernews.business-2/Alabama-supreme-court-rules](http://www.yellowhammernews.business-2/Alabama-supreme-court-rules).

### Alabama launches 'Zero Addiction' campaign to fight opioid abuse

A coalition of state agencies has launched the Zero Addiction Prescription Drug Abuse Prevention Campaign to inform Alabamians about the dangers of abusing prescription drugs, including pain killers, stimulants to treat ADHD and anti-anxiety sedatives. Read more on their website, [www.zeroaddiction.org](http://www.zeroaddiction.org).

### National News: 2014's TOP 10 stories in professional licensing

A mistake on a license application, even though unintentional, constitutes "misrepresentation," in violation of the Uniform Enforcement Act (UAD), and can lead to a justifiable denial of a license... To read about all 10 stories, go to [www.professionallicensingreport.org/2014s-top-10-stories-in-professional-licensing/](http://www.professionallicensingreport.org/2014s-top-10-stories-in-professional-licensing/).



**Look inside for important news from the Board of Medical Examiners that pertains to your license to practice medicine in Alabama.**

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**Editorial Staff**

Larry Dixon Judy DeBray  
Deana Bozeman Mary Leigh Meredith

## Free CME from the FSMB

### Safe Prescribing of Extended Release/ Long-acting Opioids

Complete all six modules to earn 3.0 *AMA PRA Category 1 Credits™* or 3 *AOA Category 2B Credits*.

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