



Alabama Board of Medical Examiners Newsletter and Report

www.albme.org

October – December 2007

Volume 22, Number 4

Inside:

Weight loss clinics

Many weight loss clinics are falling below the standard of care.

– page 2

Resigning a position or medical license

Resigning from a medical staff or not renewing your medical license may have unintended consequences.

– page 3

Over-the-counter insulin

Patients who use non-prescription insulin may not receive proper medical care.

– page 5

Q&A

Questions and answers regarding the collaborative practice registration fee.

– page 7

Board appointment

BME names new Chief Investigator.

– page 8

Meet the Board

Read profiles of the BME's Chairman and Vice Chairman.

– page 9

Methadone

Distribution of certain methadone formulations is now restricted.

– page 10

Public Actions

October – December 2007

– page 11

DEA changes rule on frequency of prescribing controlled substances

On Sept. 6, 2006, the Drug Enforcement Agency published a proposed rule to change the requirement that a new prescription be issued every 30 days for Schedule II controlled substances. After a comment period, on Nov. 7, 2007, the rule change was approved to allow a physician to issue multiple prescriptions, to constitute a total of 90 days' treatment. Each separate prescription is to have an individual "do not fill before" date. The rule became effective on Dec. 19, 2007.

The essential aspects of this rule change are:

- Prescriptions for Schedule II controlled substances may not be refilled.
- The physician has determined that each separate

(continued on page 4)

The physician provides written instructions on each prescription indicating the earliest date on which a pharmacy may fill each prescription

Events raise concerns about anabolic steroids, performance-enhancing drugs

by T. Brooks Vaughn, MD*

The recent murder-suicide in Georgia involving professional wrestler Chris Benoit has again brought attention to the potential problems with the use of anabolic steroids and other hormonal supplements. Mr. Benoit's physician is now under federal indictment for improperly prescribing steroids and other medications. Several other athletes have come under suspicion for steroid use recently, leading to widespread scandal in the Tour de France, the loss of Marion Jones' Olympic gold medals and the indictment of Barry Bonds.

Practicing physicians have two primary responsibilities when it comes to the inap-

* Dr. Vaughn is an Assistant Professor of Medicine and Pediatrics in the Division of Endocrinology, the University of Alabama at Birmingham School of Medicine.

propriate use of steroids and other hormones: they must first be aware of the limited legitimate uses for these substances, and secondly, they must be aware of the potential for surreptitious use of these substances among their patients.

In the case of Mr. Benoit, there is particular concern about the potential overuse of testosterone. In medical practice, the use of testosterone in men should be limited to those with true hypogonadism. Many of these patients will have defined endocrine disorders, including delayed puberty, pituitary insufficiency or testicular failure. Complaints of erectile dysfunction or diminished libido by themselves are not adequate to define hypogonadism. Screening for hypogonadism should be done only when there is a high index of suspicion on the part of the physician and

(continued on page 6)

**Alabama
Board of Medical
Examiners**

Jorge Alsip, MD,
Chairman
Mobile

Kenneth Aldridge, MD,
Vice Chairman
Tuscaloosa

James G. Chambers, III, MD
Huntsville

James G. Davis, MD
Birmingham

Edward C. Facundus, MD
Huntsville

Richard M. Freeman, MD
Auburn

Steven P. Furr, MD
Jackson

J. Daniel Gifford, MD
Decatur

Allan Goldstein, MD
Birmingham

B. Jerome Harrison, MD
Haleyville

David P. Herrick, MD
Montgomery

Juan Johnson, MD
Birmingham

Paul Nagrodzki, MD
Birmingham

George C. Smith, Jr., MD
Ashland

Pamela D. Varner, MD
Birmingham

Larry Dixon, Executive Director

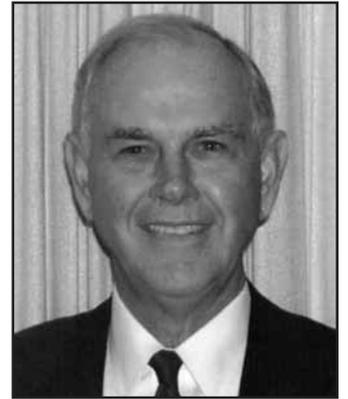
Patricia Shaner, General Counsel

Arthur F. Toole III, MD
Editor

A Message from the Executive Director Weight loss clinics cause concern for the Board

by Larry Dixon

The Alabama Board of Medical Examiners has grave concerns about too many weight loss clinics falling below the standard of care. Controlled medications for weight loss are dispensed or prescribed to patients without having a history and physical performed by a physician and, in some cases, never being seen by a physician. These medications are dispensed frequently without the physician being present, and accurate dispensing records are not kept. Often, controlled medicines are prescribed and dispensed to patients who are not medically overweight. These are some of the things the Board is finding in investigations of physicians practicing in weight loss centers.



Larry Dixon

It is the Board's position that prescribing drugs to an individual you have not personally examined is usually inappropriate. All patients receiving weight loss drugs, or any other medications, must first be examined by a licensed physician. Dispensing the drugs first and then making an appointment to see the patient at a later date is not sufficient. Controlled medications may not be dispensed if the physician is not present in the clinic, and Board rules concerning the dispensing of medications and the maintenance of records and inventories must be followed.

Generally, weight loss drugs should not be prescribed to patients who are not considered medically overweight. There will be an in-depth article about weight loss clinics in a future issue of the *BME Newsletter and Report* that will discuss these and other issues.

The Board of Medical Examiners is serious in its pursuit of unprofessional conduct in any setting and is dedicated to assuring the public that if they enroll in a weight loss program run by a physician, then the standard of care for the patient's safety, health and well being will be upheld by the Board of Medical Examiners.

The Board does note that inspections of some weight loss clinics indicate they have reputable weight loss programs and patient management, and the standard of care is being met by the physicians. In those areas where the Board finds the standard of care has not been met, the Board will seek a disciplinary action against the physician's license.

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.

Resigning hospital privileges or a medical license may have unintended consequences

Sometimes the Board sees a situation of unintended consequences arising when a physician resigns from a medical staff or does not renew his or her license. Consider a situation where you have been suspended from your hospital medical staff for actions that you believe are in error. After a bit of discussion back and forth, you tell yourself that you do not have to accept these allegations; you will just resign and move your practice to another hospital across town or in another city or state.

Or, suppose that you have a patient or another physician who has complained to the Board about you – about patient care, about your attitude or some other perceived problem. You have not been very happy in your practice and recently have seen a recruitment

letter for a position in another state. After the Board's investigator visits you and tells you what is involved in the investiga-

tion, you tell your spouse that you have had enough and are leaving to take the job offer. You do not pay to renew your Alabama medical license, allowing it to become inactive, or you voluntarily surrender your license in hopes of making a new start in another state.

In these cases, what seems like an easy way to avoid the hassle of a problem is fraught with even more problems. If you resign from a medical staff while under investigation, the hospital, by law, must report this to the Alabama Board of Medical Examiners and to the National

Practitioner Data Bank/Healthcare Integrity and Protection Databank (NPDB/HIPDB). Depending on the situation, the Board may decide to open an investigation of the hospital charges. Whether it does or does not, your new hospital will receive the NPDB/HIPDB report and may initiate an investigation on its own.

In the second case, allowing your medical license to become inactive while there is a

If you resign from a medical staff while under investigation, the hospital, by law, must report this to the Alabama Board of Medical Examiners.

Board of Medical Examiners investigation under way is not in itself an action that is subject to discipline or one that is reportable to NPDB/HIPDB.

But, it does not resolve the Board's investigation. Although your license to practice medicine is not current, you still have an Alabama medical license – a license that is subject to discipline. Depending on the facts and the events surrounding the complaint against you, the Board may complete the investigation and can still file formal charges against your license. The result of such an action is usually

reportable to the NPDB/HIPDB. A voluntary surrender of your license while under investigation is considered a disciplinary action and is reportable to the data banks.

In some instances, the Board may elect not to pursue the investigation but will hold it in abeyance. Should your situation change and you decide to return to Alabama, the Board may complete the investigation at that time. Or, it may

decide to contest the reinstatement of your license by filing formal charges with the Medical Licensure Commission.

A physician who applies for a license in another state while under investigation by the Board will nearly always be obligated to disclose that an investigation remains unresolved in Alabama. Often, that state's licensing authority will defer consideration of the physician's application until there is some resolution of the Alabama investigation.

The crux of this is: do not try to

make a problem go away by resigning your hospital privileges or medical license without knowing the potential

Do not try to make a problem go away by resigning your hospital privileges or medical license without knowing the potential ramifications.

ramifications. Get competent legal assistance to make your decision. Otherwise, you could inadvertently make your problem much worse instead of having it go away.

Controlled Substances

continued from page 1

prescription is issued for a legitimate medical purpose in the usual course of professional practice.

- The physician provides written instructions on each prescription (other than the first prescription, if the prescribing practitioner intends for that prescription to be filled immediately) indicating the earliest date on which a pharmacy may fill each prescription.
- The physician concludes that providing the patient with multiple prescriptions in this manner does not create an undue risk of diversion or abuse.
- The issuance of multiple prescriptions as described in this section is permissible under the applicable state laws.
- The physician complies fully with all other applicable requirements under the Act and these regulations.
- The physician complies with any additional requirements under the laws of the state that has issued the physician's medical license.
- Despite allowing the prescribing of a 90 day supply of Schedule II controlled substances with multiple prescriptions, this should not encourage the physician to see patients only once every 90 days when prescribing Schedule II controlled substances. Rather, physicians must determine on their own, based on sound medical judgment and in accordance with established medical standards, whether it is appropriate to issue multiple prescriptions and how often to see their patients when doing so.
- When a prescription has been written according to the above guidelines indicating a date before which the prescription may not be filled, no pharmacist may fill the prescription before that date.

The physician concludes that providing the patient with multiple prescriptions in this manner does not create an undue risk of diversion or abuse.

See the **Newsletter Links** section of www.albme.org for a link to complete information concerning the rule.

Finally, nothing in this rule changes the requirement that physicians must also abide by the laws of the states in which they practice and any additional requirements imposed by their state medical boards with respect to proper prescribing practices and what constitutes a bona fide physician-patient relationship. As set forth in this rule, the issuance of multiple Schedule II prescriptions in the manner described will only be permissible if doing so is also permissible under applicable state laws. Thus, notwithstanding this proposed rule, individual states may disallow the practice of issuing multiple Schedule II prescriptions.

**OPINIONS OF THE ALABAMA BOARD
OF MEDICAL EXAMINERS
can be found at www.albme.org.
Look in the Newsletter Links section.**

Sec. 1306.12

Refilling prescriptions; issuance of multiple prescriptions

(a) The refilling of a prescription for a controlled substance listed in Schedule II is prohibited.

(b) (1) An individual practitioner may issue multiple prescriptions authorizing the patient to receive a total of up to a 90-day supply of a Schedule II controlled substance provided the following conditions are met:

(i) The individual practitioner properly determines there is a legitimate medical purpose for the patient to be prescribed that controlled substance and the individual practitioner is acting in the usual course of professional practice;

(ii) The individual practitioner writes instructions on each prescription (other than the first prescription, if the prescribing practitioner intends for that prescription to be filled immediately) indicating the earliest date on which a pharmacy may fill the prescription;

(iii) The individual practitioner concludes that providing the patient with multiple prescriptions in this manner does not create an undue risk of diversion or abuse;

(iv) The issuance of multiple prescriptions as described in this section is permissible under the applicable state laws; and

(v) The individual practitioner complies fully with all other applicable requirements under the Act and these regulations as well as any additional requirements under state law.

(2) Nothing in this paragraph (b) shall be construed as mandating or encouraging individual practitioners to issue multiple prescriptions or to see their patients only once every 90 days when prescribing Schedule II controlled substances. Rather, individual practitioners must determine on their own, based on sound medical judgment, and in accordance with established medical standards, whether it is appropriate to issue multiple prescriptions and how often to see their patients when doing so.

– Federal Register:
[www.deadiversion.usdoj.gov/fed_regs/
rules/2007/fr1119.html](http://www.deadiversion.usdoj.gov/fed_regs/rules/2007/fr1119.html)

Individuals who use over-the-counter insulin may be forgoing regular visits with a physician

by George C. Smith, Jr., MD
Member, Alabama Board of Medical Examiners



George C. Smith, Jr., MD

The issue of over-the-counter insulin came to the Board's attention when several physicians, particularly emergency room physi-

cians, noticed patients who reported going several months and even years without being seen by a physician for new insulin prescriptions. The patients reported they would go to their pharmacist and tell them they needed insulin, and they were able to obtain it from the pharmacy without a physician's authorization.

A query to the Pharmacy Board regarding this issue resulted in several responses:

- There are many insulin products that are labeled by the FDA as available for over-the-counter purchase and do not require a physician's prescription to be obtained.
- To be reimbursed by a third party, a pharmacist must have a prescription for the insulin whether it is an over-the-counter version or a prescription version.
- By an Alabama State Board of Pharmacy rule, a pharmacist can give an emergency amount of insulin (up to 72 hours) to patients until they can get a prescription or authorization from a physician for a refill if they are using a non-OTC product.

A list of over-the-counter insulins was supplied to the Board. This list included many commonly used

insulins, among them humulin N, humulin R, humulin 70/30, Novolin N, Novolin R and Novolin 70/30. It does not include some of the newer insulins such as Humalog, Apidra, Lantus or Levemir. The list above is not comprehensive but contains some examples of what is available.

Insulin has a long history of regulation. Initially there was a specific law called *The Insulin Amendment* that passed in 1941 and required all batches of insulin to be tested for purity, strength, quality and identity before marketing. This Act was repealed by the Food and Drug Administration Modernization Act of 1997. The new rules do not require each batch to be certified. The current length of time that the various insulin preparations have had over-the-counter status is unknown, but it is at least since 1998, according to a review of the FDA Web site.

Because insulin syringes and needles are also available over-the-counter without a prescription, it would be possible for a patient to get medication for a prolonged period of time without supervision. The Board of Medical Examiners has asked the Pharmacy Board to encourage its licensees to ask patients who are obtaining their insulin in this manner to have proper follow-up visits with a physician for diabetic counseling and control.

In addition, the Pharmacy Board has posted on its Web site a reminder to pharmacists to make sure they obtain an authorizing prescription for reimbursed insulin (see side bar). The Pharmacy Board has been quite cooperative in this matter and both Boards want to encourage patients to improve their overall level of diabetic care.

Practice of Pharmacy Act 205

The Code of Alabama 1975, § 34-23-1. (9) defines "**Legend Drug**" as; *Any drug, medicine, chemical, or poison bearing on the label the words, "caution, federal law prohibits dispensing without prescription," or similar words indicating that such drug, medicine, chemical, or poison may be dispensed only upon the order of a licensed medical practitioner.*

The definition would apply to those insulin products labeled "**Rx only.**" There are a number of insulin products that do not bear the federal "**Legend Drug**" designation and therefore would only require a physician's order if the pharmacist is filing a claim with the patient's insurance company.

If a patient is in need of insulin and the prescriber is not locatable prior to issuance, Rule 680-X-2-.26 lists insulin as an emergency fill medication. This rule among other purposes allows for a 72-hour supply of medications on the list be dispensed accordingly as they are "**essential to life or the continuation of therapy in a chronic condition.**"

This is a reminder to all pharmacists to contact a physician's office for an order before filing an insurance claim for any insulin products.

Physicians should remind their insulin-dependent patients that diabetes is a disease that is best managed by regular checkups and medicine.

– *The Board of Pharmacy Web site, www.albop.com*

Anabolic Steroids

continued from page 1

should start with a **morning** total testosterone, which is typically the peak value of the day. If this value is low (typically under 250-300 ng/dl), confirmation of low testosterone is required by assessing the free testosterone and potentially the sex hormone binding globulin along with an LH and FSH level. The Endocrine Society recommends an early morning sample as the initial screening test in selected patients and does not recommend screening in the general population. Any patient with a confirmed low testosterone level and a low or normal LH and FSH should be considered to have central hypogonadism and further workup, including a prolactin determination and potentially a pituitary MRI, should be considered.

Oral testosterone is not approved in the United States, and replacement regimens should be limited to gel, patch, injectable or buccal preparations. Patients should have yearly prostate exams and prostate-specific antigen assessment, as well as a complete blood count (erythrocytosis is a potential side effect).

The relationship between testosterone replacement and prostate cancer remains controversial. It is unlikely that testosterone causes prostate cancer based on several large trials, but there remains concern whether testosterone can stimulate clinically occult prostate cancer.

The laboratory evaluation of testosterone, as well as the workup for secondary causes, can be quite complex, and referral to an

endocrinologist should be sought in difficult cases. In general, however, a complaint of low libido and erectile dysfunction in conjunction with a low random testosterone level is not a sufficient evaluation, and care should be taken before testosterone therapy is initiated. Often physicians will face pressure from patients who believe they will benefit from the drug. There are no legitimate reasons to prescribe testosterone to men with normal testosterone levels under any circumstances.

The adverse effects of excess testosterone or other androgens are significant. Common physical findings in men include gynecomastia, increased musculature and small testes.

Erythrocytosis, hepatotoxicity and mood disorders have been described. There are potential adverse effects on lipids, cardiac muscle and coagulation. In those whom the epiphyses have not closed, androgens can lead to short stature. Any of these findings, particularly in athletes, should prompt further evaluation on the part of the physician. Supraphysiologic levels of testosterone may confirm the exogenous use of testosterone; however, other forms of androgen supplementation may require specialized laboratory testing.

The use of lower doses of testosterone in women has become more

popular recently. The primary rationale is believed to be related to improvements in mood, libido, cognition and possibly bone density. A recent review by The Endocrine

The adverse effects of excess testosterone or other androgens are significant.

Society acknowledged that in selected patients there may be some benefit. On balance, however, they recommended against the widespread use of testosterone in women due to a lack of normative data and inadequate

long-term safety data. At this point, this is probably best done by physicians with extensive experience in this area.

The use of growth hormone is contraindicated in the presence of any active malignancy.

Another commonly available drug that is often used for athletic

or cosmetic reasons is recombinant growth hormone. Exogenous use of growth hormone has been notoriously difficult to detect. Again, growth hormone is used legitimately only in a few specific circumstances. It is commonly used under the guidance of pediatric endocrinologists for a variety of indications, which will not be reviewed here.

In adults, the only approved uses are in documented growth hormone deficiency and in AIDS wasting syndrome (which may represent a growth-hormone resistant state). Growth hormone deficiency is almost exclusively found in patients with a history of a pituitary lesion, pituitary surgery, infiltrative pituitary disease or other type of brain injury. Isolated growth hormone deficiency in an otherwise healthy adult is extremely rare,

(continued on page 8)

There are no legitimate reasons to prescribe testosterone to men with normal testosterone levels.

Questions and Answers: Collaborative Practice registration fee

Q: Why are physicians in collaborative practices required to pay additional fees and be subject to inspections when physicians associated with Physician Assistants (PAs) are not?

A: The Board's statutory purpose is to regulate the practice of medicine in this state, which includes practice pursuant to a collaborative agreement. In addition to collaborative practices, the Board routinely inspects other areas of physician practice, including controlled drug dispensing, record keeping and office-based surgery practices as well as

practices in which PAs are supervised. The Board is responsible for insuring, in all of these areas, that statutes and regulations are being followed, and inspections and investigations are methods of insuring compliance. Unlike CRNPs/CNMs, PAs are regulated solely by the Board, and fees that are assessed and collected to support regulation of physician practices utilizing PAs are assessed to the PA, although they are often paid by the supervising physician or group practice. Because, in a collaborative practice, the Board has regulatory authority only over the physician, not the nurse practitioner or nurse midwife, the fee is assessed to the physician.

Q: Have the Board's inspectors identified problems with collaborative practices that were significant enough to justify regulatory oversight of collaborative practices and assessment of the collaborative practice registration fee?

A: Yes. The regulation of collaborative practices is a statutory mandate of the Alabama Legislature, and from 2003 to the present, there have been more than 40 inspections of collaborative practices where audits have shown significant deviation from statutes and rules. As a result, according to information published by the Alabama Board of Nursing, there have been at least 20 disciplinary actions taken by the Nursing Board against CRNPs and CNMs engaged in collaborative prac-

The regulation of collaborative practices is a statutory mandate of the Alabama Legislature

Over this same period there have been several disciplinary actions concerning physicians in collaborative practices, along with multiple letters of concern and orders for continuing medical education.

Q: Are RNs qualified to inspect collaborative practices when CRNPs and CNMs have more expansive training and education?

A: The RNs who work as Inspectors for the Board are inspecting the physician part of the collaborative practice to determine if statutes and rules are being followed, and all of this information ultimately is reviewed and decided upon by a peer group – the physicians who make up the Board of

Medical Examiners. Likewise, other inspections and investigations conducted by the Board are also accom-

plished by non-physician investigators, and reports are made to the physician peer group, the Board, for disposition.

Q: Doesn't assessing a collaborative practice fee to the physician make the CRNP/CNM's ability to work dependent upon the physician for timely compliance and payment of the fee, because nonpayment of the fee would result in the CRNP/CNM not being able to work?

A: Since 1995, when the legislation mandating the Board's regulation of collaborative practices was enacted, collaborative practices and the ability of the CRNP/CNM to work have always hinged upon a dependent relationship with the collaborating physician. Most professionals are responsible for the timely payment of fees that impact their ability to engage in professional practice, and the licenses of physicians, nurse practitioners and PAs are similar in that respect. If a collaborating physician does not pay his or her physician license renewal fee, there is no collaborative practice agreement because the physician is not authorized to practice medicine. Likewise, Physician Assistant prac-

tices hinge upon a dependent relationship with the supervising physician. If the supervising physician does not pay the license renewal

If a collaborating physician does not pay his or her physician license renewal fee, there is no collaborative practice agreement because the physician is not authorized to practice medicine.

fee in a timely manner, the PA is prevented from engaging in his or her profession.

Board appoints Chief Investigator

Ray Murray, the Board's previous Chief Investigator, retired from the Board on Sept. 30, 2007. An investigator with the Board since 1993, Mr. Murray was appointed Chief Investigator in 1999. Before coming to work with the Board, Mr. Murray was Chief Investigator for the Montgomery County District Attorney's office, which he joined after his retirement as a Lieutenant from the Department of Public Safety



with 27 years of experience.

The Board appointed Mr. Jim Nichols to succeed Mr. Murray as Chief Investigator. Mr. Nichols has been employed with the Board since 1998, and was Assistant Director of Investigations from 2003 until his appointment as Chief Investigator in 2007. He served for 20 years with the Alabama Attorney General's Office,

(continued on page 9)

Anabolic Steroids

continued from page 6

and evaluation of the growth hormone axis should only be performed if there is a high index of suspicion. When screening, there is no role for assessing random growth hormone levels, as it is secreted in a pulsatile fashion. The insulin-like growth factor I (IGF-I) level is often used as a screening test for growth hormone status. It should be interpreted in the context of age-appropriate normal values. In terms of diagnosing growth hormone deficiency, the IGF-I is merely a screening test, and is insufficient by itself to establish the diagnosis of growth hormone sufficiency or insufficiency unless the patient has documented deficiency of other pituitary hormones. Dynamic testing (growth hormone stimulation) performed by various means is required to verify the diagnosis in all other cases. Due to the expense of the drug, insurance companies have developed strict criteria for establishing the diagnosis and may mandate stimulation testing. Unfortunately, it is clear that some patients are acquiring the drug by other means for off-label use.

Potential benefits of growth hormone supplementation in patients who need it include improvements in lean body composition, cardiac function and insulin resistance, among others. Potential detriments are those associated with acromegaly, including cardiac hypertrophy, alterations in soft tissue and bones, and diabetes. Of note, the use of growth hormone is contraindicated in the presence of any active malignancy.

Most endocrinologists believe that testosterone therapy may be safely prescribed after a thorough evaluation and with close follow up by many non-endocrinologists. However, most endocrinologists think (and guidelines have suggested) that growth hormone should be prescribed under their care due to the complexities surrounding its use.

As the recent events in Atlanta

illustrate, physicians may be held responsible for adverse events related to these medications. Our best defense will be to ensure that they are written for legitimate reasons and to seek further advice in cases that are unclear. Patients may have unrealistic expectations

in regards to these therapies, and may

not realize that unneeded hormonal therapy can have significant adverse effects.

Useful References:

- Testosterone Therapy in Adult Men with Androgen Deficiency Syndromes: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinology and Metabolism*, Vol. 91: 1995-2010, 2006.
- Androgen Therapy in Women: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinology and Metabolism*, Vol. 91: 3697-3716, 2006.
- Evaluation and Treatment of Adult Growth Hormone Deficiency: An Endocrine Society Clinical Practice Guideline. *Journal of Clinical Endocrinology and Metabolism*, Vol. 91, Issue: 1621-1634, 2006.

Editor's note: An additional site for information on this subject is the DEA Web site:

www.usdoj/dea/concern/steroids.html.

While this subject has been publicized by the Benoit tragedy and recently with the publication of the Mitchell Report on drug abuse in baseball, the Board has seen inappropriate prescribing for anabolic steroids in several cases in Alabama, including use for body-building, for treatment of general inanition or for unspecified and unknown reasons.

The only approved uses (of growth hormones) are in documented growth hormone deficiency and in AIDS wasting syndrome

Meet the Board

Jorge A. Alsip, MD, an emergency physician from Daphne, has been a member of the Alabama Board of Medical Examiners since 1999 and has served as Chairman since 2006. The Mobile native received his bachelor's degree and MBA from the University of Alabama and his medical degree from the University of Alabama School of Medicine. Dr. Alsip completed an internship in Internal Medicine at UAB Medical Center and performed his Emergency Medicine residency training at Richland Memorial Hospital in Columbia, SC. He is certified by the American Board of Emergency Medicine. Dr. Alsip is an Emergency Department attending physician at Springhill Medical Center in Mobile where he has practiced for the past 20 years. He has



Jorge A. Alsip, MD

also served as a consultant at several major medical centers in the Southeast, assisting their implementation of quality improvement processes and advanced technology to improve patient safety. Dr. Alsip and his family reside in Daphne where they are active in their church and community.

Kenneth W. Aldridge, MD, is a urologist who has been in private



Kenneth W. Aldridge, MD

practice in Tuscaloosa since 1986. He became a member of the Board in 2001 and has served as Vice Chairman since 2006. Dr. Aldridge received his bachelor's degree at the University of Alabama at Birmingham and his medical degree from the University of Alabama School of Medicine. He completed an internship and PGY II in general surgery at the Medical University of South Carolina before completing a residency in urology at the University of Alabama at Birmingham. He is certified by the American Board of Urology. Dr. Aldridge holds active privileges at DCH-Northport Hospital and DCH Medical Center. He and his family live in Tuscaloosa and enjoy participating in church and community activities.

Chief Investigator

continued from page 8

retiring as a Senior Special Agent prior to his association with the Board. His experience also includes service with Montgomery Police Department and the Jacksonville State University Police Department.

Mr. Ed Munson is the Board's Senior Investigator. He assists the Chief Investigator and also performs the duty of Complaint Intake Coordinator. Mr. Munson has been an investigator with the Board of Medical Examiners since 1981. Before joining the Board investigative staff, he had 11 years' experience as an investigator with the Montgomery Police Department.

Medical Records: A Reminder

In its investigations, the Board continues to see medical records that may not be accurate. There have been situations where a patient went from one physician to another, either on referral or by a voluntary change of physicians. When the second physician reviewed the first physician's medical record with the patient, the patient told the second physician or the consulting physician that the first physician did not do what is contained in the medical record. In a worse case, the record describes a complete physical examination when the patient adamantly stated that the physician performed no examination at all.

While some of these cases may represent mistakes in entering information, whether by dictation, a check list, hand written or electronically, each physician has the responsibility to verify that what is in the medical record is complete and accurate.

Methadone manufacturers restrict distribution

As of Jan. 1, 2008, manufacturers of methadone hydrochloride tablets, 40 mg (dispersible), have voluntarily agreed to restrict distribution of this formulation to only those facilities authorized for detoxification and maintenance treatment of opioid addiction, and to hospitals. Manufacturers will instruct their wholesale distributors to discontinue supplying this formulation to any facility that does not meet the above criteria.

Methadone is a long-lasting opioid medication that is used in the treatment of pain and for narcotic addiction. The 5 mg and 10 mg formulations that are indicated for the treatment of pain will continue to be available to all authorized registrants, including retail pharmacies.



The 40 mg methadone formulation is indicated for the detoxification and maintenance treatment of opioid addiction. The 40 mg strength is not FDA approved for use in the management of pain. Thus, the distribution and availability of the 40 mg formulation will be limited to registrants in those settings using the 40 mg formulation for the appropriate indication.

The DEA and pharmaceutical industry agree that the reported increase in methadone-related adverse events merits action and further agree to make a united effort to assure that methadone is properly distributed, consistent with its approved uses. Industry and the federal entities involved commit to monitor the progress of this initiative.

www.albme.org

The following forms are available on the Board of Medical Examiner's Web site:

- Retired Senior Volunteer license application
- CME worksheet
- Request for waiver from CME due to retirement
- Address change form
- Application for replacement of lost or destroyed license
- Malpractice payment report form for insurance companies
- Dispensing physician registration form
- Office based surgery registration form
- Office based surgery adverse event reporting form
- Laser/pulsed light device procedures registration form
- Laser/pulsed light device procedure adverse event reporting form
- Sample notification of commencement or termination of collaborative practice
- Sample collaborative practice QA forms, chart review audits

Notice regarding CME:

Physicians and PAs are required to maintain documentation of CME attendance and hours earned for a minimum of three years.

More information can be obtained from the *Newsletter Links* section of the Board's website, www.albme.org.

No greater opportunity, responsibility or obligation can fall to the lot of a human being than to become a physician. In the care of the suffering he needs technical skill, scientific knowledge and human understanding. He who uses these with courage, with humility and with wisdom will provide a unique service for his fellow man, and will build an enduring edifice of character within himself. The physician should ask of his destiny no more than this; he should be content with no less.

– Tinsley R. Harrison, MD

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

Medical Licensure Commission October 2007

None.

Board of Medical Examiners October 2007

◆ On Oct. 17, the Board denied the application for a certificate of qualification for a license to practice medicine of **Michael E. Kuglitsch, MD**, Butte, MT.

◆ On Oct. 17, the Board accepted the Voluntary Restriction on certificate of qualification and license to practice medicine in Alabama of **James C. Dilday, MD**, license number MD.12437, Tuscaloosa, AL. Dr. Dilday's license to practice medicine in Alabama was reinstated with the Voluntary Restriction on Oct. 25.

Medical Licensure Commission November 2007

◆ On Nov. 5, the Commission entered an Order reinstating to full, unrestricted status the license to practice medicine in Alabama of **Onelio E. Perdomo, MD**, license number MD.10606, Norcross, GA.

◆ On Nov. 5, the Commission entered an Order denying the application for reinstatement of license of **Seyed Moayedpardazi, MD**, license number MD.11144, Decatur, AL.

◆ On Nov. 28, upon the stipulation of the parties, the Commission entered an Order reprimanding the license to practice medicine in Alabama of **William H. Whiteside, MD**, license number MD.8524, Kechi, KS, and assessing an administrative fine.

Board of Medical Examiners November 2007

◆ On Nov. 14, the Board entered an Order denying the application of **Rebecca Hicks, MD**, license number MD.14402, Scottsboro, AL, for reinstatement of prescribing privileges in Schedules II and III. Dr. Hicks remains authorized to prescribe medications in Schedules IV and V .

◆ On Nov. 14, the Board entered an Order denying the application of **George A. Payne, Jr., PA**, license number PA.85, Tampa, FL, for reinstatement of his license to practice as a physician assistant in Alabama.

Medical Licensure Commission December 2007

◆ On Dec. 3, the Commission entered an Order reinstating in full the license to practice medicine in Alabama of **Oscar D. Almeida, Jr., MD**, license number MD.12933, Mobile, AL.

On Dec. 3, the Commission entered an Order removing all restrictions previously placed on the license to practice medicine in Alabama of **Michael J. Rallo, MD**, license number MD.26734, Columbus, GA.

On Dec. 6, upon the stipulation of the parties, the Commission entered an Order reinstating the license to practice medicine in Alabama of **Robert H. Carlson, MD**, license number MD.8549, Birmingham, AL. Prior to engaging in practice in Alabama, there are certain requirements which must be met.

Board of Medical Examiners December 2007

None.

Do You Perform Surgery, Treatments or Examinations with any Sedation?

If so, you may be required to register with the Alabama Board of Medical Examiners and maintain specific equipment, procedures and records in your office or clinic. Check the Newsletter Links section of the Alabama Board of Medical Examiners website at www.albme.org to determine whether your practice is required to register.



Alabama State Board of Medical Examiners

Newsletter and Report

Alabama Board of Medical Examiners
P.O. Box 946
Montgomery, AL 36102-0946

STANDARD
PRESORTED
U.S. POSTAGE
PAID
Montgomery, AL
Permit No. 417

***Look inside
for important news
from the Board of Medical
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 bmenews@masalink.org.

Change of Address

The code of the state of Alabama 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.