



# Alabama Board of Medical Examiners Newsletter and Report

www.albme.org

July – September 2008

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## Professional Sexual Misconduct: A new paradigm of understanding



Gregory E. Skipper, MD

by Gregory E. Skipper, MD, Medical Director, Alabama Physician Health Program, and Stephen J. Schenthal, MD, Founder, President, Professional Boundaries, Inc., Miramar Beach, Fla.

An overworked married pediatrician was attracted to a single mom in his practice. They became friendly and one day he offered to help if she ever needed anything fixed around the house. Eventually she called and asked him to come over to fix a leaky faucet. This started an affair that lasted several months. When his wife discovered the affair, he broke it off. The mother became angry, felt exploited and retained an attorney. **Comment: It’s important to realize that family of patients can be considered patients too, especially in pediatrics, where the parents are considered patients along with their children.**



Stephen J. Schenthal, MD

A general surgeon kissed an employee, who was also his patient, when she came to him crying about a problem she was having. Word got out in the office and a formal complaint was made to the medical board. **Comment: Treating an employee, neighbor, or anyone else, means that the person then becomes a patient.**

A family practitioner finally gave in to a seductive patient who brazenly seduced him. **Comment: Claiming that an affair was the**  
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## License renewal time is here

Beginning in October, all physicians and physician assistants with active licenses will be mailed to their address of record a postcard detailing the license renewal process. Licensees may renew their licenses, Alabama Controlled Substances Certificates (ACSC), and collaborative practice registrations online in one or multiple secure sessions by using a credit card. If you wish to pay by check, you can log into the online renewal site, fill in the information, then print the form, sign it, and mail it in with a check. The Board/Commission must be in receipt of the application containing your original signature; copies will not be accepted. You can also request that the Commission mail you a paper renewal application.

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**If you have moved since renewing your 2008 license, be sure the Commission has your correct address. A change of address form is available online. An incorrect address may result in your not receiving a renewal notice.**

## Alabama Board of Medical Examiners

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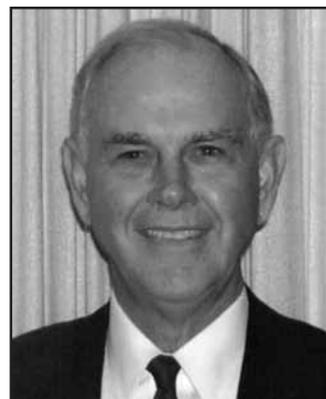
Larry Dixon, Executive Director  
Patricia Shaner, General Counsel

Carla Kruger, Staff Editor

## A Message from the Executive Director Legislature requires BME to obtain criminal background checks

by Larry Dixon

The Alabama Legislature recently enacted Act Nos. 08-378 and 08-397, which, among other things dealing with the Alabama Board of Medical Examiners, placed on the Board the responsibility to conduct criminal background checks on all new applicants for medical and physician assistant licensure. Act 08-097 also requires the Medical Licensure Commission to conduct criminal background checks on all applicants for license reinstatement. The Commission has been an advocate of criminal background checks for some time, believing there is the possibility of undiscovered criminal activity that exists in the background of some applicants. Alabama is now joining the approximately 35 other states that already require criminal background checks.



Larry Dixon

The Board of Medical Examiners has signed a contract with the Alabama Bureau of Investigation (ABI), Department of Public Safety, where the ABI will provide official fingerprint cards to be included in all licensure application packets. When applications are received with the completed fingerprint cards and the payment of applicable fees, the cards will be transmitted to the ABI to conduct statewide criminal history checks, and the ABI will also forward the information to the FBI for a nationwide check.

This process will lengthen the time it takes to obtain an initial license or reinstatement of license, and physicians seeking to recruit other physicians to their practices or to their areas need to be aware of this new requirement. It will take approximately three to five weeks for cards to be submitted, the state and national checks run, and a report provided to the Board of Medical Examiners. If a fingerprint card is not legible (many are not, even when the applicant goes to a law enforcement agency to have fingerprints made), it takes between five to eight days before the Board will be notified that the fingerprints are not legible, and the applicant will be sent another fingerprint card.

These extra steps in the licensure process could result in approval of a physician's license application taking one to two months longer than the six to eight weeks it took in the past. The Board will attempt to expedite this process as much as possible; however, physicians and assistants to physicians need to be aware that the licensure process will take a longer time now that criminal background checks are required. The Board has instructed its staff to assist the applicants as much as possible without violating state law.

### 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.

## Professional Sexual Misconduct

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*patient's fault doesn't work. It's the doctor's sole responsibility to set limits and act professionally. If the doctor is uncomfortable with a seductive patient, the patient should be referred.*

These are but a few fictional examples drawn from compilations of real cases.

Betrayal and exploitation are among the most egregious of human offenses, and when they involve a health professional preying on a vulnerable patient, the most basic of ethical principles are violated. When the patient-physician relationship is exploited and Professional Sexual Misconduct (PSM) occurs, it is particularly problematic because it strikes at the core spirit of the profession.

The breach of trust associated with PSM is damaging to the patient, the health professional and the medical profession at large.

The patient is exploited and may never trust a health professional again. Health professionals often lose their reputations, find their finances plundered, licenses revoked, and in more than two dozen states, find themselves subject to criminal charges and imprisonment. Finally, the perceived legitimacy of the medical profession at large is degraded each time this happens.

Unfortunately, claims of PSM are not rare. A confidential survey found that 8 percent of physicians admitted committing some degree of PSM with one or more patients, and most physicians acknowledge they've been

tempted. (Bayer T, Coverdale J, Chiang E. *A National Survey of*

*Physicians' Behaviors Regarding Sexual Contact with Patients. SMJ October 1996.*) Despite this, there is a generalized denial in the health professions regarding the risks and/or existence of PSM and a taboo regarding discussing it. Even with the "sexual" nature of the offense, it turns out that health professionals who've committed PSM rarely have any type of sexual disorder. Very few are true sociopaths. Most of the time, in fact, these physicians simply lose good judgment and believe they've "fallen in love" with the patient.

Most physicians who commit PSM do so in times of personal trauma or professional crisis, when judgment is diminished. Unresolved vulnerabilities may arise associated with overwork or professional dissatisfaction. The turbulent times of midlife often trigger PSM. To flee the pain of parental

death, a failing marriage or empty nest issues with the departure of children to college are times when physicians may "act out" inappropriately.

All this becomes more relevant by the fact that PSM is preventable.

Educating physicians about good boundaries and helping them become more aware of their vulnerabilities and risks and

ways of setting up their practices to protect patients and themselves is critical. Not only is PSM preventable, but

doctors who commit PSM are usually treatable, and relapses are rare when good treatment and education occurs and precautions are taken.

Considering the very damaging real life consequences of PSM, it is surprising how casually PSM is depicted on TV and in movies.

The discordance between how professional boards and criminal agencies view PSM versus its media portrayal is troubling and may contribute to the risk of PSM because it creates a false sense of the acceptability of inappropriate relationships with patients.

Additionally, there are many stories about relationships between doctors and their patients leading to successful marriage, without any apparent harm. These, however, are the exceptions. More typically, the patient eventually becomes aware of a sense of exploitation and becomes very angry.

Not uncommon are cases in which a physician-patient marriage ends in divorce, at which time the ex-spouse files a complaint and law suit ... and wins.

It's tragic that as terrible and devastating as PSM is, it is essentially a taboo subject; little or nothing is taught regarding PSM in medical schools, and it's rarely a subject for postgraduate training.

To help prevent PSM it's important to have a basic understanding of boundary theory and the dynamics that underlie boundary violations, to

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### To help prevent PSM:

- Understand the boundary theory and the dynamics that underlie boundary violations,
- Develop vigilance for early warning signs of potential boundary problems with patients, and
- Gain insight into professional and personal vulnerabilities and risk factors.

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## Professional Sexual Misconduct

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develop vigilance for early warning signs of potential boundary problems with patients, and to gain insight into professional and personal vulnerabilities and risk factors. Excellent CME based courses are available for further in-depth training.

PSM (synonymous with “sexual boundary violation”) can be defined as any action of a sexual nature that oversteps or disregards ethical or legal limits of professional behavior. For our purposes, sexual refers to any erotic physical contact, and may also include sexual behavior involving language or gesture. Even the use of sexual humor or informal speech can be deemed misconduct. The somewhat vague concept of “boundary” is made more explicit by reference to professional ethical and legal norms.

Ethical prohibition against sexual relations with patients dates back at least as far as the Hippocratic Oath of ancient Greece. An abbreviated version of the passage states: “[I] will abstain from every voluntary act of mischief and corruption; and, further from the seduction of females or males, of freemen or slaves.”

Most professional societies have a code of ethics which contain clear statements regarding what constitutes appropriate sexual boundaries. The major area in which these codes differ is regarding how long, if ever, it is necessary following termination of the patient-physician relationship before a relationship can be pursued. On the subject of where the lines are drawn inside the professional relationship,

they are essentially identical.

The Federation of State Medical Boards, in a policy statement in 2007, clearly defines what it considers sexual boundaries, and states that disciplinary action should be taken against any physician who violates them.

Here are some salient excerpts from that document:

*“Physician sexual misconduct is behavior that exploits the physician-patient relationship in a sexual way. This behavior ... may be verbal or physical, and may include expressions of thoughts and feelings or gestures that are sexual or that reasonably may be construed by a patient as sexual.*

*...There are primarily two levels of sexual misconduct: sexual violation and sexual impropriety. Behavior listed in both levels may be the basis for disciplinary action by a state medical board. ... Sexual violation may include physician-patient sex, whether or not initiated by the patient, and engaging in any conduct with a patient that is sexual or may be reasonably interpreted as sexual. Sexual impropriety may comprise behavior, gestures, or expressions that are seductive, sexually suggestive, or sexually demeaning to a patient.”*

The documents goes on to state, *“Findings of sexual misconduct are often sufficiently egregious as to warrant revocation of a physician’s medical license, although a lesser action may be considered for cases of sexual impropriety.”*

It is important to know that most acts of PSM occur following progressive problems with boundaries that precede the PSM. Often these steps are referred to as “boundary crossings,” which may be initiated with the best of intentions, but progressively tumble down a “slippery slope” of professional destruction. While these precedent behaviors are not necessarily unethical in and of themselves, they are major warning signs. In order to prevent sexual boundary violations it is important to understand this progression and the precedent boundary disturbances.

Sometimes these boundary disturbances are limited to one patient or one particular type of patient, and in other cases they may characterize the clinician’s general practice style.

In the context of rehabilitation from sexual boundary violation(s), it is incumbent on the professional to address all of these boundary issues.

Precedent boundary problems can include time issues, such as extending the time of office visits (often by scheduling at the end of the day), conducting the visit during non-business hours or by extending the visit from

the last appointment of the day into non-business hours (after the staff leave the office).

Another category of precedent behaviors

includes “concepts of place and space.” For example, making home visits (except when clearly part of regular practice), meeting a patient at a social occasion or agreeing to share a meal with a patient at a restaurant.

Another area, giving or receiving gifts, can be a problem if it tends to “deprofessionalize” the relationship,

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***PSM can be defined as any action of a sexual nature that disregards ethical or legal limits of professional behavior.***

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## Meet the Board

**William E. Goetter, MD**, currently practices pulmonary medicine in Fairhope, Alabama, and is medical director for critical care and respiratory care at Thomas Hospital. He became a member of the Board in June 2008.

Dr. Goetter graduated from Emory University School of Medicine and completed his post graduate education in internal medicine and pulmonary disease at University of Alabama. He had faculty appointments at UAB and Cooper Green Hospital, achieving the rank of assistant professor of medicine. In 1988, Dr. Goetter moved to Fairhope and entered private practice.

He is board certified in internal medicine and pulmonary diseases and is a clinical associate professor of medicine with the University of South Alabama Medical College. Balancing his professional life are interests in sailing, fitness and target shooting.

**Timothy A. Stewart, MD**, also became a member of the Board in June 2008. Dr. Stewart is a pediatrician who has been practicing in Huntsville since 1985.

After graduating from the University of South Alabama College of Medicine, he completed postgraduate training at the USA

Medical Center. Dr. Stewart worked with the National Health Service Corps at a community health clinic in Huntsville before joining Huntsville Pediatric Associates.

Dr. Stewart is board certified in pediatrics and is a Clinical Associate Professor of Pediatrics at the University of Alabama School of Medicine, Huntsville Regional Medical Campus. He is a past president of the Madison County Medical Society and a current member of the Board of Directors for the Alabama Chapter of the American Academy of Pediatrics. He and his wife April, an English teacher at Randolph School, have two children in high school.

## Professional Sexual Misconduct

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encourage romanticizing of the relationship or interfere with therapeutic aims. In general, it is a good idea to have an office policy that gifts from patients are not accepted (except to the office as a whole).

Physical contact is another area of concern. There are times in the course of clinical practice where touching the patient outside of a physical examination is accepted, such as a handshake at the beginning or end of an appointment, or the placing of a hand on the shoulder as a comforting gesture. Some practitioners also feel it is permissible to hug patients at times, though, depending on the characteristics of the patient, this can be very dangerous. Context is clearly important in determining to what extent a hug may be thought of in this way. Hugging can cause serious confusion in the professional relationship, be interpreted or experienced in a romantic way by the patient, and can lead to

greater intimacy. An important adage to remember is that when it comes to boundaries, "perception is everything." The misinterpretation of a therapeutic hug as romantic may be impossible to defend.

Boundary issues involving money can precede PSM. Examples include lending to or borrowing money from patients, business activities with patients or even bartering in place of the standard fee.

It's also important to be careful with language with patients. Using the title of doctor, for example, helps establish the professional relationship. The use of too familiar a tone of voice, the use of inappropriate colloquial language or the use of first names can be risky, especially in some settings.

Wearing a white coat reinforces the professional image. Informal dress may convey the opposite.

Finally, the issue of self-disclosure should be mentioned. While it is not uncommon for clinicians to occasionally share a story with a patient or to reveal selective aspects of their personal experience, the injudicious sharing of private information is clearly a boundary crossing and interferes with the aim of the professional relationship. The disclosure of personal problems is virtually always inappropriate. Sharing by the doctor with the patient that he has an unethical attraction to them is highly inappropriate. This

type of boundary crossing commonly precedes PSM.

Preexisting vulnerabilities afflicting the physician, such as psychiatric illness, alcohol and/or substance abuse disorder, paraphilias, personality disorder, mood disorder, sexual compul-

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## License Renewal

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Licensees are encouraged to use the online renewal system. With online renewals, your license/registration is renewed as of the day (or next business day) you complete the online application(s), and you can print a receipt and confirmation of the renewal(s), whereas paper applications can get lost in the mail or the application is sent back because a check is not enclosed or the application is not filled out completely.

The Board and Commission strongly suggest that licensees complete the online and paper renewal applications themselves, because they are certifying that all of the information is true and correct. If another individual completes your application for you, you should review it for accuracy before completing the transaction. Pay special attention to the questions regarding CME and collaborative practices. These are questions that are often answered incorrectly when someone other than the licensee fills out the application. The Board is not inclined to accept "someone else filled it out" as an excuse for incorrect answers on applications.

In November, a second postcard will be sent to licensees who have not yet renewed their licenses, and a third notice will be sent in December. Licenses expire Dec. 31, but there is a grace period for renewing (with an extra \$100 late charge) from Dec. 31 through Jan. 31. On Feb. 1, all licenses that have not been renewed will automatically be placed on inactive status. **There is no grace period for renewing a PA license, an ACSC or a Collaborative Practice Registration.**

### On the Net:

Address change form:

<http://www.albme.org/Documents/Address%20Change%20Request.pdf>

Renewal site:

<http://www.alrenewals.org/>

Board's Web page concerning 2009 renewals:

<http://www.albme.org/Default.aspx?Page=2009RenewalInfo>

## Meet the staff Board Secretary Amy Dorminey

Ms. Dorminey has been employed as Board Secretary since August 2006. From October 2001 to August 2006 she was the Executive Secretary of the Medical Licensure Commission. Among her many varied duties, Ms. Dorminey is responsible for producing each month's Board meeting agenda and minutes of the meetings as well as assisting the Executive Director with outgoing correspondence resulting from Board actions. In addition, she assists the Executive Director with planning and organizing meetings and educational conferences.

## Professional Sexual Misconduct

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sivity or addiction and/or insufficient support, supervision, oversight or accountability make PSM more likely to occur.

Other factors that can predispose the physician to PSM include marital/family problems, midlife or late midlife stage-of-life crisis and burnout.

Similar preexisting vulnerabilities affecting a patient can also increase risk. Patients with histories of sexual abuse appear to be particularly vulnerable.

It's important for every physician to know that PSM is unethical and can carry harsh consequences. Physicians should recognize inappro-

priate behaviors and not act inappropriately due to their emotional attractions to patients. Ultimately, it's best to refer the patient causing concerns to another physician.

Before pursuing a relationship with a former patient, contact your specialty society and/or the Alabama Board of Medical Examiners for more guidelines to be sure it is ethical and safe. Consulting a good therapist prior to taking any action is also a good idea.

We physicians are also ethically responsible to protect our colleagues.

**Ultimately, it's best to refer the patient causing concerns to another physician.**

If we see red flags of an evolving boundary problem in another physician, we must consider an intervention. Stepping in can save a professional and protect a patient. Failing to follow these recommendations is very likely to be costly to everyone involved.

### On the Net:

Federation of State Medical Boards' policy statement on sexual misconduct:

[http://www.fsmb.org/pdf/GRPOL\\_Sexual%20Boundaries.pdf](http://www.fsmb.org/pdf/GRPOL_Sexual%20Boundaries.pdf)

## Treating and prescribing to family members

The Board frequently receives inquiries from licensees, pharmacists and others concerning the Board's position on treating and prescribing to family members. The Board looks to the ethical opinion of the American Medical Association's Council on Ethical and Judicial Affairs when considering unprofessional conduct issues. AMA opinion E-8.19, Self Treatment or Treatment of Immediate Family Members, states as follows:

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician. Concerns regarding patient autonomy and informed consent are also relevant when physi-

cians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care. It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

In addition, in Administrative Rule 545-X-4-.06, the Medical Licensure Commission includes in its definition of unprofessional conduct "**prescribing or dispensing a controlled substance to oneself or to one's spouse, child, or parent, unless such prescribing or dispensing is necessitated by emergency or other exceptional circumstances.**"

**On the Net:**

AMA Web site: <http://www.ama-assn.org>

MLC Administrative Rules: <http://www.alabamaad-ministrativecode.state.al.us/docs/mlc/index.html>

### Notice regarding Questions and Answers:

The Board of Medical Examiners and the Medical License Commission welcome questions and comments. A comment or question will be published with the physician's name who submits the item unless the physician expresses a desire that the name be withheld. If a topic is presented that may be of very broad interest, the editor may paraphrase the question or comment, and print it as a clarification. The Board will not respond to anonymous or unsigned comments or questions.

## ADPH publishes list of controlled substances

The Alabama Department of Public Health (ADPH) periodically publishes the State of Alabama Official Controlled Substances List. An updated list was approved on Sept. 10, 2008, and is available at the ADPH Web site.

There are times when the state law differs from the federal law on whether a medication is controlled or not. At this date, there are three medications in this category:

- **Butalbital** (Fioricet)

Not controlled by federal law.  
Controlled by Alabama law as  
Schedule III substance.

- **Carisoprodol** (Soma):  
Not controlled by federal law.  
Controlled by Alabama law as  
Schedule IV substance.

- **Cough syrup containing codeine:**  
Schedule V by federal law.  
Schedule III by Alabama law.

It has become apparent to the Board that some physicians are not aware of these differences. Physicians are encouraged to review the state controlled substances list as well as other resources when researching medications.

### On the Net:

ADPH controlled substances list:  
<http://www.adph.org/pharmacyunit/assets/controlledsubstanceslist.pdf>.

What are a  
physician's  
obligations  
when closing  
or leaving  
a medical  
practice?

Find helpful  
information at  
[www.albme.org](http://www.albme.org)

## www.albme.org

### The following forms are available on the BME'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
- Notification of commencement or termination of collaborative practice
- Collaborative practice QA forms, chart review audits

*Medicine – however much it develops – must always remain an “applied science,” and one differing from all the rest in that the application is to man himself. Were there no sick persons there would be no need for Medicine, either the Science or the Art. So long as there are, both will be necessary. The application of its Science, to be of value, must be made in such a way that it will produce the maximum of relief to the sick man. This calls for certain qualities in the practicing physician which differ entirely from anything required in the practice of the other applied sciences. Herein lies the Art of Medicine. The need for it is as great today as it ever was, or ever will be, so long as human sickness continues.*

– Sir Arthur Hall  
Practitioner, 1941

From *The Quiet Art: A Doctor's Anthology*, Dr. Robert Coope

## Ensuring Quality in the Collaborative Practice: The 2008 Series Responsibilities and Resources for Physicians and Nurse Practitioners

**Presented by:**  
The Medical Association of the State of Alabama  
The Alabama Board of Medical Examiners  
The Alabama Board of Nursing

### Course Details

**Who should attend?**

Doctors of Medicine and Osteopathy, and Advanced Practice Nurses including Certified Registered Nurse Practitioners and Certified Nurse Midwives involved in a collaborative practice agreement.

**Upon completion of this educational activity, participants will be able to:**

1. Identify the application, approval and renewal requirements for CRNP/CNMs and required credentials.
2. Identify the responsibilities of both physicians and nurses in a collaborative practice. Common problems seen and methods to correct them.
3. Apply the regulations for prescribing drugs, quality assurance review, remote sites and specific practice settings.

**Final course for 2008: Tuesday, December 9**

**Registration Deadline: December 2**

**Renaissance Hotel & Convention Center, Montgomery**

**The \$75 fee includes all course materials and box lunch/dinner.**

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### Course Registration Form

Name \_\_\_\_\_

Company \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_ Other \_\_\_\_\_

E-mail \_\_\_\_\_

Payment:  Check (made payable to MASA)       Charge      Amount \_\_\_\_\_

Card # \_\_\_\_\_ Exp. Date \_\_\_\_\_ Security Code \_\_\_\_\_

Session you will attend: (check one)  Session One (1 – 4 p.m.) OR  Session Two (6 – 9 p.m.)

*Cancellation/Refund Policy: If you cancel 2 weeks before seminar, you will receive half of your registration fee and course materials. If you cancel less than 2 weeks before seminar, you will receive NO refund and NO course materials.*

**Copy this form and send to:**

**MASA Education Department  
19 South Jackson Street  
Montgomery, AL 36104**

**Phone: (334) 954-2500 • (800) 239-6272 • Fax: (334) 269-5200**

## Web site provides free, accredited CME courses on pharmaceutical industry marketing practices

Federation of State Medical Boards' News Release of July 8, 2008

A national program funded by a grant from the Attorney General Consumer and Prescriber Education Grant Program provides a Web portal providing U.S. physicians



with access to free, accredited CME courses about pharmaceutical industry marketing techniques and their effect on prescribing practices.

Courses currently available include:

- Drug approval in the U.S.: how drugs get to market
- Generic drugs: prescribing sensibly

- What's hype? What's right? Assessing new information from pharm reps to the latest journals
- Why and how are drugs approved?
- There's no such thing as a free lunch ... or dinner
- A clinician's guide to critical appraisal of clinical trials
- Pharmaceutical marketing: its goal is to influence your prescribing practices
- Principles of rational prescribing

### On the Net:

Federation of State Medical Boards' News Release:  
[http://www.fsmb.org/pdf/NR\\_ag\\_grant\\_0708.pdf](http://www.fsmb.org/pdf/NR_ag_grant_0708.pdf)

Federation of State Medical Boards' Prescriber Education Network:  
<http://www.fsmb.org/re/open/modules.html>

## License renewal time is here – Are your CMEs up to date?

### Now is the time to review your CME file and be sure:

- You have at least 12 **Category 1** hours earned or accrued in 2008 (never assume an activity confers Category 1 hours if you don't have a certificate or other reliable information stating that it does)
- You have documentation of your completed CME
- Your documentation includes the date of the activity and states the activity was accredited for Category 1 hours

Review your CME file **before** completing a renewal application so you are certain you are answering correctly when you certify that you have met the CME requirement. Do not certify to hours you have not yet earned. If, for example, you are short on CME hours and have a CME activity scheduled for December, then you will need to wait until you have completed the activity before completing a license renewal application.

Board rules require licensees to retain CME records for three years. The Board may request copies of your documentation at any time.

Please do not hesitate to call the Board's office with any questions about the CME requirement. The Board's Web page concerning CME may also help.

### On the Net:

Board's Web page about CME:

<http://www.albme.org/Default.aspx?Page=CME>

## Do You Collaborate with a Certified Nurse Practitioner?

If you have a collaborative practice agreement with a Certified Registered Nurse Practitioner, be aware that it is under your medical license that the CRNP practices. Even if the CRNP works in a group setting, with only one physician as the primary collaborator, it is that physician's license that authorizes the CRNP to practice.

If the collaborating physician leaves the group or otherwise changes jobs but the CRNP does not go to the new practice, the collaborative agreement remains active until the physician notifies the Board of its dissolution.

Thus, even though the physician is no longer in the same practice with the CRNP, if the agreement has not been terminated, then that physician remains responsible for any unauthorized performance by the CRNP and the actions and decisions of the CRNP, and risks a Board action for non-compliance with Board rules concerning collaborative practices.

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

### MLC – June 2008

◆ Based on the stipulation of the parties, the Commission entered an Order reprimanding the license to practice medicine in Alabama of **Frank S. Pair, MD**, license number MD.17448, Huntsville, AL, and requiring completion of additional continuing medical education, based on failure to comply with continuing medical education requirements.

◆ Based on the stipulation of the parties, the Commission entered an Order reprimanding the license to practice medicine in Alabama of **Grover Travis Paul, MD**, license number MD.21209, Bay Minette, AL, assessing an administrative fine and costs, and requiring completion of additional continuing medical education, based on failure to comply with continuing medical education requirements.

◆ Based on the stipulation of the parties, the Commission entered an Order reprimanding the license to practice medicine in Alabama of **Charles Jess Veale, MD**, license number MD.10204, Auburn, AL, assessing an administrative fine and costs, and requiring completion of additional continuing medical education, based on failure to comply with continuing medical education requirements.

### MLC – July 2008

◆ On July 3, the Commission entered an Order revoking the license to practice medicine in Alabama of **Steven Jeffrey Dick, MD**, license number MD.21416, Buffalo, NY. Dr. Dick is no longer authorized to practice medicine in Alabama.

◆ On July 30, the Commission removed all restrictions from and reinstated in full the license to practice medicine in Alabama of **John P. Eitzen, MD**, license number MD.13382, Montgomery, AL.

◆ On July 30, the Commission removed all restrictions from and reinstated in full the license to practice medicine in Alabama of **Mark P. Koch, DO**, license number DO.322, Frisco City, AL.

◆ On July 30, the Commission removed all restrictions from and reinstated in full the license to practice medicine in Alabama of **George S. Kouns, DO**, license number DO.493, Sumiton AL.

### BME – August 2008

◆ On Aug. 20, the Board accepted the voluntary surrender of the certificate of qualification and license to practice medicine in Alabama of **Charles M. McInteer, MD**, license

number MD.22296, Guntersville, AL. Dr. McInteer is no longer authorized to practice medicine in Alabama.

### MLC –September 2008

◆ On Sept. 17, the Commission entered an Order reinstating the license to practice medicine in Alabama of **Samuel W. Beenken, MD**, license number MD.15438, Montevallo, AL. Prior to reentering the practice of medicine he shall submit for prior approval a detailed plan of practice.

◆ On Sept. 17, the Commission entered an Order temporarily suspending the license to practice medicine in Alabama of **David J. Pavlakovic, MD**, license number MD.22143, Birmingham, AL, until such time as the Administrative Complaint of the Board shall be heard and a decision rendered thereon.

◆ On Sept. 18, the Commission revoked the license to practice medicine in Alabama of **John A. King, DO**, aka **Christopher W. Martin, DO**, license number DO.127, Birmingham, AL. Dr. King is no longer authorized to practice medicine in Alabama.

◆ On Sept. 30, the Commission revoked the license to practice medicine in Alabama of **Gregory A. Johns, MD**, license number MD.17135, Dothan, AL.

## National Clearinghouse on Internet prescribing report

According to the Federation of State Medical Boards' *RxBeat*, the newsletter for the National Clearinghouse on Internet Prescribing:

- A California physician was indicted on counts of conspiracy to commit money laundering, distribution of anabolic steroids and misbranding drugs held for sale with intent to defraud and mislead in an indictment unsealed April 9, 2008.
- A Florida physician's license was reprimanded and sus-

pending for six months and he was fined \$45,000 and required to complete particular courses and community service for prescribing medicine via the Internet.

- A Michigan physician was fined \$5,000 for prescribing medicine over the Internet.

### On the Net:

Federation of State Medical Boards' *RxBeat*:  
[http://www.fsmb.org/ncip\\_newsletter.html](http://www.fsmb.org/ncip_newsletter.html)



Alabama State Board of Medical Examiners

*Newsletter and Report*

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## 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.