



ALABAMA Board of Medical Examiners Medical Licensure Commission

Newsletter and Report

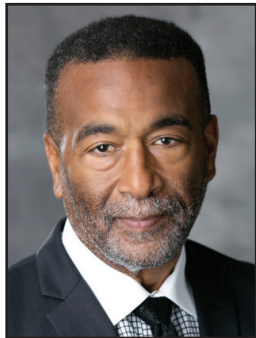
www.albme.org

January 2018

African-American female Dr. Halle Tanner Dillon: Unsung hero of early Alabama medicine

by Jefferson Underwood, III, MD

There are many individuals who have made this state a leader in medicine. Many of these individuals have been memorialized in granite on countless numbers of buildings throughout our state and the nation.



Jefferson Underwood III, MD

However, I would like to tell you about one unsung hero whose name can only be found etched into a tombstone in Davidson County, Tenn. Her name is Dr. Halle Tanner Dillon.

Halle Dillon was born in

Pittsburgh, Penn., in 1864 to Benjamin and Sarah Elizabeth Tanner. Her mother was biracial and a free slave who escaped via what is known as the "Underground Railroad." She had nine siblings, one of whom became a world renowned painter, Henry O. Tanner. Two of his most famous paintings are entitled, "The Banjo Lesson," and "Daniel in the Lion's Den."

She was just 24 and a recent widow when she decided to enter medical school. She enrolled at the Woman's Medical College of Pennsylvania as the only African-American in her class and graduated with honors in 1891. The Woman's Medical College of Pennsylvania was one of two medical schools established solely for the medical education of women. It later became Hahnemann Medical College.

Shortly after Dr. Dillon graduated from medical school, she learned that Booker T. Washington was in search of a resident physician to serve the students and faculty at the newly formed Tuskegee Institute. Dr. Dillon accepted the offer for \$600 a month, which included housing and meals. But before she could practice in Alabama, she had to do one thing... pass the Alabama state medical examination.

Mr. Washington arranged for her to study for the exam with Dr. Cornelius Dorsette, the first licensed African-American physician in Montgomery and the first in the state of Alabama to be certified by the Medical Association of the State of Alabama. The first was

Dr. Burgess E. Scruggs of Huntsville.

The state certifying examination was an arduous 10-day test, which she passed with flying colors. Some of her examiners were Dr. Peter Bryce, Dr. Jerome Cochran, Dr. George A. Ketchum and Dr. James T. Searcy. It was reported she had the most difficult exam to date. Dr. Dillon's accomplishment at that time made national and international news. Whereas, many newspapers in the south reported on her accomplishment in a very scornful and divisive manner, the *New York Times* noted that Dr. Dillon passed this "unusually severe" examination to become not only the first "colored female physician, but the first woman of any race" to officially practice medicine in Alabama. This accomplishment is noted in the Transactions of the Medical Association of 1892 on page 128, including that Dr. Dillon was the first "colored woman" examined in the state of Alabama.

During her tenure at Tuskegee Institute, Dr. Dillon was responsible for the medical care of 450 students as well as 30 officers, teachers and their families. She established and owned the Lafayette Pharmacy, taught several classes at the college, often mixed her own medicines, and started a nursing school, now known as the Tuskegee University School of Nursing.

Dr. Dillon remarried in 1894 and, unfortunately, died of complications from childbirth in 1901.

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Repairing “difficult” patient-clinician relationships

*by Denise M. Dudzinski, PhD, MTS, and Carrol Alvarez, MS, RN
AMA Journal of Ethics. April 2017, Volume 19,
Number 4: 364-368*

Abstract

Using a case example, we offer guidance for improving “difficult” clinician-patient relationships. These relationships may be repaired by acknowledging a clinician’s part in conflict, empathizing with patients, identifying a patient’s skill deficits, and employing communication and engagement techniques used by mental health professionals. Clinicians will inevitably take on more of the work of repairing damaged relationships, but doing so improves the odds of these patients receiving the help they need.

Introduction

Jane, a patient with hypertension, diabetes, and chronic back pain, calls your internal medicine clinic asking to see you urgently. She has missed every scheduled appointment in the past two months but calls the office several times a week requesting narcotics prescriptions or same-day appointments. You have been treating her for a year, and she rarely follows your treatment regimen. When you see her the next day, she again requests a prescription for narcotics for her back pain. As always, you suggest other remedies including exercise, nonsteroidal anti-inflammatory drugs (NSAIDs), and relaxation techniques. Jane becomes angry, confrontational, and tearful. She yells, “Why don’t you believe me? You don’t feel what I feel! I’m telling you what I need. I know what works and I’m in pain – lots of pain! I’ve tried all those routines before and they’re worthless. Do you care about me at all?” Dr. Balewa tries to keep calm, but his anger escalates with hers. He tells her if she misses another appointment, he will have to

stop seeing her. She storms off but calls the next day for an appointment, telling the receptionist what a great doctor he is. He is exhausted from yesterday’s appointment, dreads seeing her again, and feels guilty that he can’t seem to help her and probably made things worse. He feels like a failure.

Many physicians find themselves in Dr. Balewa’s place. Jane regularly and urgently requests help managing her chronic medical conditions then ignores or rejects most of the care offered. She requests medications not indicated, then becomes agitated and disruptive when a prescription is not forthcoming. “Difficult” patients commonly struggle with chronic, incurable, or elusive illnesses [1, 2], which may be borne of tragedy, loneliness, poverty, or other psychosocial factors. Communication is frustrating for both patient and physician. Despite his efforts to maintain professional equanimity, Dr. Balewa became angry and responded with an ultimatum. Both physician and patient seemed to expect failure from themselves and each other, and their expectations were met. What can Dr. Balewa do to repair this relationship?

Clinicians will inevitably encounter patients with whom they share strained and complicated relationships. Initially it might seem that the problem is due to the patient’s noncompliance, substance abuse, mental illness, or demanding or disruptive behavior. In contrast, bioethicist Autumn Fiester describes the “difficult” patient as “someone who perceives himself as wronged in the medical encounter – perceives being treated unfairly, disrespectfully, dismissively, condescendingly, or offensively” [3]. By acknowledging that the difficulty resides in the relationship, not the patient, clinicians honor their fiduciary responsibility to take the

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Refresher training for Certified Medical Examiners provided at no cost

To remain eligible for listing on the Federal Motor Carrier Safety Administration's (FMCSA) National Registry, Certified Medical Examiners must maintain medical examiner certification by completing training and testing requirements. FMCSA has announced it will provide the five-year refresher training online to Medical Examiners at no cost. Medical Examiners eligible to take the five-year periodic online training will be notified by FMCSA when the training is available and the examiner is able to access the training site.

Please insure your National Registry account profile information page is accurate and current. Failure to complete the required training will result in removal from the National Registry.

If you have questions, contact the Medical Program Office at (202) 366-4001.

- Federal Motor Carrier Safety Administration: www.fmcsa.dot.gov
- Medical Review Board: www.fmcsa.dot.gov/mrb
- National Registry of Certified Medical Examiners: www.nationalregistry.fmcsa.dot.gov

Difficult patients, cont.

lead in ameliorating conflict. We argue that when a clinician brings hope, encouragement, and optimism to an encounter, he sets himself and the patient up for success. In this article, we discuss communication and interpersonal strategies designed to repair difficult patient-clinician relationships.

Take stock

After exiting the exam room, it is tempting to leave the unpleasant experience behind, but reflecting on the encounter is more productive. Ask yourself what went wrong. Ascertain how you have participated in the malignant relationship by identifying your "triggers" [4]. Do other patients, friends, or family members prompt similar reactions in you? What responses to you do these friends and the patients have in common? Try to identify patterns. Do you tend to feel exasperated with patients who need your help with nonmedical issues or who demand treatments you deem inappropriate?

Set tone and expectations

Jane's emotions got the better of her, prompting Dr. Balewa's invalidation of her internal experiences when what she, and others like her, seeks is validation [5]. Dr. Balewa could help by lowering his voice, being still and calm in the midst of Jane's anger, and by setting concrete expectations and boundaries early in the appointment. With preparation and practice, he can de-escalate emotional intensity by creating a more collaborative atmosphere. For example, he could begin by saying, "I would like us to find a plan that we both believe will work for you, one that is within standards of good clinical care. We might have to start with small steps. In order to accomplish our goal, we will have to be respectful of each other. If one of us becomes too frustrated to continue, we may have to stop at that point and pick up again at our next visit." This approach improves collaboration and emphasizes mutual respect and

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Prescription Drug Monitoring Program update

by Nancy Bishop, RPh, ADPH State Pharmacy Director

An enhancement to the Prescription Drug Monitoring Program (PDMP) is coming soon. Starting April 2018, a quarterly *Prescriber Report* will be sent to any prescriber who has written at least one opioid prescription in the past six months. The report reflects opioid and anxiolytic medications reported to the PDMP database and includes:

- Comparison of prescribing behavior to red flag indicators such as high dose, combination therapies, and treatment utilization.
- Comparison of prescriber behavior to peers in their specialty field and statewide.
- Summary of patient and prescription volumes.
- Information on potential prescriber and pharmacy shoppers.
- Summary of PDMP usage.

The *Prescriber Report* will be sent via email so it is important that your email address remains current. This report is based on the specialty that is currently listed in your PDMP account.

Attention Physician Assistants!

**2018 ASPA CME Meeting
March 1 - 4, 2018
Embassy Suites Hoover**

**Registration information
available at
www.myaspa.org.**

Difficult patients, cont.

responsibility, because the plan applies to both patient and physician. It also avoids the abrupt imposition of an ultimatum borne of the physician's frustration. This strategy is useful in that it allows a time-out period for the patient, and perhaps the physician, early rather than late in the escalation process. Patients with emotional dysregulation may have difficulty regaining control once escalation has begun, and providing a structured way to interrupt the process is beneficial.

Empathize with patients in their attempts to solve problems

It's helpful to recognize that the patients' behaviors are attempts to problem-solve. For example, Janet might believe the physician does not appreciate the intensity of her pain and distress. She believes shouting will call attention to her needs, and she is right. Often patients seek human interaction and empathy from caregivers. Jodi Halpern describes empathy as including "not only spontaneous emotional attunement... but also a conscious process of cultivating curiosity about another's distinct perspective" [6]. Sympathy, on the other hand, is "resonating emotionally with the patient" [6]. When the patient is angry, empathy de-escalates conflict and sympathy escalates it. After listening with interest and curiosity to Jane's angry accusations, Dr. Balewa could have said, "I know you've been frustrated and felt unheard. I'm not intending to be disrespectful of your experience. I have guidelines I must follow, but perhaps we can begin with a specific goal and try different approaches." This approach validates the patient's distress and promises a commitment to creatively resolve the patient's perception of the problem.

Assess Patient's Skill Deficits

Behaviors that provoke emotional reaction in others may represent skill deficits in the patient. The skills Jane lacks include the ability to effectively regulate intense negative emotions and to communicate effectively in the midst of conflict. Jane might not be able to self-soothe, expecting relief to come from external sources such as the physician or narcotics. Finally, she likely has limited experience of self-efficacy, which plays out in her inability to effectively make and keep medical appointments. If Dr. Balewa sees Jane's behaviors as coping strategies rather than noncompliance, his empathy may increase and he may be better able to help her.

Strategically manage this and future appointments

Dr. Balewa suspects that Jane's diabetes and hypertension are poorly controlled due to a sedentary lifestyle and medication nonadherence. He could begin the next appointment by inquiring about one or two things that have gone well since her last appointment. This strategy would begin the session with an opportunity to reinforce (even limited) successes and could help physicians calibrate how ambitious their next steps should be. In this way, Dr. Balewa would decrease his risk of getting caught up in Jane's emotional intensity. Instead, he could: (1) help Jane maintain her composure with a matter-of-fact manner of interacting; (2) validate her reaction as understandable within her unique experience and context, rather than invalidate it within his own; and (3) refocus on tasks and strategies that are most useful to her

Setting clear limits provides structure [7] that will help Jane over time. For example, Dr. Balewa can talk with Jane about ways to improve her ability to keep her appointments, while also developing strategies for missed appointments and requests for

next-day appointments. Dr. Balewa can invite Jane to determine whether shorter appointments at shorter intervals would work better, noting that the appointment may end early if an emotional stalemate occurs, with unfinished business deferred to a later appointment.

Once these basic and immediate structures have been established, the physician could invite Jane to set goals by asking what she would like to accomplish for herself in the appointment and in the next few months. He could ask if she would be willing to take small steps toward at least one of those goals and report back about what does and does not work. Modest recommendations generated together allow additional successes for Jane to build upon. In the face of Jane's health problems these small steps might seem inadequate to the physician, but they may allow for better health outcomes in the long run.

Finally, the recommendation that doctors spend more time listening and interrupt less is especially important in difficult encounters [8]. Physicians are inclined to interrupt the patient about 18 seconds after greeting him or her. However, it only takes about 2.5 minutes for patients to tell their stories uninterrupted, which makes patients feel heard, provides rich history relevant to the rest of the visit, and likely saves time overall [9].

Conclusion

Clinicians readily accommodate patients' physical disabilities, but they might neglect to take into account patients' deficits in social and life skills or thorny personal styles. The latter signal the need for different kinds of accommodations. Patients' personal histories may influence their expression of distress, communicated in ways that complicate their ability to receive necessary care. When a clinical encounters a patient

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How to make HIPAA disclosures during mass tragedies

By Kelli Fleming, partner with Burr & Forman LLP, practicing in the firm's Health Care Industry Group

In light of the recent incident in Las Vegas, the Office of Civil Rights (OCR), the government entity responsible for HIPAA Compliance, issued clarification guidance on the ability of a healthcare provider to share patient information during such situations. While such incidents are taxing on healthcare providers in terms of treating capacity and ability, it is important that providers keep in mind the requirements of HIPAA regarding the disclosure of certain information to the public. A summary of OCR's recent clarification is provided below, as it serves as a good reminder regarding what information can be shared under HIPAA in these types of mass-casualty, disaster scenarios.

Disclosures to family, friends and others involved in an individual's care and for notification

You may share health information with a patient's family members, relatives, friends or other persons identified by the patient as involved in the patient's care. You may also share information about a patient as necessary to identify, locate and notify family members, guardians or anyone else responsible for the patient's care, of the patient's location, general condition, or death. This may include, where necessary to notify family members and others, the police, the press or the public at large.

- ❖ You should get verbal permission from the patient when feasible or otherwise be able to reasonably infer that the patient does not object to the disclosure. If the individual is incapacitated or not available, you may share information for these purposes if, in your professional judgment, doing so is in the patient's best interest.
- ❖ In addition, you may share protected health information with disaster relief organizations that are authorized by law or by their charters to assist in disaster relief efforts (e.g., American Red Cross), for the purpose of coordinating the notification of family members or other persons involved in the patient's care, of the patient's location, general condition or death. It is unnecessary to obtain a patient's permission to share the information in this situation if doing so would interfere with the organization's ability to respond to the emergency.

Disclosures to the media or others not involved in the care of the patient/notification

Upon request for information about a particular patient by name, you may release limited facility directory information to acknowledge that an individual is a patient at the facility and provide basic information about the patient's condition in general terms (e.g., critical or stable, deceased or treated and released) if the patient has not objected to or restricted the release of such information or, if the patient is incapacitated, if the disclosure is believed to be in the best interest of the patient and is consistent with any prior expressed preferences of the patient. In general, affirmative reporting to the media or the public at large about an identifiable patient, or the disclosure to the public or media of specific information about the treatment of an identifiable patient, such as specific tests, test results or details of a patient's illness, may not be done without the patient's written authorization (or that of his/her personal representative).

Interstate Medical Licensure Compact (IMLCC) Update

In October 2017, the IMLCC released preliminary data regarding applications processed and licenses issued via the ILMCC process. The information below represents the work completed through Sept. 30, 2017, and illustrates how volume has increased at a rapid and steady pace since the first license was issued in April 2017.

Date	Applications Processed	License Issued
April to July 2017	157	140
August 2017	49	78
September 2017	91	146
Renewals April to Sept.	0	20
TOTAL	297	384

CME in 2018

New BME CME rule

Beginning Jan. 1, 2018, all Alabama Controlled Substances Certificate (ACSC) holders must earn or obtain, every two years, 2 *AMA PRA Category 1 Credits*[™] or equivalent continuing medical education credits in the areas of controlled substances prescribing practices, recognizing signs of the abuse or misuse of controlled substances, or controlled substance prescribing for chronic pain. CME credits obtained prior to Jan. 1, 2018, cannot be counted toward the new requirement.

For more information, see Prescribing Controlled Substances FAQs on the Board's web page, www.albme.org/csfaq.html.

PCSS-O offers FREE CME

Providers' Clinical Support System for Opioid Therapies (PCSS-O) clinical experts led by Roger Chou, MD, FACP, and Melissa B. Weimer, DO, MCR, have developed and made available at no cost a comprehensive core curriculum for providers who want in-depth knowledge in treating chronic pain. The 11 modules that make up the curriculum give up-to-date and evidence-based information on best opioid prescribing practices. Each module (except the Overview module) is designed for 1 *AMA PRA Category 1 Credit*[™]. Learn more at www.pcss-o.org/education-training/core-curriculum/.

2018 Prescribing and Pharmacology of Controlled Drugs

New Topics, New Speakers!

March 17-18

- Prescribing and Pharmacology of Controlled Drugs
Renaissance Montgomery Hotel & Spa

August 3-5

- Prescribing and Pharmacology of Controlled Drugs
Sandestin Golf & Beach Resort

Nov. 17-18

- Prescribing and Pharmacology of Controlled Drugs
Hyatt Regency Birmingham – The Wynfrey Hotel

Also ...

Nov. 16

- Ensuring Quality in the Collaborative Practice
- Medical Ethics
Hyatt Regency Birmingham – The Wynfrey Hotel

For information and to register, go to www.alamedical.org/prescribing.

Difficult patients, cont.

whose behaviors are disruptive and distressing, a step back for reflection can provide a shift in perspective.

The basis of trust in the patient-clinician relationship is a fiduciary obligation to protect, respect, and heal vulnerable patients. The patient-clinician relationship is inherently unequal, and the physician marshals her knowledge and power solely to aid the patient. Consequently, clinicians always have more responsibility to repair and rebuild the relationship than patients. The strategies discussed here can help clinicians do just that.

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AMA Journal of Ethics is available at <http://journalofethics.ama-assn.org/>.

The viewpoints expressed in this article are those of the author(s) and do not necessarily reflect the views and policies of the AMA.

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

Mission: The Alabama Board of Medical Examiners and the Medical Licensure Commission are charged with protecting the health and safety of the citizens of the state of Alabama.

MLC – September 2017

◆ Effective Sept. 5, the Commission issued an Order placing on probation the license to practice medicine in Alabama of **James E. Mallette, III, DO**, lic. no. DO.749, Florence, AL, and restricting him from prescribing any Schedule II controlled substances.

BME – September 2017

◆ On Sept. 20, the Board issued a Consent Order placing on probation the Alabama Controlled Substances Certificate of **Frederick H. Stevens, MD**, lic. no. MD.12389, Athens, AL.

◆ Effective Sept. 21, the Board accepted the Voluntary Surrender of the Alabama Controlled Substances Certificate of **Elizabeth Campbell Korcz, MD**, lic. no. MD.28343, Hoover, AL.

◆ On Sept. 25, the Board entered a Consent Order restricting the Alabama Controlled Substances Certificate of **Celia W. Lloyd-Turney, MD**, lic. no. MD.11042, Toney, AL, effective Nov. 24, 2017.

MLC – October 2017

◆ On Oct. 31, the Commission entered an Order returning to full, unrestricted status the license to practice medicine in Alabama of **David G. Morrison, MD**, lic. no. MD.20819, New Orleans, LA.

BME – October 2017

◆ On Oct. 9, the Board entered an Amended Consent Order concerning the Alabama Controlled Substances Certificate of **Larry Taylor Bolton, MD**, lic. no. MD.5951, Scottsboro, AL.

◆ On Oct. 18, the Board entered a Consent Order revoking the license to practice as a physician assistant in Alabama of **Ashla Elam-Bryant, PA**, lic. no. PA.1013, Columbus, GA.

◆ On Oct. 18, the Board accepted the voluntary surrender of the Alabama Controlled Substances Certificate of **Anthony A. Cibulski, MD**, lic. no. MD.6557, Birmingham, AL.

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

None at this time

Actions on ACSC for not being registered for PDMP (administrative fine):

• **Thien Steven Duc Quach, MD**, lic. no. MD.28764, Dunwoody, GA

Actions on ACSC for prescribing controlled substances with expired ACSC (administrative fine):

• **Stewart Hill Tankersley, MD**, lic. no. MD.23941, Montgomery, AL

540-X-9-.11 Contact with patients before prescribing

(1) It is the position of the Board that, when prescribing medications to an individual, the prescriber, when possible, should personally examine the patients. Before prescribing a medication, a physician should make an informed medical judgment based on appropriate medical history, the circumstances of the situation and on his or her training and experience. This process must be documented appropriately.

(2) Prescribing medications for a patient whom the physician has not personally examined may be suitable under certain circumstances. These circumstances may include but not be limited to electronic

encounters such as those in telemedicine; admission orders for a patient newly admitted to a health care facility; prescribing for a patient of another physician for whom the prescribing physician is taking call; or continuing medication on a short-term basis for a new patient prior to the patient's first appointment.

(3) Licensees are expected to adhere to all federal and state statutes regarding the prescribing of controlled substances and all Alabama Board of Medical Examiners' Rules regarding the prescribing of controlled substances.

Effective Date: November 27, 2017



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2018 BME Meeting Dates

January 17	May 16	September 19
February 21	June 20	October 17
March 21	July 18	November 21
April 12 & 14	August 15	December 19

The public portion of each meeting is scheduled for 10:00 a.m. CT (unless otherwise indicated) in the Dixon-Parker Building located at 848 Washington Avenue, Montgomery, Ala.

Meeting agendas and a full list of meeting dates and times can be found on the Board's website:

www.albme.org

2018 MLC Meeting Dates

January 24	May 23	September 26
February 28	June 27	October 24
March 28	July 25	November 28
April 18	August 22	December 20

Meetings are held in the Dixon-Parker Building located at 848 Washington Avenue, Montgomery, Ala.

QUESTIONS OR ASSISTANCE

Alabama Board of Medical Examiners (334) 242-4116

- Administration:** Edward H. Munson Jr., Acting Executive Director
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Amy Wybenga, CRNP, Nurse Consultant

Medical Licensure Commission (334) 242-4153

Executive Assistant: Karen Silas