Alabama Board of Medical Examiners
Newsletter and Report
www.albme.org | January – March 2007 | Volume 22, Number 1

Inside:

Is advertising by physicians and physician groups ethical?

Advertising by members of the learned professions was considered unethical and, in some cases, illegal for several decades in the 20th century. In the 1960s some professionals challenged this ethic. The challenge rose to the U.S. Supreme Court in a case brought by an attorney against his state bar association (*Bates v. State Bar of Arizona, 433 US 350, 369-70 n.20*).

"The Court held that the state may regulate some aspects of advertising, but that a blanket prohibition against advertising by attorneys was unconstitutional as a violation of the first amendment." (Taken from the *American Medical Association's Code of Medical Ethics*, page 128.)

The Alabama Medical Licensure Commission formulated a rule that does not prohibit physician advertisement, as long as the statements made in the advertisement are accurate and verifiable. The rule sets as an example of unprofessional conduct "intentionally or knowingly making a false, deceptive or misleading statement in any advertisement or commercial solicitation for professional services and/or intentionally or knowingly making a false, deceptive or misleading statement about another physician or group of physicians in any advertisement or commercial solicitation for professional services." *Medical Licensure Commission Rule 545-X-4-.06(7).*

Following the U.S. Supreme Court ruling, the AMA reviewed its position on physician advertising and updated it in the *Code of Medical Ethics*. The position relating to physician advertising is in Opinion E-5.02:

"There are no restrictions on advertising by physicians except those that can be specifically justified to protect the public from deceptive practices. A physician may publicize him or herself as a physician through any commercial publicity or other form of public communication (including any newspaper, magazine, telephone directory, radio, television, direct mail, or other advertising) provided that the communication shall not be misleading because of the omission of necessary material information, shall not contain any false or misleading statement, or shall not otherwise operate to deceive.

(continued on page 4)

Considerations for Physician Advertising

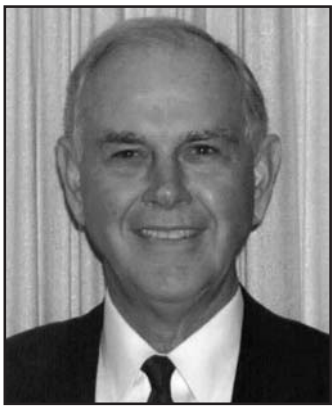
- **Verify that the content is true and is not misleading.**
- **Ascertain that the wording of the advertisement is not deceptive.**
- **Be sure that claims regarding competence, quality and experience can be factually supported.**
- **One must be able to document claims of a unique skill or remedy.**
- **Determine that your advertising message is explicitly and implicitly truthful.**

A Message from the Executive Director

Annual report of the Alabama BME

by Larry Dixon

The 2006 Annual Report of the Alabama Board of Medical Examiners indicates fairly consistent increases between the 2005 and 2006 reports on the number of new physicians who are first time licensees in the State of Alabama. The Medical Licensure Commission received a Certificate of Qualification to Practice Medicine in Alabama on 630 applicants by endorsement and 172 applicants by examination – within 22 of the number of new physicians when compared to 2005. The Board of Medical Examiners and its staff have compiled an Annual Report for your information.



Larry Dixon

Alabama Board of Medical Examiners Annual Report – 2006

Applicants Certified To Medical Licensure Commission
1. Applicants by endorsement 630
2. Applicants by examination 172

Applicants Certified For Limited License 97

Applicants Taking SPEX Examinations
1. Applicants passing examinations.....11
2. Applicants failing examinations 8

Advanced Practice Nurses (CRNP/CNM)
1. Certified Registered Nurse Practitioner Collaborations Approved.....688
2. Certified Nurse Midwife Collaborations Approved.....0

Physician Assistants
1. Physician Assistants Licensed.....60
2. Physician Assistants Registered to Physicians (new applications).....151
3. Physician Assistants Granted Temporary Licensure 21
4. Temporary Licensure Converted to Full Licensure (after passing exam) .21
5. Temporary Licensees Granted Registration 18
6. Anesthesiologist Assistants Licensed 3
7. Anesthesiologist Assistants Granted Temporary License.....0
8. Anesthesia Assistants Registered to Physicians (new applications) 3

ACSC Issued/Renewed 11,532

Disciplinary/Confidential Actions
1. ACSC Surrender / Revocation / Restriction / Reinstatement 4
2. Certificates of Qualification Denied / Surrendered.....8
3. Certificates of Qualification with Agreements / Restrictions 3
   Certificate of Qualification Restrictions Terminated 2
4. Letters of Concern 61
5. Patient Complaints Received 467
6. Patient Complaints Investigated.....380

(continued on page 6)

The Alabama Prescription Drug Monitoring Program

by Kenneth W. Aldridge, MD, vice chairman

Kenneth W. Aldridge, MD

BME Executive Director Larry Dixon discussed Alabama's Controlled Substance Prescription Database legislation in the BME's most recent newsletter. The official name for the program created by that legislation is the "Alabama Prescription Drug Monitoring Program" (PDMP). This program arose out of a need to better monitor controlled substance use (and abuse) in our state. The PDMP was created by a 2004 Act (2004-443, SB 35), authorizing that the program be created under the direction of the Alabama Department of Public Health (ADPH) (*Code of Alabama,* Sections 20-2-210, et. seq.). Its purpose as described in the Act is: "To collect data on all Schedule II, III, IV, and V controlled substances dispensed in the state of Alabama or for patients residing in Alabama."

Prescription drug diversion for illegal use is a known problem nationally. In 2000, *National Household Survey* estimated 14 million illicit drug users in the United States (6.3 percent of the population over age 12). Presently, the only way an investigator in Alabama can learn of possible diversion or abuse of controlled substances is through verbal reports (tips).

According to the DEA, Alabama ranks third in the per capita prescription of Hydrocodone, and 11th in the prescription of Oxycodone. The PDMP will provide needed information to monitor controlled substance use in Alabama, and eventually states will be able to share data.

Before reviewing the reporting requirements of the PDMP, it is important to emphasize the difference between a physician who **prescribes** a controlled substance and one who **dispenses** the controlled substance. A **prescribing** physician is one who has an Alabama Controlled Substance Certificate (ACSC) and who provides a prescription authorizing a pharmacy or appropriate supplier to dispense the requested controlled substance to the patient. A **dispensing** physician is described in a white paper on the PDMP as follows:

"If the provider orders drugs in forms other than sample medications, whether they are prepackaged or packaged by the provider, and dispenses these medications to a patient, for their use off of the premises, (s)he is considered a **dispenser**."

Reporting Requirements

The **only** physicians who must register with and report to the ADPH PDMP are those who are ordering/obtaining/purchasing **controlled substances** in any form, other than **free samples** that may be provided by a drug company, to **dispense** to patients.

A physician **is not** required to report sample medications dispensed, controlled substances administered by injection, pain pump refills, topical application, suppository or oral administration during the course of treatment **on the premises**.

Registration and reporting of **legend drug** dispensing **is not** required.

Reporting is to be done in an approved electronic format (reporting in ways such as CD, disk, or paper, must be done with the approval of the ADPH, via a waiver obtained in advance).

This information is available in detail through the ADPH (www.adph.org) or Health Information Designs, Inc. (pdminfo@hidinc.com).

Other registrants will include dentists, veterinarians, podiatrists and optometrists.

All dispensers (and pharmacies) must collect and report the following information:

- Recipient full name
- Recipient identification number
- Recipient date of birth
- Recipient gender
- Recipient address
- Prescriber name and DEA number
- National Drug Code of the drug
- Quantity dispensed
- The number of days supplied
- Origin of the prescription (written, phoned, faxed, etc.)

Reporting must be done **within seven days of dispensing**; non-compliance will be reported to the appropriate regulatory board by the ADPH. Failure to comply with the reporting requirements of the PDMP can result in fines of up to $10,000. Thus far, despite publications, press releases, direct mailings and newsletter articles, statewide compliance with the reporting requirements has been slow to occur. More than 75 percent of Alabama physicians who are registered as dispensing physicians have failed to submit any reports to the PDMP since the requirement took effect April 1, 2006. The BME, charged by statute with enforcing this law, has recently undertaken another bulk mailing to the registered dispensing physicians who have not submitted any reports thus far, in the hope of avoiding having to take action against those who are not in compliance. As outlined in Mr. Dixon's article in the most recent newsletter, there may be many physicians who are mistakenly and unnecessarily registered, and who may need to terminate their registration. Otherwise, registered physicians **must** comply with the statute to avoid future fines.

Access to the PDMP Databank should be available for physicians by early summer 2007. This will allow registrants to run patient profiles on the controlled substance activities of any of their present or prospective patients.

Advertising by physicians

continued from page 1

"Because the public can sometimes be deceived by the use of medical terms or illustrations that are difficult to understand, physicians should design the form of communication to communicate the information contained therein to the public in a readily comprehensible manner. Aggressive, high-pressure advertising and publicity should be avoided if they create unjustified medical expectations or are accompanied by deceptive claims. The key issue, however, is whether advertising or publicity, regardless of format or content, is true and not materially misleading.

"The communication may include (1) the educational background of the physician, (2) the basis on which fees are determined (including charges for specific services), (3) available credit or other methods of payment, and (4) any other nondeceptive information.

"Nothing in this opinion is intended to discourage or to limit advertising and representations which are not false or deceptive within the meaning of Section 5 of the Federal Trade Commission Act. At the same time, however, physicians are advised that certain types of communications have a significant potential for deception and should therefore receive special attention. For example, testimonials of patients as to the physician's skill or the quality of the physician's professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimoniant's condition generally receive.

"Objective claims regarding experience, competence, and the quality of physicians and the services they provide may be made only if they are factually supportable. Similarly, generalized statements of satisfaction with a physician's services may be made if they are representative of the experiences of that physician's patients.

"Because physicians have an ethical obligation to share medical advances, it is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible. Similarly, a statement that a physician has cured or successfully treated a large number of cases involving a particular serious ailment is deceptive if it implies a certainty of result and creates unjustified and misleading expectations in prospective patients.

"Consistent with federal regulatory standards which apply to commercial advertising, a physician who is considering the placement of an advertisement or publicity release, whether in print, radio, or television, should determine in advance that the communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered. Inclusion of the physician's name in advertising may help to assure that these guidelines are being met. (II) Issued prior to April 1977; Updated June 1996."

The Alabama Medical Licensure Commission's rule and the AMA's ethical opinion are considered by the Board of Medical Examiners and the Medical Licensure Commission when someone sends a complaint about an adverstisement.

If a physician plans to advertise a medical practice, it is prudent to consider several items when constructing a publicity message.

1. Carefully review whether the advertising or publicity, regardless of format or content, is true and not materially misleading, either from information stated or from information omitted.

2. Recognize that certain types of communications, such as patient testimonials, have a significant potential for deception and should therefore receive special attention. Testimonials of patients as to the physician's skill or the quality of the physician's professional services tend to be deceptive when they do not reflect the results that patients with comparable conditions generally receive. Do not select a patient to make a testimonial that is more satisfied that your average patient.

3. Investigate and document objective claims regarding experience, competence, and the quality of physicians and the services they provide; these may be made only if they are factually supportable.

4. Claims that imply a truly exclusive or unique skill or remedy can be deceptive. These are accepable only if they purport the physician to be the only one with these unique skills in a certain geographic area and there is documentation to support the claim.

5. A physician who is considering the placement of an advertisement or publicity release, whether in print, radio, television or Internet, should determine in advance that the communication or message is explicitly and implicitly truthful and not misleading. These standards require the advertiser to have a reasonable basis for claims before they are used in advertising. The reasonable basis must be established by those facts known to the advertiser, and those which a reasonable, prudent advertiser should have discovered.

Physicians – it's not too early to review your compliance with CME rules

by Carla Kruger, Board of Medical Examiners, administrative assistant

Editor's Note: The Board and Commission receive numerous requests about the annual Continuing Medical Education requirement. Carla Kruger, administrative assistant for the Board, wrote this clarification. She emphasizes some of the problems that the Board has seen when conducting its annual CME compliance review.

In order to avoid the possibility of receiving an embarrassing public reprimand and substantial fine, just read and follow these guidelines:

- It is **your** responsibility, not a staff person's or spouse's, to ensure you have earned or accrued the minimum hours and to maintain adequate documentation. Be sure that if the Board requests documentation of your CME, you can produce it quickly and it is accurate.
- **Keep a file** containing the documentation of your CME hours earned. You should keep at least the last three years' worth of CME documentation. Do not send your CME certificates unsolicited or with your renewal application – they will be discarded. If the Board or Commission wants to see your documentation, you will receive formal notification.
- Be sure you have adequate documentation **before** certifying and submitting your renewal application. You cannot certify to hours you have not yet received. **Don't wait** until you have received a letter from the Board!
- Be sure your documentation is adequate:
    - Adequate documentation means you have a document stating the entity that sponsored the educational activity, the date the activity was completed, your name, and the number of Category 1 or equivalent hours earned. If you were not issued a document after completion of an activity, you should contact the sponsoring entity to obtain one.
    - If your document says "CEUs," "Category 2," "contact hours," or something other than "Category 1" (AMA/MASA), "Category 1-A" (AOA), "prescribed hour" (AAFP), or "cognates" (ACOG), it will not be accepted by the Board as adequate documentation.
    - Be certain before completing the CME activity that it has been accredited to confer Category 1 hours. **Not all PLAS, ACLS and BLS courses are accredited**, for example.
- If you receive formal notification from the Board to submit your documentation, you should respond immediately. If there is any question in your mind that your documentation is not sufficient or received, call the Board's office. **Never assume** your documentation has been properly maintained or submitted by another individual.
- Inform your staff to immediately, personally deliver any correspondence from the Board of Medical Examiners or Medical Licensure Commission. Often such correspondence is mistaken for "junk" mail or placed in a full "In box," never to be seen again.
- Just because you have retired from the active practice of medicine, you are not exempt from the CME requirement, unless you have **requested and obtained** a retirement waiver or have allowed your medical license to expire.
- Don't assume you have hours from previous years that will cover you for any particular year. If you intend to use "carryover" hours, be sure you know how the carryover works.

Using Carryover Hours:

You will certify on your 2008 license renewal application that you earned or accrued at least 12 hours of Category 1 CME in calendar year 2007.

Hours earned in excess of 12 in 2006 may be carried forward to meet the 2007 requirement.

Example 1:

2006: 17 hours earned
2007: 16 hours earned

Bring the 5 excess hours from 2006 forward to 2007; you will use 7 of the 16 hours earned in 2007 (5 + 7 = 12), and the remaining 9 hours earned in 2007 may be carried forward to 2008.

Example 2:

2006: 75 hours
2007: 5 hours

Bring 12 of the excess hours from 2006 forward to meet the 2007 requirement; additional hours cannot be brought forward and are lost. The 5 hours earned in 2007 can be carried forward to 2008.

Please see Newsletter Links at www.albme.org for a link to a more detailed explanation of the CME requirement and information about exemptions from the requirement.

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.

Board Opinions

Board of Medical Examiners Decision – Mid-Level Practitioners and Joint Injections

Physician Assistants who have been approved for performing joint injections may perform injections of the greater trochanteric bursa but are not approved to inject the hip joint.

Certified Nurse Practitioners who have been approved for performing joint injections may submit a training plan to the Board for training to perform injections of the greater trochanteric bursa. They are not approved to train to inject the hip joint.

Public Hearing Notice:

Guidelines for the Use of Lasers in the Practice of Medicine

Guidelines for the Use of Lasers in the Practice of Medicine (Board of Medical Examiners proposed Administrative Rule 540-X-11) was published in the March 30, 2007, *Alabama Administrative Monthly*.

The comment period ends on Friday, May 4, 2007.

A public hearing to receive oral comments concerning the proposed Rule is scheduled on Friday, April 27, 2007, at 9:00 a.m., at the Alabama State House, 11 South Union Street, Montgomery, Alabama 36130, in the 8th Floor Joint Conference Room.

A copy of the proposed Rule can be downloaded at the Board's web site. See the Newsletter Links page at www.albme.org.

BME Annual Report

continued from page 1

7. Other Complaints Investigated 92
8. Investigations Completed 367
9. Collaborative Practice Inspections 88
10. Collaborative Practice Compliance Seminars 9
11. Office Based Surgery Site Inspections 1
12. Interviews Conducted 61
13. Complaints filed with Medical Licensure Commission 29
14. Evaluations Ordered 5
15. Voluntary Agreements Entered Into 6
    Voluntary Agreements Removed 4
16. Voluntary Restrictions Entered Into 0
    Voluntary Restrictions Removed 1
17. Impaired Physician Coordinator Monitoring 61
    Number monitored since 1990 760
18. Requested CME Course Attendance 7
19. Sent for Expert Review 15
20. Administrative Fines Assessed (18 Cases) $162,000
21. Summary Suspensions 5
22. Summary Suspensions – Revocation 1
23. Summary Suspensions – Pending a Hearing before the MLC 3
24. Summary Suspensions – Dismissed 1
25. Voluntary Surrender of Alabama Medical License 5

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 noncompliance with Board rules concerning collaborative practices.

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

MLC – January 2007

On Jan. 4, the Commission entered an Order revoking the license to practice medicine in Alabama of **Allie Cosper Boyd III, MD**, license number MD.3883, Tuscaloosa, AL.

On Jan. 4, the Commission entered an Order restoring the license to practice medicine in Alabama of **Michael C. Caruso, MD**, license number MD.14848, Gainesville, GA, to full and unrestricted status.

On Jan. 4, the Commission entered an Order denying the application for reinstatement of license to practice medicine in Alabama of **Walter O. Anderson, MD**, license number MD.19547, Yucaipa, CA.

On Jan. 10, the Commission entered an Order terminating the probationary status of the license to practice medicine in Alabama of **Charles M. McInteer, MD**, license number MD.22296, Albertville, AL. Dr. McInteer now possesses a full, unrestricted license.

On Jan. 23, the Commission entered an Order reinstating the license to practice medicine in Alabama of **John A. Frenz, MD**, license number MD.16764, Flowood, MS.

On Jan. 30, the Commission entered an Order removing all restrictions previously placed on the license to practice medicine in Alabama of **Bruce H. Brennaman, MD**, license number MD.18575, Columbus, GA.

On Jan. 30, the Commission entered an Order removing the probationary status and restoring to unrestricted status the license to practice medicine in Alabama of **Rassan M. Tarabein, MD**, license number MD.18124, Daphne, AL.

On Jan. 30, the Commission entered an Order affirming the denial by the Board of Medical Examiners of the application for reinstatement of the certificate of qualification of **Marcus E. Ward, MD**, license number MD.11178, Gulf Shores, AL.

BME – January 2007

On Jan. 5, **William S. Chitwood, MD**, license number MD.16602, Wetumpka, AL, voluntarily surrendered his certificate of qualification and license to practice medicine in Alabama while under investigation by the Board for alleged violations of Ala. Code §34-24-360.

On Jan. 17, the Board entered an Order reinstating the certificate of qualification to practice medicine in Alabama of **Lloyd A. Manchikes, MD**, license number MD.13075, Mayslick, KY, based upon certain conditions.

MLC – February 2007

On Feb. 28, the Commission entered an Order summarily suspending the license to practice medicine in Alabama of **Lawrence R. Jellinek, MD**, license number MD.23229, Santa Barbara, CA, until such time as the Administrative Complaint filed by the Board shall be heard and a decision rendered thereon.

On Feb. 28, upon the stipulation of the parties, the Commission entered a Consent Order reprimanding the license to practice medicine in Alabama of **Mohammad Ismail, MD**, license number MD.19946, Anniston, AL, and assessing an administrative fine.

BME – February 2007

On Feb. 21, the Board denied the application for a certificate of qualification to practice medicine in Alabama of **Raymond M. Shapiro, MD**, Gaithersburg, MD.

On Feb. 22, the Board issued an Order terminating the voluntary restrictions heretofore entered against the certificate of qualification and license to practice medicine in Alabama of **John Henry Kimmons, MD**, license number MD.3434, Coppell, TX.

On Feb. 28, **Robert D. Phillips, MD**, MD.3394, Morris, AL, voluntarily surrendered his controlled substances prescribing privileges for Schedules II and III.

MLC – March 2007

On March 9, the Commission entered an Order terminating the probationary status of the license to practice medicine in Alabama of **Darryl A. Ellis, MD**, license number MD.18084, Phenix City, AL.

BME – March 2007

On March 21, the Board accepted the voluntary surrender of the certificate of qualification and license to practice medicine in Alabama of **Robert A. Hillman Jr., MD**, license number MD.6898, Dothan, AL.

On March 21, the Board denied the application for a certificate of qualification to practice medicine in Alabama of **Kishore S. Thakur, MD**, Unucsville, CT.

Alabama State Board of Medical Examiners
Newsletter and Report

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

Look inside for

important news

from the

Board of Medical Examiners

that pertains to your license

to practice medicine

in Alabama.

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.