MINUTES
Monthly Meeting
MEDICAL LICENSURE COMMISSION OF ALABAMA
Meeting Location: 848 Washington Avenue
Montgomery, Alabama 36104

June 28, 2023

MEMBERS PRESENT IN PERSON

Craig H. Christopher, M.D., Chairman
Jorge Alsip, M.D., Vice-Chairman
Kenneth W. Aldridge, M.D.
L. Daniel Morris, Esq.
Paul M. Nagrodzki, M.D.
Pamela Varner, M.D.

MEMBERS NOT PRESENT

Howard J. Falgout, M.D.
Gary Hill, D.O.

MLC STAFF

Aaron Dettling, General Counsel, MLC
Rebecca Robbins, Operations Director (Recording)
Nicole Hardy, Administrative Assistant (Recording)
Heather Lindemann, Licensure Assistant

OTHERS PRESENT

BME STAFF

Buddy Chavez, Investigator
Rebecca Daniels, Investigator
Randy Dixon, Investigator
Amy Dorminey, Operations Director
Alicia Harrison, Associate General Counsel
Chris Hart, Technology
Effie Hawthorne, Associate General Counsel
Wilson Hunter, General Counsel
Roland Johnson, Physician Monitoring
Winston Jordan, Technology
Stephen Lavender, Investigator
William Perkins, Executive Director
Tiffany Seamon, Director of Credentialing
Christy Stewart, Paralegal

Call to Order: 9:00 a.m.

Prior notice having been given in accordance with the Alabama Open Meetings Act, and with a quorum of six members present, Commission Chairman, Craig H. Christopher, M.D. convened the monthly meeting of the Alabama Medical Licensure Commission.

Executive Director's Report

Mr. William Perkins, BME Executive Director, provided a brief update on the Alabama Medical Cannabis Commission. Mr. Perkins noted that, due to delays in the issuance of licenses by the Medical Cannabis Commission, the BME would not be issuing medical cannabis permits to physicians in the immediate future. Mr. Perkins further noted that some members of the public are confusing the Medical Cannabis Commission with the Medical Licensure Commission. Any inquiries may be directed to BME Legal.

OLD BUSINESS

Minutes May 22, 2023

Commissioner Alsip made a motion that the Minutes of May 22, 2023, be approved. A second was made by Commissioner Nagrodzki. The motion was approved by unanimous vote.

Minutes May 24, 2023

Commissioner Alsip made a motion that the Minutes of May 24, 2023, be approved. A second was made by Commissioner Nagrodzki. The motion was approved by unanimous vote.

NEW BUSINESS

Full License Applicants

	Name	Medical School	Endorsement
1.	Houston Michael Aaron	Louisiana State University Medical Center in Shreveport	USMLE/TX
2.	Ahmed R M Abdelkader	Al-Azhar University Faculty of Medicine	USMLE/MI
3.	Jose Acevedo Echevarria	Ponce School of Medicine	USMLE/CA
4.	Asif Ikram Ahmad	St. George's University School of Medicine, Grenada	USMLE/PA
5.	Amar Anand	St. George's University School of Medicine, Grenada	USMLE/SC
6.	James Andrews	Stanford University School of Medicine	USMLE/CA
7.	Cody Dylan Bulger	Alabama College of Osteopathic Medicine	COMLEX

	Name	Medical School	Endorsement
8.	Wesley Croft Burkett	University of Alabama School of Medicine Birmingham	USMLE/OK
9.	Daniel Paul Carriger	Alabama College of Osteopathic Medicine	COMLEX/VA
10.	Victoria Underwood Clay	University of Alabama School of Medicine Birmingham	USMLE/KY
11.	Ian Oluremilekun Cole	University of Michigan Medical School	USMLE/NC
12.	Vincent Julian Costers	University of South Florida College of Medicine	USMLE/FL
13.	Wesley Cowan	University of Alabama School of Medicine Birmingham	USMLE/VA
14.	Hajrunisa Cubro	University of Sarajevo	USMLE/IN
15.	Justin Tyler Cullifer	Alabama College of Osteopathic Medicine	COMLEX
16.	Aakash Desai	B.J. Medical College	USMLE/CT
17.	Andrew Mark Erwood	University of Iowa Carver College of Medicine	USMLE/GA
18.	Michael Ewing	University of Alabama School of Medicine Birmingham	USMLE/MO
19.	Oluwatoyin E Falodun	SUNY Downstate Health Sciences University	USMLE/NJ
20.	Susan Gacheri	Sidney Kimmel Medical College at Thomas Jefferson University	USMLE/PA
21.	Juan Jose Gallegos	University of Texas Medical School at Galveston	USMLE/FL
22.	Deepthi Ganta	St. George's University School of Medicine, Grenada	USMLE
23.	Kevin Gil	Florida State University College of Medicine	USMLE/FL
24.	Sean K Grumbach	University of South Carolina School of Medicine	USMLE/SC
25.	Alec Bryan Guerzon	Our Lady of Fatima University	USMLE
26.	Christopher Scott Hall	Johns Hopkins University School of Medicine	USMLE/CA
27.	Bradley Daily Harris	University of South Alabama College of Medicine	USMLE
28.	Ashley Henning	West Virginia School of Osteopathic Medicine	COMLEX
29.	Douglas Kent Holmes	Univ of North Carolina School at Chapel Hill School of Medicine	FLEX/IA
30.	Justin Edward Hughes	University of South Alabama College of Medicine	USMLE
31.	Lawrence Eric Isaacs	Univ of Medicine & Dentistry New Jersey R W Johnson Med School	NBME/PA
32.	Mary Margaret Johnson	Alabama College of Osteopathic Medicine	COMLEX/KY
33.	Ehtesham Khalid	Nishtar Medical College, Bahuddin Zakaria University	USMLE/TN
34.	Muhammad Awais Khan	Aga Khan Medical College, Aga Khan University	USMLE/PA
35.	Carson E P Klein	University of Alabama School of Medicine Birmingham	USMLE
36.	Henry J Konzelmann	Southern Illinois University School of Medicine	USMLE/IL
37.	Christopher J Kovalsky	Louisiana State University Medical Center in Shreveport	USMLE
38.	Cassandra C Krause	Loma Linda University School of Medicine	USMLE/CA
39.	Clarissa Sunshine Krinsky	University of New Mexico School of Medicine	USMLE/NM
40.	Garrett Huckiang Lim	Univ of Tennessee Health Science Center College of Medicine	USMLE
41.	Scott Alexander Marshall	St. George's University School of Medicine, Grenada	USMLE/WI
42.	Patrick Mattern	Drexel University College of Medicine	USMLE/NJ
43.	Christine M McBride	Edward Via College of Osteopathic Medicine-Auburn campus	COMLEX
44.	Sarah Frances McClees	University of Alabama School of Medicine Birmingham	USMLE
45.	Mihaela Florescu Missel	William Carey University College of Osteopathic Medicine	COMLEX/NV
46.	Adam James Morris	Indiana University School of Medicine Indianapolis	USMLE
47.	David James Nye	Midwestern University, Arizona Campus	COMLEX/MA
48.	Nwanneka M Okwundu	Philadelphia College of Osteopathic Medicine	COMLEX/WA
49.	Kanvar Singh Panesar	University of Washington School of Medicine	USMLE

	Name	Medical School	Endorsement
50.	Sagar Ashwin Patel	Augusta University	USMLE
51.	Darren Doyle Phelan	University of California, San Francisco School of Medicine	NBME/CA
52.	Jordan M F Polistico	University of Santo Tomas	USMLE/MI
53.	Rishi Rane	Florida International Univ Herbert Wertheim College of Medicine	USMLE/FL
54.	Azima Rasiwala	West Virginia School of Osteopathic Medicine	COMLEX/NY
55.	Kristen Schultz Reed	University of South Alabama College of Medicine	USMLE
56.	Jordan Paul Reynolds	Northeastern Ohio Universities College of Medicine	USMLE/MN
57.	Hina Samad	Services Institute of Medical Sciences	USMLE/FL
58.	Kamila Seilhan	New York College of Osteopathic Medicine	COMLEX/ NY
59.	Christopher W Spruell	University of Texas Medical School at Galveston	USMLE/TX
60.	Kyle Spencer Stigall	University of Kentucky College of Medicine	USMLE/NE
61.	Soujanya Thummathati	Osmania Medical College	USMLE/MA
62.	Dennis Truong	Michigan State University College of Human Medicine	USMLE/VA
63.	John Chandler Van Dyke	University of South Alabama College of Medicine	USMLE/LA
64.	Erica Lyn Lam Warkus	University of Hawaii John A Burns School of Medicine	USMLE/FL
65.	Bradley Compton Wham	Wake Forest University School of Medicine	USMLE
66.	Raeann Lanae Whitney	Duke University School of Medicine	USMLE
67.	Elizabeth C B Wonpat	St. Matthew's University	USMLE/WI
68.	Alexus Briana Young	University of Alabama School of Medicine Birmingham	USMLE/NC
69.	*Mary B Blankenship	University of South Alabama College of Medicine	USMLE/UT
70.	*Winston M Crute	University of South Alabama College of Medicine	USMLE
71.	*John S Peters	West Virginia School of Osteopathic Medicine	COMLEX/GA
72.	*Garima Gupta	Saint Georges University	USMLE/OH
73.	Mohabe Anthony Vinson	University of Cincinnati College of Medicine	USMLE

**Approved pending acceptance and payment of NDC issued by BME.*

A motion was made by Commissioner Alsip with a second by Commissioner Morris to approve applicant numbers one through seventy-three (1-73) for full licensure. The motion was approved by unanimous vote.

Limited License Applicants

	Name	Medical School	Endorsement	Location	License
1.	Wadey Abdel Qader	FSU College of Medicine	LL/AL	USA IM	R
2.	Rida Ahmad	Aga Khan University	LL/AL	USA Surgery	R
3.	Samuel Bryan Anich	Alabama College of Osteopathic Med	LL/AL	USA Emergency Medicine	R
4.	Belinda Carrie Bell	Mercer University School of Medicine	LL/AL	South Baldwin FM	R
5.	Sarah C Bertrand	LSU Medical Center in Shreveport	LL/AL	Cahaba FM	R
6.	Austin James Bettridge	Alabama College of Osteopathic Med	LL/AL	USA Orthopedic Surgery	R
7.	Ryan Douglas Blackwell	U of Texas Medical School at Galveston	LL/AL	Southeast Health Transitional Yr	R

	Name	Medical School	Endorsement	Location	License
8.	Christopher Chase Britt	UAB	LL/AL	UAB - Tuscaloosa FM	R
9.	Emily Sutton Brown	UAB	LL/AL	UAB - Tuscaloosa FM	R
10.	Madison Jade Bruce	UAB	LL/AL	USA Surgery	R
11.	Matthew R S Carr	Univ of Illinois College of Med at Peoria	LL/AL	USA IM	R
12.	Marialaina D Carter	Edward Via C of Osteo Med -Auburn	LL/AL	USA IM	R
13.	Claire Victoria Cawthon	USA College of Medicine	LL/AL	South Baldwin FM	R
14.	Troye S Christmas, Jr.	Alabama College of Osteopathic Med	LL/AL	Crestwood IM	R
15.	Paris Long Cooke	U of Alabama School of Med Tuscaloosa	LL/AL	UAB - Tuscaloosa FM	R
16.	William Robert Craig	Alabama College of Osteopathic Med	LL/AL	USA Emergency Medicine	R
17.	Patrick Kelley Cutrell	USA College of Medicine	LL/AL	USA Health IM	R
18.	Taylor Elizabeth Delie	Trinity School of Medicine	LL/AL	Southeast Health Transitional Yr	R
19.	Donald B M Dennis	University of Texas at Austin	LL/AL	USA IM	R
20.	Hamza El Ayadi	University of Florida College of Medicine	LL/AL	USA IM	R
21.	David Allen Engerson	USA College of Medicine	LL/AL	USA IM	R
22.	Alina Farah	Alabama College of Osteopathic Med	LL/AL	USA FM	R
23.	Sarah E Fillingim	USA College of Medicine	LL/AL	USA IM	R
24.	Leigh M Fountain	Alabama College of Osteopathic Med	LL/AL	USA OB/GYN	R
25.	Kevin Riley Gallagher	Alabama College of Osteopathic Med	LL/AL	USA Psychiatry	R
26.	Michael T Garner	Univ of Central Florida College of Med	LL/AL	USA Surgery	R
27.	Lydia Mariam George	St. Martinus University	LL/AL	Southeast Health IM	R
28.	Aidan Dunning Gilbert	USA College of Medicine	LL/AL	USA Surgery	R
29.	Kenneth Hau	Ross University	LL/AL	Southeast Health Transitional Yr	R
30.	Andrew Jearald Heflin	U of Texas Medical School at Galveston	LL/AL	USA Orthopaedic Surgery	R
31.	Callie Alein Hillman	Arkansas College of Osteopathic Med	LL/AL	UAB Tuscaloosa FM	R
32.	Jesse Danielle Hunt	Edward Via C of Osteo Med - Carolinas	LL/AL	USA FM	R
33.	Erskine Hunter	Indiana University	LL/AL	Southeast Health Transitional Yr	R
34.	Michael L Jackson	USA College of Medicine	LL/AL	USA Surgery	R
35.	Ajay Jayesh Jani	Ross University	LL/AL	Southeast Health Transitional Yr	R
36.	Polly Merin Jasper	Univ of South Carolina College of Med	LL/AL	USA Surgery	R
37.	Christopher W Johnson	USA College of Medicine	LL/AL	USA IM	R
38.	Alena R A Kirstein	Nova SE Univ Patel College of Osteo Med	LL/AL	Gadsden Regional FM	R
39.	Neethu Mary Kurien	U of Tennessee Health Sci Ctr C of Med	LL/AL	UAB Tuscaloosa FM	R
40.	Rebekah E Kurtaneck	Edward Via C of Osteo Med - Auburn	LL/AL	Cahaba FM	R
41.	Stephen A Lavanier	Boston University School of Medicine	LL/AL	Southeast Health Transitional Yr	R
42.	Lauren Sanda Lopansri	USA College of Medicine	LL/AL	USA Surgery	R
43.	Kaleb Vachun Malone	USA College of Medicine	LL/AL	USA Surgery	R
44.	Hallie Smith Masters	Augusta University School of Medicine	LL/AL	USA Surgery	R
45.	John Everett McGann	Edward Via C of Osteo Med - Auburn	LL/AL	South Baldwin Med Center FM	R
46.	Kevin Earl Meek	A T Still Univ School of Osteo Med	LL/AL	Southeast Health Dothan IM	R
47.	Tyler Frederick Morgan	Texas Tech U Health Sciences Center	LL/AL	Southeast Health Transitional Yr	R
48.	Japhet Walker Nylen	Alabama College of Osteopathic Med	LL/AL	Southeast Health Transitional Yr	R
49.	Olaitan K Okungbowa	University of Benin	LL/AL	Cahaba FM	R

CAC

	Name	Medical School	Endorsement	Location	License
50.	Leena Bipin Patel	USA College of Medicine	LL/AL	USA IM	R
51.	Haley R Roberts	UAB	LL/AL	Cahaba FM	R
52.	Mina M Mousa Saba	Cairo University Faculty of Medicine	LL/AL	Southeast Health Transitional Yr	R
53.	Sangya Sharma	Edward Via C of Osteo Med - Virginia	LL/AL	USA IM	R
54.	Eric Mitchell Stringfield	University of Kansas School of Medicine	LL/AL	Cahaba FM	R
55.	Lucas R Tarvainen	Michigan State University Marquette	LL/AL	UA FM	R
56.	Elizabeth Taylor	Lincoln Mem U Debusk C of Osteo Med	LL/AL	Cahaba FM	R
57.	Alina A Teslenko	Alabama College of Osteopathic Med	LL/AL	USA Department of Psychiatry	R
58.	Garrett Thomas Tobin	LSU School of Medicine New Orleans	LL/AL	USA IM	R
59.	John Anthony Vallas	Alabama College of Osteopathic Med	LL/AL	Southeast Health Transitional Yr	R
60.	Giavanna Verdi	St. George's U School of Med, Grenada	LL/AL	Heersink Pediatric/Med Genetics	R
61.	Anastasia N Walloga	Edward Via C of Osteo Med - Virginia	LL/AL	Gadsden Regional FM	R
62.	Eric Riley Whalen-Kelly	Alabama College of Osteopathic Med	LL/AL	Southeast Health Transitional Yr	R

A motion was made by Commissioner Aldridge with a second by Commissioner Alsip to approve applicant numbers one through sixty-two (1-62) for limited licensure. The motion was approved by unanimous vote.

Provisional License Applicants

	Name	Medical School	Endorsement
1.	Zainab O Agboola	Morehouse School Of Medicine	USMLE
2.	Alexandria A Anderson	St. George's University School of Medicine, Grenada	USMLE
3.	Joseph N Anderson	University of Alabama School of Medicine Birmingham	USMLE
4.	Pamela A Angelo	Ross University	USMLE/WA
5.	Fadi Edmoun Bader	Jordan University of Science & Technology	USMLE
6.	Marie Nicole Baker	Ross University	USMLE/LA
7.	Afrin Anowar Biswas	Saba University School of Medicine	USMLE
8.	Sydney Bland	University of South Carolina School of Medicine	USMLE
9.	Robin Anna Marie Boyer	Ross University	USMLE
10.	Austin Hamilton Brooks	University of Alabama School of Medicine Birmingham	USMLE
11.	Jeremy Richard Brozyna	Saba University School of Medicine	USMLE/MA
12.	Aleena Marisa Bubb	Augusta University	USMLE
13.	Savannah Russell Bunnell	University of Alabama School of Medicine Birmingham	USMLE
14.	Gary Jonathan Carbell	Sackler School of Medicine, Tel Aviv University	USMLE/PA
15.	Melinda Diandra Chance	American University of Antigua	USMLE
16.	Mandeep Chatha	American University of Antigua	USMLE
17.	Vijaya Chelikani	Guntur Medical College, Nagarjuna University	USMLE/MI
18.	Hunter Allen Cutlip	West Virginia University School of Medicine	USMLE
19.	Peter De Mola	Ross University	USMLE/MI
20.	FNU Duremala	Aga Khan Medical College, Aga Khan University	USMLE

	Name	Medical School	Endorsement
21.	Khushboo Golani	Dr. D.Y. Patil Medical College	USMLE
22.	Michael Goldenberg	The Ohio State University College of Medicine	USMLE
23.	Jared Hall	University of Louisville School of Medicine	USMLE
24.	Houston Ray Hodges II	American University of The Caribbean	USMLE
25.	Jose S Ibarra Lopez	Free University of Colombia	USMLE
26.	Nighat Purnima Kabir	Armed Forces Medical College, University of Pune	USMLE/GA
27.	Alexander M Kofskey	University of Alabama School of Medicine Birmingham	USMLE
28.	Himabindu Kolli	Rangaraya Medical College	USMLE
29.	Binay Kumar Kshetree	Manipal College of Medical Sciences	USMLE
30.	Donaldson Cameron Lee	University of Alabama School of Medicine Birmingham	USMLE
31.	Hongli Liu	Shanghai Jiao Tong University School of Medicine	USMLE
32.	Rabeea Rafiq Lodhra	Ross University	USMLE/WI
33.	Olivia Lucas	Medical University of South Carolina College of Medicine	USMLE
34.	Christopher D Maughan	Rocky Vista University College of Osteopathic Medicine	COMLEX
35.	Timothy Neal Maxwell	University of Iowa Carver College of Medicine	USMLE
36.	Michael G McNabney	University of Tennessee Health Science Center College of Medicine	USMLE
37.	David W Merkley	Des Moines University of Osteopathic Medical Center	COMLEX
38.	Jonathan Mikhail	American University of Antigua	USMLE
39.	Whitney Lachelle Morgan	St Georges University of London	USMLE
40.	Abdullah Awsaf Noor	University of Queensland	USMLE
41.	Matthews M O'Connor	University of South Alabama College of Medicine	USMLE
42.	Celestine I Odigwe	University of Calabar	USMLE
43.	Bukola A Olagbende	Zaporozhye State Medical University	USMLE
44.	Jeremy James Osborne	University of Medicine and Health Sciences, St. Kitts	USMLE
45.	Jordan Taylor Patrick	Meharry Medical College School of Medicine	USMLE
46.	Joshua Ware Purvis	University of Alabama School of Medicine Birmingham	USMLE
47.	Tatiana Maria Sanchez	American University of The Caribbean	USMLE
48.	Vikrant Singh Sandhu	St. George's University School of Medicine, Grenada	USMLE
49.	Kyle J Scheuerman	Saba University School of Medicine	USMLE
50.	Jordan T Schouten	Saint Louis University School of Medicine	USMLE
51.	Nurbanu Selvi	American University of Antigua	USMLE
52.	Timothy Robert Sevcik	University of Iowa Carver College of Medicine	USMLE
53.	Manpreet Kaur Singh	Saba University School of Medicine	USMLE
54.	Daniel Brent Thomas	University of Texas - Houston Medical School	USMLE
55.	Marko Velickovic	St. George's University School of Medicine, Grenada	USMLE/FL
56.	Leonardo W F Dos Santos	Federal Univ of Health Sciences of Porto Alegre – Brazil	USMLE
57.	Tiffany Leigh Watson	American University of Antigua College of Medicine	USMLE

A motion was made by Commissioner Alsip with a second by Commissioner Morris to approve applicant numbers one through fifty-seven (1-57) for provisional licensure. The motion was approved by unanimous vote.

IMLCC Report

The Commission received as information a report of the licenses that were issued via the Interstate Medical Licensure Compact from May 1, 2023, through May 31, 2023. A copy of this report is attached as Exhibit "A".

APPLICANTS FOR REVIEW

Michelle B. Cung, D.O.

A motion was made by Commissioner Aldridge with a second by Commissioner Alsip to approve Dr. Cung's application for full licensure. The motion was approved by unanimous vote.

Wesley S. Hoskyns, D.O.

A motion was made by Commissioner Alsip with a second by Commissioner Morris to defer any action on Dr. Hoskyns' application for licensure until the July 27, 2023 Commission meeting. The motion was approved by unanimous vote.

Steven G. Miller, M.D.

A motion was made by Commissioner Morris with a second by Commissioner Nagrodzki to approve Dr. Miller's application for licensure, with the same restrictions that exist upon Dr. Miller's Certificate of Qualification pursuant to his Voluntary Restriction with the Alabama State Board of Medical Examiners. The motion was approved by unanimous vote. A copy of the Commission's order is attached as Exhibit "B".

Robert F. Vickers, M.D.

A motion was made by Commissioner Alsip with a second by Commissioner Morris to approve Dr. Vickers' application for full licensure. The motion was approved by unanimous vote.

Melissa A. West, M.D.

A motion was made by Commissioner Alsip with a second by Commissioner Morris to defer any action on Dr. West's application for licensure until the July 27, 2023 Commission meeting. The motion was approved by unanimous vote.

REPORTS

Physician Monitoring Report

The Commission received as information the physician monitoring report dated June 15, 2023. A copy of the report is attached as Exhibit "C".

DISCUSSION ITEMS

BME Rule for Publication: The Repeal of 540-X-251, Policy on DATA 2000

The Commission received as information the BME Rule for Publication: The Repeal of 540-X-251, Policy on DATA 2000. A copy of the rule is attached as Exhibit "D".

BME Rule for Publication: 540-X-11 Guidelines for the Use of Lasers and Other Affecting Living Tissue

The Commission received as information the BME Rule for Publication: 540-X-11 Guidelines for the Use of Lasers and Other Affecting Living Tissue. A copy of the rule is attached as Exhibit "E".

Election of Officers

A motion was made by Commissioner Alsip to nominate Commissioner Christopher as Chairman of the Medical Licensure Commission for the 2023 calendar year. A second was made by Commissioner Nagrodzki. A vote was taken, and Commissioner Christopher was elected Chairman of the Commission by unanimous vote.

A motion was made by Commissioner Aldridge to nominate Commissioner Alsip as Vice Chairman of the Medical Licensure Commission for the 2023 calendar year. A second was made by Commissioner Nagrodzki. A vote was taken, and Commissioner Alsip was elected Vice Chairman of the Commission by unanimous vote.

ADMINISTRATIVE FILINGS

Alvin Macon Stinson, III, M.D.

The Commission received an Administrative Complaint filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Alsip with a second by Commissioner

Nagrodzki to enter an order setting a hearing for November 20, 2023. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "F".

Albert W. Pearsall, IV, M.D.

The Commission received a Joint Settlement Agreement and Consent Order between Dr. Pearsall and the Alabama State Board of Medical Examiners. A motion was made by Commissioner Alsip with a second by Commissioner Morris to accept the Joint Settlement Agreement and to enter a Consent Decree incorporating its terms. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "G".

Kimberly Balasky, D.O.

The Commission received a Joint Settlement Agreement and Consent Order between Dr. Balasky and the Alabama State Board of Medical Examiners. A motion was made by Commissioner Alsip with a second by Commissioner Morris to accept the Joint Settlement Agreement and to enter a Consent Decree incorporating its terms. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "H".

James Steven St. Louis, D.O.

The Commission received an Administrative Complaint and a Notice of Intent to Contest Reinstatement filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Alsip with a second by Commissioner Morris to enter an order setting a hearing for November 20, 2023. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "I".

Gary Royce Wisner, M.D.

The Commission received a Motion to Continue Hearing regarding the Administrative Complaint filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Morris with a second by Commissioner Nagrodzki to enter an order resetting a hearing for November 20, 2023. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "J".

Scott W. Smith, M.D.

A motion was made by Commissioner Alsip with a second by Commissioner Morris to accept the Voluntary Surrender of Dr. Smith's medical license. The motion was approved by unanimous vote. A copy of the Voluntary Surrender is attached hereto as Exhibit "K".

Robert E. Taylor, M.D.

A motion was made by Commissioner Alsip with a second by Commissioner Morris to accept the Voluntary Surrender of Dr. Taylor's medical license. The motion was approved by unanimous vote. A copy of the Voluntary Surrender is attached hereto as Exhibit "L".

John M. Henderson, D.O.

The Commission received a Joint Status Report filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Alsip with a second by Commissioner Morris to enter an order setting a hearing for September 27, 2023. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "M".

Thomas P. Alderson, M.D.

The Commission received as information Dr. Alderson's answer to the Administrative Complaint filed by the Alabama State Board of Medical Examiners. A hearing was reset for August 9, 2023. A copy of the Commission's order is attached hereto as Exhibit "N".

Rodney L. Dennis, M.D.

The Commission received as information Dr. Dennis' answer to the Administrative Complaint filed by the Alabama State Board of Medical Examiners. A hearing was reset for August 9, 2023. A copy of the Commission's order is attached hereto as Exhibit "O".

Cosmin Dobrescu, M.D.

A motion was made by Commissioner Alsip with a second by Commissioner Varner to grant Dr. Dobrescu's Motion to Continue and to reset the hearing for December 20, 2023. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "P".

Shakir Raza Meghani, M.D.

A motion was made by Commissioner Alsip with a second by Commissioner Varner to grant Dr. Meghani's Motion to Continue and to reset the hearing for October 26, 2023. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "Q".

At 10:18 a.m., the Commission entered closed session pursuant to Alabama Code § 34-24-361.1 to hear and consider the following matters:

HEARINGS

Vanessa A. Ragland-Payne, D.O.

A motion was made by Commissioner Alsip with a second by Commissioner Varner to approve the Three-Member Panel's Recommended Findings of Fact and Conclusions of Law. The motion was approved by unanimous vote. A copy of the Commission's order is attached as Exhibit "R".

Carlos A. Liotta, M.D.

A motion was made by Commissioner Alsip with a second by Commissioner Varner to approve the Three-Member Panel's Recommended Findings of Fact and Conclusions of Law. The motion was approved by unanimous vote. A copy of the Commission's order is attached as Exhibit "S".

Sharon G. Griffitts, M.D.

At the conclusion of this hearing, a motion was made by Commission Alsip with a second by Commissioner Aldridge to issue an order reprimanding Dr. Griffitts' Alabama medical license, assessing an administrative fine in the amount of $10,000, and requiring Dr. Griffitts to obtain an additional 50 continuing medical education credits by December 31, 2023, for a total of 75 continuing medical education credits during the 2023 calendar year. The motion was approved by unanimous vote. A copy of the Commission's order is attached as Exhibit "T".

Andre V. Haynes, M.D.

At the conclusion of this hearing, a motion was made by Commissioner Alsip with a second by Commissioner Aldridge to issue an order reinstating Dr. Haynes' Alabama medical license with a reprimand, assessing an administrative fine in the amount of $15,000 and requiring Dr. Haynes' to attend a prescribing course. The motion was approved by unanimous vote. A copy of the Commission's order is attached as Exhibit "U".

Mark A. Murphy, M.D.

At the conclusion of this hearing, a motion was made by Commissioner Alsip with a second by Commissioner Nagrodzki to issue an order revoking Dr. Murphy's Alabama medical license and assessing an administrative fine in the amount of $50,000. The motion was approved by unanimous vote. A copy of the Commission's order is attached as Exhibit "V".

Meeting adjourned at 12:25 p.m.

PUBLIC MEETING NOTICE: The next meeting of the Alabama Medical Licensure Commission was announced for Thursday, July 27, 2023, beginning at 9:00 a.m.

CRAIG H. CHRISTOPHER, M.D., Chairman
Alabama Medical Licensure Commission

Rebecca Robbins

Rebecca Robbins, Director of Operations
Recording Secretary
Alabama Medical Licensure Commission

07/21/2023

Date Signed

CHC

EXHIBIT A

IMLCC Licenses Issued May 1, 2023 - May 31, 2023 (120)

Name	License Type	License Number	Status	Issue Date	Expiration Date	State of Principal Licensure
Ronald Joseph Paler	MD	46481	Active	5/3/2023	12/31/2023	Arizona
Nancy Ann Blum	DO	3266	Active	5/5/2023	12/31/2023	Arizona
Hollis Ann Tripp Burggraf	MD	46606	Active	5/24/2023	12/31/2023	Arizona
Summer Charise Aymar	DO	3301	Active	5/25/2023	12/31/2023	Arizona
John Sungwon Lee	MD	46627	Active	5/25/2023	12/31/2023	Arizona
Mitali Mehta	MD	46453	Active	5/2/2023	12/31/2023	Colorado
Katherine Elizabeth Uvelli	MD	46496	Active	5/5/2023	12/31/2023	Colorado
Angelique Nicole McKinney-Bourne	MD	46527	Active	5/15/2023	12/31/2023	Colorado
Arvin John Pourtorkan	DO	3277	Active	5/17/2023	12/31/2023	Colorado
Michael John Torres	DO	3284	Active	5/23/2023	12/31/2023	Colorado
TianChu Shih	DO	3285	Active	5/23/2023	12/31/2023	Colorado
Vladimir Janvelian	MD	46628	Active	5/25/2023	12/31/2023	Colorado
Courtney Phyllis Wilczynski	DO	3264	Active	5/3/2023	12/31/2023	Delaware
Alexander Evans Moore	MD	46408	Active	5/1/2023	12/31/2023	Georgia
Nischala Dhanekula	MD	46470	Active	5/2/2023	12/31/2023	Georgia
Faiz Rehman	MD	46497	Active	5/5/2023	12/31/2023	Georgia
Brian Russell	MD	46508	Active	5/8/2023	12/31/2023	Georgia
Ron Alleyne	MD	46528	Active	5/15/2023	12/31/2023	Georgia
Bereket Tessema Lodebo	MD	46536	Active	5/17/2023	12/31/2023	Georgia
Angelina Postoev	MD	46625	Active	5/25/2023	12/31/2023	Georgia
Mohammad Annaba	MD	46635	Active	5/30/2023	12/31/2023	Georgia
Arun Gunda	MD	46454	Active	5/2/2023	12/31/2023	Illinois
Julie Anderson Rothschild	MD	46519	Active	5/11/2023	12/31/2023	Illinois
Mohammad Daaif	MD	46617	Active	5/24/2023	12/31/2023	Illinois
Donna Lynn Lorenzo-Bueltel	MD	46619	Active	5/24/2023	12/31/2023	Illinois
Brian James Hartman	MD	46550	Active	5/23/2023	12/31/2023	Indiana
Taniya Pradhan	MD	46503	Active	5/8/2023	12/31/2023	Iowa
James Douglas Sigler	MD	46529	Active	5/15/2023	12/31/2023	Kansas
Manmeet Kaur Sandhu	MD	46511	Active	5/8/2023	12/31/2023	Kentucky

Javed Iqbal	MD	46548	Active	5/19/2023	12/31/2023	Kentucky
Lee Stevens	MD	46492	Active	5/4/2023	12/31/2023	Louisiana
Karen Fay Ross	MD	46493	Active	5/4/2023	12/31/2023	Louisiana
Angela E Green	DO	3275	Active	5/15/2023	12/31/2023	Louisiana
Scott Michaelson	DO	3297	Active	5/24/2023	12/31/2023	Louisiana
Elizabeth Mae Coe	MD	46477	Active	5/3/2023	12/31/2023	Maryland
Abhimabyu Aggarwal	MD	46498	Active	5/5/2023	12/31/2023	Maryland
Otibhor Igene	MD	46530	Active	5/15/2023	12/31/2023	Maryland
Naveed Hasan	MD	46632	Active	5/30/2023	12/31/2023	Maryland
Richard Veyna	MD	46468	Active	5/2/2023	12/31/2023	Michigan
Michael Justin Coffey	MD	46495	Active	5/5/2023	12/31/2023	Michigan
Shawn Adam Achtman	DO	3268	Active	5/8/2023	12/31/2023	Michigan
Ajay Kishore Desai	DO	3273	Active	5/11/2023	12/31/2023	Michigan
James Edward Dudo	MD	46547	Active	5/18/2023	12/31/2023	Michigan
Chad Michael Kovala	DO	3278	Active	5/19/2023	12/31/2023	Michigan
Andrew Rathnasamy Xavier	MD	46553	Active	5/23/2023	12/31/2023	Michigan
Mala Singh	DO	3305	Active	5/26/2023	12/31/2023	Michigan
Stuart Remer	MD	46638	Active	5/30/2023	12/31/2023	Minnesota
Meghana Ghanashyam Halker	MD	46645	Active	5/31/2023	12/31/2023	Minnesota
Perry James Walton	DO	3279	Active	5/19/2023	12/31/2023	Mississippi
Kyle David Hirschman	DO	3304	Active	5/25/2023	12/31/2023	Nebraska
Martin Jude Cotti	MD	46407	Active	5/1/2023	12/31/2023	New Hampshire
Arvind Vasudevan	MD	46554	Active	5/23/2023	12/31/2023	New Hampshire
Kristen Lea Veal	MD	46555	Active	5/23/2023	12/31/2023	New Hampshire
Shao-Hwa Pius Wei	DO	3282	Active	5/23/2023	12/31/2023	New Hampshire
Jason Patrick Stabley	DO	3283	Active	5/23/2023	12/31/2023	New Hampshire
Sohaib Syed Hussaini	MD	46636	Active	5/30/2023	12/31/2023	North Dakota
Joel Richard Schwartz	DO	3247	Active	5/1/2023	12/31/2023	Ohio
Margaret Susan Lohre	MD	46465	Active	5/2/2023	12/31/2023	Ohio
George Maidaa	MD	46502	Active	5/8/2023	12/31/2023	Ohio
Aaron Boster	MD	46524	Active	5/11/2023	12/31/2023	Ohio
Virginia Miller	DO	3274	Active	5/12/2023	12/31/2023	Ohio

Mark David Saling	DO	3281	Active	5/23/2023	12/31/2023	Ohio
Malik Nauman Shahid	MD	46473	Active	5/3/2023	12/31/2023	Oklahoma
Elizabeth Stoddard Monnot	DO	3303	Active	5/25/2023	12/31/2023	Oklahoma
Eric Joseph Ex	MD	46506	Active	5/8/2023	12/31/2023	Tennessee
Zahily Fals	MD	46509	Active	5/8/2023	12/31/2023	Tennessee
Linda Morgan Baki	DO	3269	Active	5/11/2023	12/31/2023	Tennessee
Steven David Tishler	MD	46521	Active	5/11/2023	12/31/2023	Tennessee
Yvette Marie LeFebvre	DO	3270	Active	5/11/2023	12/31/2023	Tennessee
Joan Arlene Kaufman	MD	46545	Active	5/18/2023	12/31/2023	Tennessee
Mahmoud Salhab	MD	46557	Active	5/23/2023	12/31/2023	Tennessee
Ethen Daniel Miller	MD	46403	Active	5/1/2023	12/31/2023	Texas
Edward John Matheis	MD	46404	Active	5/1/2023	12/31/2023	Texas
Christopher Shaw Gouner	MD	46409	Active	5/1/2023	12/31/2023	Texas
Krishna Kishore Kambhampati	MD	46466	Active	5/2/2023	12/31/2023	Texas
Vinay K Puduvalli	MD	46482	Active	5/4/2023	12/31/2023	Texas
Shiao-Pei Sheena Weathers	MD	46483	Active	5/4/2023	12/31/2023	Texas
Arjun Girish Karkhanis	MD	46485	Active	5/4/2023	12/31/2023	Texas
Stephen Yenzen Lai	MD	46489	Active	5/4/2023	12/31/2023	Texas
Ashley Elimar Aaroe	MD	46499	Active	5/5/2023	12/31/2023	Texas
Aysha Nasir Chaudhri	MD	46500	Active	5/5/2023	12/31/2023	Texas
Carlos Kamiya Matsuoka	MD	46501	Active	5/8/2023	12/31/2023	Texas
Adeline T Kikam	DO	3267	Active	5/8/2023	12/31/2023	Texas
William Christian Haden	MD	46504	Active	5/8/2023	12/31/2023	Texas
Jianbo Wang	MD	46505	Active	5/8/2023	12/31/2023	Texas
Sergy Viktorovich Lemeshko	MD	46512	Active	5/8/2023	12/31/2023	Texas
Pavan Kumar Irukulla	MD	46513	Active	5/9/2023	12/31/2023	Texas
Mohamed Shakeelur Rahman	MD	46520	Active	5/11/2023	12/31/2023	Texas
Kinber Lee Foust	MD	46525	Active	5/11/2023	12/31/2023	Texas
Vikram Mathagondapally Anand	MD	46526	Active	5/12/2023	12/31/2023	Texas
Rajendar Kumar Agarwal	MD	46531	Active	5/15/2023	12/31/2023	Texas
Gautam Baskaran	MD	46532	Active	5/16/2023	12/31/2023	Texas
Hemant Dand	MD	46533	Active	5/16/2023	12/31/2023	Texas

Sapna Pradyunman Patel	MD	46534	Active	5/16/2023	12/31/2023	Texas
Jenny Jing Li	MD	46535	Active	5/16/2023	12/31/2023	Texas
Aung Naing	MD	46537	Active	5/17/2023	12/31/2023	Texas
Matthew Thien-An Doan	MD	46538	Active	5/17/2023	12/31/2023	Texas
Jose Ochoa	MD	46539	Active	5/17/2023	12/31/2023	Texas
Syed Wamique Yusuf	MD	46541	Active	5/17/2023	12/31/2023	Texas
Kara Annette Thompson	MD	46542	Active	5/18/2023	12/31/2023	Texas
Zaid Salam Abbas Qaraghan	MD	46543	Active	5/18/2023	12/31/2023	Texas
John Mark Pool	MD	46544	Active	5/18/2023	12/31/2023	Texas
George Jae-Shik Chang	MD	46546	Active	5/18/2023	12/31/2023	Texas
Surena F Matin	MD	46556	Active	5/23/2023	12/31/2023	Texas
Denise Brown	MD	46626	Active	5/25/2023	12/31/2023	Texas
Craig Alan Messick	MD	46629	Active	5/26/2023	12/31/2023	Texas
Mimi I-Nan Hu	MD	46630	Active	5/26/2023	12/31/2023	Texas
Anita Kuo Ying	MD	46631	Active	5/26/2023	12/31/2023	Texas
Cristhiam Mauricio Rojas Hernandez	MD	46637	Active	5/30/2023	12/31/2023	Texas
Farouk Talakshi	MD	46639	Active	5/30/2023	12/31/2023	Texas
Ihab Rafic Hamzeh	MD	46642	Active	5/31/2023	12/31/2023	Texas
Maria Kim-Thuy Nguyen	MD	46644	Active	5/31/2023	12/31/2023	Texas
Matthew Aaron Williams	DO	3265	Active	5/4/2023	12/31/2023	Utah
Jay Lawrence Stahl-Herz	MD	46551	Active	5/23/2023	12/31/2023	Utah
Jeremy Robert Burt	MD	46552	Active	5/23/2023	12/31/2023	Utah
Kara Munira Nakisbendi	MD	46540	Active	5/17/2023	12/31/2023	Washington
Laurie Jean Mercier	MD	46549	Active	5/23/2023	12/31/2023	Washington
Diego Lopez de Castillo Koster	MD	46643	Active	5/31/2023	12/31/2023	Washington
Theodore Kent Vye	DO	3307	Active	5/31/2023	12/31/2023	Washington
Charles William Andrews Jr.	MD	46515	Active	5/9/2023	12/31/2023	Wisconsin

**Total licenses issued since April 2017 - 2,868*

EXHIBIT B

In re:	BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA
STEVEN G. MILLER, M.D.	

ORDER

This matter is before the Medical Licensure Commission of Alabama on the application for licensure of Steven G. Miller, M.D. Dr. Miller has executed a voluntary restriction on his Certificate of Qualification, limiting his practice in Alabama to the University of South Alabama Surgical Critical Care Fellowship.

The Commission grants and issues a license to practice medicine in the State of Alabama to Steven G. Miller, M.D., likewise restricted to the University of South Alabama Surgical Critical Care Fellowship. *See* Ala. Code § 34-24-361(g) ("If the board attaches restrictions to a physician's . . . certificate of qualification, it shall notify the commission of the restrictions and the commission shall also place the restrictions on the physician's . . . license to practice medicine or osteopathy in the State of Alabama."). This restriction may be removed only by further order of the Commission.

It is further ordered that the Board's Physician Monitor shall periodically monitor Dr. Miller's practice.

DONE on this the 30th day of June, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-06-30 11:40:08 CDT

Craig H. Christopher, M.D.
its Chairman

EXHIBIT C

STATE *of* ALABAMA
MEDICAL LICENSURE COMMISSION

To: Medical Licensure Commission

From: Nicole Hardy

Subject: June Physician Monitoring

Date: Report 6/15/2023

The physicians listed below are currently being monitored by the MLC.

Physician:	**Eldred Brunson, M.D.**
Order Type:	MLC
Due Date:	Other
Order Date:	6/22/2022
License Status:	Suspension
Requirements:	Administrative Cost $4,395 (Balance $2,625.05)
	Administrative Fine $10,000 (Balance $8,019.35)
	Monthly payments of $626.15
	Fine and Cost to be paid in full no later than May 31, 2024
Received:	*Last payment was received 12/15/2022
	Late payment total $3,756.90

Physician:	**Gary M. Bullock, D.O.**
Order Type:	MLC
Due Date:	Other
Order Date:	1/26/2022
License Status:	Active-Probation
Requirements:	Administrative Cost ($27,460.27)
	Administrative Fine ($20,000)
	Monthly payments of $160 for 6 months (February 2023 – July 2023)
	Monthly payments of $4,066.57 starting August 2023
Received:	$160 payment received 6/8/2023
	Administrative Cost balance is $27,300.27
	Administrative Fine balance is $17,472

Physician:	**Linda C. Clemons, M.D.**
Order Type:	MLC
Due Date:	Monthly
Order Date:	11/22/2022
License Status:	Active
Requirements:	Administrative Fine $5,000 (To be paid in full no later than 9/20/2023) Monthly payments of $500
Received:	$1000 payment received 5/21/2023 Administrative Fine balance $1,500

Physician:	**Sharon G. Griffitts, M.D.**
Order Type:	MLC
Due Date:	Monthly
Order Date:	11/22/2022
License Status:	Active
Requirements:	Administrative Fine $5,000 (To be paid in full no later than 8/31/2023) Monthly payments of $500
Received:	$500 payment received 5/25/2023 Administrative Fine balance $1,500

EXHIBIT D

ALABAMA STATE BOARD OF MEDICAL EXAMINERS
WILLIAM M. PERKINS, EXECUTIVE DIRECTOR

P.O.BOX 946
MONTGOMERY, ALABAMA 36101-0946
848 WASHINGTON AVE.
MONTGOMERY, ALABAMA 36104

TELEPHONE: (334) 242-4116
E MAIL: bme@albme.gov

MEMORANDUM

To: Medical Licensure Commission

From: Mandy Ellis

Date: June 15, 2023

Re: Administrative Rule Approved for Publication

The Board of Medical Examiners, at its meeting June 15, 2023, approved the following rules to be published for public comment in the *Alabama Administratively Monthly*:

- The Repeal of Administrative Rules, Chapter 540-X-21, *Policy on DATA 2000: Guidelines for the Treatment of Opioid Addiction in the Medical Office*

In 2022, the Board voted to repeal Chapter 540-X-21 and replace it with rules developed pursuant to the MAT Act of 2019. However, after receiving public comments and information regarding the elimination of the federal waiver requirement for addiction treatment with buprenorphine, the Board voted to table the rules and review the matter in the 2023 legislative session. The MAT Act was ultimately repealed by the Legislature.

The existing rules remain out of date and possibly in conflict with more recent laws and are due to be repealed.

With an expected publication date of June 30, 2023, the public comment period ends August 4, 2023. The anticipated effective repeal date is October 15, 2023.

Attachments:

Administrative Rules, Chapter 540-X-21, *Policy on DATA 2000: Guidelines for the Treatment of Opioid Addiction in the Medical Office*

REPEAL

RULES OF THE
ALABAMA BOARD OF MEDICAL EXAMINERS

CHAPTER 540-X-21
POLICY ON DATA 2000: GUIDELINES FOR THE
TREATMENT OF OPIOID ADDICTION IN THE MEDICAL OFFICE[1]

Table of Contents

540-X-21-.01 Introduction.

(1) Role of Federal Legislation.

(a) The use of buprenorphine for the treatment of opioid addiction is governed by the federal Drug Addiction Treatment Act of 2000, commonly referred to as "DATA 2000" (Public Law 106-310, Title XXXV, Sections 3501 and 3502). This legislation allows physicians to treat opioid addiction with FDA-approved controlled drugs in office-based settings. Specifically, DATA 2000 allows physicians to use buprenorphine and other controlled substances in the federal Controlled Substances Act (21 U.S.C. §§ 801, et. seq.) (CSA) Schedules III, IV, and V, which have been approved by the FDA for the treatment of opioid dependence, to treat patients in office-based settings, provided certain conditions are met.

(b) DATA 2000 lifted the requirement that patients who need opioid agonist

[1]These rules are directly based on the Federation of State Medical Boards Model Policy on DATA 2000 and Treatment of Opioid Addiction in the Medical Office, April 2013, and the authorities referenced and cited in that policy. The complete Federation of State Medical Boards Model Policy with references and citations may be accessed at www.fsmb.org.

treatment can receive such treatment only in specially licensed opioid treatment programs (OTPs), often referred to as "methadone clinics."

(c) For the implementation of DATA 2000, the Secretary of the Department of Health and Human Services (HHS) delegated authority in this area to the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA).

(2) Role of State Medical Boards.

(a) The use of opioid agonist medications to treat opioid-addicted patients in the offices of individual physicians significantly increases the role of state medical boards in overseeing such treatment. For this reason, the Federation of State Medical Boards (FSMB) entered into an agreement with SAMHSA to develop model guidelines for use by state medical boards in regulating office-based treatment of addiction.

(b) The agreement between FSMB and SAMHSA resulted in a Model Policy adopted by FSMB in 2002. The Model Policy was updated in April 2013. The Model Policy encourages state medical boards to adopt consistent standards, to promote the public health by making appropriate treatment available to opioid-addicted patients, and to educate the regulatory and physician communities about the potential of new treatment modalities for opioid addiction.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Alabama §§ 34-24-53
History: Approved for publication: January 21, 2015. Effective Date: April 23, 2015.

540-X-21-.02 Preamble.

(1) The Alabama Board of Medical Examiners (Board) Requirements.

(a) The Board is obligated under the laws of the state of Alabama to protect the public health and safety. The Board recognizes that the principles of high-quality medical practice dictate that the people of Alabama have access to appropriate, safe and effective medical care, including the treatment of addiction. The application of up-to-date knowledge and evidence-based treatment modalities can help to restore function and thus improve the quality of life of patients who suffer from addiction.

(b) In this context, the Board recognizes the body of evidence for the effectiveness of buprenorphine in the office-based treatment of opioid addiction, when such treatment is delivered in accordance with current standards of care and the requirements of DATA 2000 and the Board.

(c) The Board will determine the appropriateness of a particular physician's prescribing practices on the basis of the physician's overall treatment of patients and the available documentation of treatment plans and outcomes. The goal is to provide appropriate treatment of the patient's opioid addiction (either directly or through referral), while adequately addressing other aspects of the patient's functioning, including co-occurring medical and psychiatric conditions and pressing psychosocial issues.

(2) Federal Requirements to Prescribe Buprenorphine for Addiction.

(a) Physicians who wish to treat opioid addiction with buprenorphine in their medical offices must demonstrate that they have met the requirements of the DATA 2000 legislation and obtained a waiver from SAMHSA[2]. To qualify for such a waiver,

[2]The "waiver" allows an exception to the Harrison Narcotics Act of 1914, which made it illegal for a

physicians must hold a current controlled substance registration with the U. S. Drug Enforcement Administration (DEA) and a current license in the state in which they practice. They also must meet one or more of the following qualifications:

1. Subspecialty board certification in addiction psychiatry from the American Board of Medical Specialties;

2. Subspecialty board certification in addiction medicine from the American Osteopathic Association;

3. Addiction certification from the American Board of Addiction Medicine;

4. Completion of not less than eight hours of training related to the treatment and management of opioid addiction provided by the American Academy of Addiction Psychiatry, the American Society of Addiction Medicine, the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, or other approved organizations; or

5. Participation as an investigator in one or more clinical trials leading to the approval of an opioid drug in Schedule III, IV, or V or a combination of such drugs for treatment of opioid-addicted patients.

(b) To obtain a waiver, a physician must notify SAMHSA in writing of his or her intent to prescribe an approved opioid medication to treat addiction, certifying the physician's qualifications and listing his/her DEA registration number. SAMHSA will then notify DEA whether a waiver has been granted. If SAMHSA grants a waiver, DEA

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physician to prescribe an opioid to any patient with opioid addiction for the purpose of managing that addiction or acute withdrawal. Prior to DATA 2000, the only exception to the Harrison Act was federal legislation that allowed the establishment of methadone maintenance treatment (MMT) clinics, now referred to as Opioid Treatment Programs (OTPs). That exception only allowed the use of methadone to treat addiction or withdrawal within specially licensed and regulated facilities, but not in office-based medical practice.

will issue an identification number no later than 45 days after receipt of the physician's written notification. (If SAMHSA does not act on the physician's request for a waiver within the 45-day period, DEA will automatically assign the physician an identification number.) This process is explained, and can be accessed at the following website: http://buprenorphine.samhsa.gov/howto.html.

(c) If a physician wishes to prescribe or dispense an appropriately available and approved opioid medication for maintenance treatment or detoxification (so as to fulfill the requirements of DATA 2000) on an emergency basis before the 45-day waiting period has elapsed, the physician must notify SAMHSA and the DEA of his or her intent to provide such emergency treatment.

(d) In addition to a waiver, a physician who wishes to prescribe buprenorphine or another approved opioid for the treatment of addiction in an office setting must have a valid DEA registration number and a DEA identification number that specifically authorizes him or her to engage in office-based opioid treatment.

(3) Prescription Requirements. Prescriptions for buprenorphine and buprenorphine/naloxone must include full identifying information for the patient, including his or her name and address; the drug name, strength, dosage form, and quantity; and directions for use. Prescriptions for buprenorphine and/or buprenorphine/naloxone must be dated as of, and signed on, the day they are issued (21 CFR 1306.05[a]). Both the physician's regular DEA registration number and the physician's DATA 2000 identification number (which begins with the prefix X) must be included on the prescription (21 CFR 1301.28[d][3]).

(4) For detailed guidance, physicians are referred to the Buprenorphine Clinical Practice Guidelines published by CSAT/SAMHSA, which can be accessed at http://buprenorphine.samhsa.gov/Bup_Guidelines.pdf.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Alabama §§ 34-24-53
History: Approved for publication: January 21, 2015. Effective Date: April 23, 2015.

540-X-21-.03 Guidelines.

(1) General.

(a) Multiple studies have shown that opioid addiction treatment with buprenorphine can be successfully integrated into office practice by physicians who are not addiction specialists. In such studies, patient outcomes are comparable to or better than outcomes of patients treated in specialized clinics. However, as in the treatment of any medical disorder, physicians who choose to offer addiction treatment need to understand the nature of the underlying disorder, the specific actions of each of the available medications (as well as any associated contraindications or cautions), and the importance of careful patient selection and monitoring.

(b) The Board has adopted the following guidelines for the treatment of opioid addiction in office-based settings. **The guidelines are not intended to define complete or best practice, but rather to communicate what the Board considers to be within the boundaries of accepted professional practice.**

(2) Physician Qualifications.

(a) The diagnosis and medical management of opioid addiction should be

based on current knowledge and research, and should encompass the use of both pharmacologic and nonpharmacologic treatment modalities. Thus, before beginning to treat patients for opioid addiction, the physician should become knowledgeable about opioid addiction and its treatment, including the use of approved pharmacologic therapies and evidence-based nonpharmacologic therapies.

(b) Physicians who wish to prescribe or dispense buprenorphine for the treatment of opioid addiction must meet the requirements of DATA 2000, which are that the physician must be licensed in the state, have a valid DEA controlled substances registration and identification number, comply with federal and state regulations applicable to controlled substances, and hold a current waiver.

(c) In addition to these requirements, DATA limits the number of patients that a physician is permitted to treat at any one time to 30 in the first year after obtaining a waiver, and to 100 patients thereafter. The physician who wishes to treat more than 30 patients after the first year must file an application with the DEA to extend his or her waivered capacity to do so.

(d) DATA 2000 also requires that a physician who wishes to treat opioid addiction with buprenorphine in an office setting must demonstrate a capacity to offer (or refer patients for) appropriate counseling and other ancillary services, and to recognize when those services are needed.

(e) Physicians are not permitted to delegate the prescribing of buprenorphine to non-physicians. Even physicians who hold DEA registrations to prescribe controlled substances for other conditions are not allowed to prescribe buprenorphine for the

treatment of addiction unless they meet the DATA requirements and hold a waiver. However, non-physician professionals can play an active role in evaluating and monitoring patients and providing other elements of care, in accordance with state regulations and rules governing physician supervision and medical oversight.

(f) Physicians should consult federal regulations (21 CFR § 1301.28) and statutes (21 USC 823 (g)); the resources available on the DEA's website (at www.deadiversion.usdoj.gov); and Board rules governing the issuance of prescriptions for controlled substances.

(3) Patient Assessment.

(a) The objectives of the patient assessment are to determine a given patient's eligibility for treatment, to provide the basis for a treatment plan, and to establish a baseline measure for use in evaluating a patient's response to treatment. Accordingly, the assessment should be designed to achieve the following:

1. Establish the diagnosis of opiate addiction, including the duration, pattern and severity of opioid misuse; the patient's level of tolerance; results of previous attempts to discontinue opioid use; past experience with agonist therapies; the nature and severity of previous episodes of withdrawal; and the time of last opioid use and current withdrawal status.

2. Document the patient's use of other substances, including alcohol and other drugs of abuse.

3. Identify comorbid medical and psychiatric conditions and disorders and determine how, when and where they will be addressed.

4. Screen for communicable diseases and address them as needed. Evaluate the patient's level of physical, psychological and social functioning or impairment.

5. Assess the patient's access to social supports, family, friends, employment, housing, finances and legal problems.

6. Determine the patient's readiness to participate in treatment.

(b) Assessment usually begins at the time of the patient's first office visit and continues throughout treatment. While the evidence is not conclusive, consensus opinion is that an initial patient assessment is of higher quality when it includes a medical and psychiatric history, a substance abuse history, and an evaluation of family and psychosocial supports, as well as a pregnancy test for all women of childbearing age. The physical examination, if performed during the initial assessment, can be focused on evaluating neurocognitive function, identifying sequelae of opioid addiction, and looking for evidence of severe hepatic dysfunction.

(c) As a general rule, a urine drug screen or other toxicologic screen should be part of the initial evaluation to confirm recent opioid use and to screen for unreported use of other drugs. Ideally, this drug screen should include all opioids commonly prescribed and/or misused in the local community, as well as illicit drugs that are available locally. It also is advisable to access the patient's prescription drug use history through the Alabama Department of Public Health Prescription Drug Monitoring Program (PDMP), both to confirm compliance in taking prescribed medications and to detect any unreported use of other prescription medications.

(d) Information from family members and significant others can provide useful additional perspectives on the patient's status, as can contact with or records from clinicians who have treated the patient in the past.

(4) Treatment Planning.

(a) There is an emerging consensus among addiction experts that treatment medications such as buprenorphine should be considered as an option for every opioid-addicted patient. However, the failure to offer medication-assisted treatment does not in itself constitute substandard care. No single treatment is appropriate for all persons at all times. **Therefore, an individualized treatment plan is critical to the patient's ultimate success in returning to productive functioning.**

(b) The treating physician should balance the risks and benefits of medication-assisted treatment in general -- and treatment with buprenorphine in particular -- against the risks associated with no treatment or treatment without medication. The various options include:

1. Simple detoxification and no other treatment;
2. Detoxification followed by antagonist therapy;
3. Counseling and/or peer support without medication-assisted treatment;
4. Referral to short-term or long-term residential treatment;
5. Referral to an OTP for methadone maintenance; or
6. Treatment with buprenorphine or buprenorphine/naloxone in an office-based setting.

Patients may be suitable candidates for treatment with buprenorphine even if

past treatment episodes were not successful.

(c) If a decision is made to offer the patient treatment with buprenorphine, the risks associated with possible misuse and diversion are such that the combination buprenorphine/naloxone product is preferable for most patients. The monoproduct should be used only rarely except in pregnant women, for whom it is the preferred formulation.

(d) Psychosocial and other nonpharmacologic interventions often are useful components of treatment. Such interventions typically work best in conjunction with medication-assisted therapies; in fact, there is some evidence that the combination of pharmacologic and non-pharmacologic interventions may be more effective than either approach used alone. **The ability to offer patients psychosocial supports, either on-site or through referral, is a requirement of the DATA 2000 legislation.**

(5) Educating the Patient.

(a) Every patient to whom buprenorphine is prescribed should be cautioned to follow the directions exactly, particularly during the induction stage. Critical issues involve when to begin dosing, the frequency of subsequent doses, and the importance of avoiding the use of any other illicit or prescription opioid.

(b) Concurrent use of non-opioid sedating medications or over-the-counter products also should be discussed, and patients should be advised to avoid the use of alcohol.

(c) Patients should be cautioned about potential sedation or impairment of psychomotor function during the titration phase of induction with buprenorphine.

(d) Finally, because opioids can contribute to fatal overdoses in individuals who have lost their tolerance to opioids or in those who are opioid-naive (such as a child or other family member), proper and secure storage of the medication must be discussed. Particularly where there are young people in the patient's home, the subject of safe storage and use should be revisited periodically throughout the course of treatment, with the discussions documented in the patient record.

(6) Informed Consent.

(a) Although agonist medications such as buprenorphine clearly are effective for the treatment of opioid dependence, they do entail a substitute dependence on the prescribed medication to replace the prior dependence on the misused opioid. This issue should be thoroughly discussed with the patient in terms of potential risks and benefits as part of the informed consent process. Patients and family members often are ambivalent about agonist treatment for this reason and their concerns may influence subsequent treatment choices. Possible topics of discussion include the difference between addiction and physical dependence (including an explanation of why agonist therapy is not simply "switching one addiction for another"), the likelihood of relapse with and without medication-assisted treatment, the projected duration of the treatment, the potential for successfully tapering from agonist therapy at some point in the future, and the role and importance of adjunctive therapies such as counseling and peer support. With the patient's consent, this conversation could include family members, significant other(s), or a guardian.

(b) A written *informed consent* document, discussed with and signed by the

patient, can be helpful in reinforcing this information and establishing a set of "ground rules." The practitioner should document the informed consent in the patient's medical record.

(7) Treatment Agreement.

(a) The terms of treatment agreements vary widely, but typical provisions include an acknowledgment of the potential benefits and risks of therapy and the goals of treatment; identification of one provider and one pharmacy from whom the patient will obtain prescriptions; authorization to communicate with all providers of care (and sometimes significant others) and to consult the PDMP; other treatments or consultations in which the patient is expected to participate, including recovery activities; avoidance of illicit substances; permission for drug screens (of blood, urine, saliva or hair/nails) and pill counts as appropriate; mechanisms for prescription renewals, including exclusion of early renewals; expected intervals between office visits; and specification of the conditions under which therapy will be continued or discontinued.

(b) The agreement also should include a statement instructing the patient to stop taking all other opioid medications unless explicitly told to continue. Such a statement reinforces the need to adhere to a single treatment regimen. Inclusion in the agreement of a pharmacy address and telephone number reinforces to the patient the importance of using one pharmacy to fill prescriptions.

(c) Finally, the treatment agreement should set forth the objectives that will be used to evaluate treatment success, such as freedom from intoxication, improved

physical and psychosocial function, and adherence to the treatment regimen.

(d) Copies of the treatment agreement and informed consent should be provided to the patient and all other care providers, and filed in the patient's medical record. The agreement should be reviewed regularly and adjusted as needed.

(8) Induction, Stabilization, and Follow-up.

(a) The goal of induction and stabilization is to find the lowest dose of buprenorphine at which the patient discontinues or markedly reduces the use of other opioids without experiencing withdrawal symptoms, significant side effects, or uncontrollable craving for the drug of abuse.

(b) The initial induction process requires a higher degree of attention and monitoring than the later maintenance phase. Particular attention should be given to the timing of the initial doses so as to minimize untoward outcomes. Withdrawal symptoms can occur if either too much or too little buprenorphine is administered (i.e., spontaneous withdrawal if too little buprenorphine is given, precipitated withdrawal if buprenorphine is administered while the opioid receptors are substantially occupied by an opioid agonist). Undermedication or overmedication can be avoided through a flexible approach to dosing, which sometimes requires higher doses of treatment medication than expected, and by taking into account patient-reported symptoms.

(c) The stabilization phase is focused on finding the right dose for an individual patient. A patient is stabilized when the dose allows him or her to conduct activities of daily living and to be aware of his or her surroundings without intoxication and without suffering withdrawal or distressing drug craving. Although there is no

precise way to determine in advance what the optimal dose for a particular patient will be, most patients are likely to stabilize on eight to 16 mg. of buprenorphine per day, although some may need doses of up to 24 mg per day. As the dose of Buprenorphine increases, the board recognizes that the risk for diversion and abuse also increases. While the board recognizes that from time to time a patient may need a higher dose of Buprenorphine, it is expected that the clinical reasons for an increased dose be documented in the medical records, and that the clinician utilize available resources to be vigilant for risk of diversion regardless of dosage prescribed.

(d) Buprenorphine blood concentrations stabilize after approximately seven days of consistent dosing. If withdrawal symptoms subsequently emerge during any 24-hour dosing interval, the dose may be too low, or other factors may be involved. Medical factors that may cause a patient's dose requirements to change include (but are not limited to) starting, stopping. or changing the dose of other prescription medications; onset and progression of pregnancy; onset of menopause; progression of liver disease; and significant increase or decrease in weight.

(e) Dose adjustments generally can be made in increments of 2 mg/day. Because buprenorphine has a long plasma half-life and even longer duration of action at the mu opioid receptor, five days should be allowed between dose adjustments.

(f) Patient adherence to medication regimens and session appointments is associated with better treatment outcomes, and regular monitoring can help patients plan for possible obstacles and teach them ways to handle any problems that occur. Regular assessment of the patient's level of engagement in treatment and the strength

of the therapeutic alliance allows for modification of the treatment plan and level of care in response to the patient's progress or lack thereof.

(g) Early in treatment, medications should be prescribed and follow-up visits scheduled commensurate with the patient's demonstrated stability. Until patients have shown the ability to be compliant with the treatment plan and responsible with their medication supplies, and have discontinued high-risk behaviors and associated diversion risks, they should be seen more frequently and given supplies of medication only as needed until the next visit. As patients demonstrate stability and the risk declines, they can be seen less often (typically once a month) and prescribed larger supplies of medication.

(h) Patient monitoring during follow-up visits should address the following points:

1. Whether the patient continues to use alcohol or illicit drugs, or to engage in non-medical use of prescription drugs;

2. The degree of compliance with the treatment regimen, including the use of prescribed medications as directed;

3. Changes (positive or negative) in social functioning and relationships;

4. Avoidance of high-risk individuals, situations, and diversion risk;

5. Review of whether and to what degree the patient is involved in counseling and other psychosocial therapies, as well as in self-help activities through participation in mutual support meetings of groups such as Narcotics Anonymous;

6. The presence or absence of medication side effects; and

7. The presence or absence of medical sequelae of substance use and its remission.

(i) The patient's compliance with regard to use of prescribed buprenorphine and avoidance of other opioids should be monitored through patient report, regular toxicologic analyses, reports from significant others, and regular checks of the PDMP.

(j) Individuals being treated with medication-assisted treatment often demonstrate dramatic improvement in addiction-related behaviors and psychosocial functioning. Such positive changes should be acknowledged and reinforced by the prescribing physician whenever possible. Reducing the frequency of monitoring visits, with their associated costs, and increasing the patient's responsibility for medications are examples of how positive, responsible behaviors can be reinforced.

(9) Adjusting the Treatment Plan.

(a) Treatment outcomes typically are positive for patients who remain in treatment with medication-assisted therapies such as buprenorphine. However, some patients struggle to discontinue their misuse of opioids or other drugs, are inconsistent in their compliance with treatment agreements, or succeed in achieving some therapeutic goals while not doing well with others.

(b) Behaviors that are not consistent with the treatment agreement should be taken seriously and used as an opportunity to further assess the patient and adapt the treatment plan as needed. In some cases, where the patient's behavior raises concerns about safety or diversion of controlled medications, there may be a need to refer the patient for treatment in a more structured environment (such as an OTP).

However, behavior that violates the treatment agreement or a relapse to nonmedical drug use do not constitute grounds for automatic termination of treatment. Rather, they should be taken as a signal to reassess the patient's status, to implement changes in the treatment plan (as by intensifying the treatment structure or intensity of services), and to document such changes in the patient's medical record.

(c) Whenever the best clinical course is not clear, consultation with another practitioner may be helpful. The results of the consultation should be discussed with the patient and any written consultation reports added to the patient's record.

(d) Patients with more serious or persistent problems may benefit from referral to a specialist for additional evaluation and treatment. For example, the treatment of addiction in a patient with a comorbid psychiatric disorder may be best managed through consultation with or referral to a specialist in psychiatry or addiction psychiatry. In other instances, aberrant or dysfunctional behaviors may indicate the need for more vigorous engagement in peer support, counseling, or psychotherapies, or possibly referral to a more structured treatment setting.

(10) Preventing and Managing Relapse.

(a) Relapse always should be ruled out as a reason for loss of stability. Relapse to drug use has been described as "an unfolding process in which the resumption of substance abuse is the last event in a long series of maladaptive responses to internal or external stressors or stimuli." It rarely is caused by any single factor; rather, it is a dynamic process in which the patient's readiness to change interacts with other external and internal factors. Patients in relapse vary in the

quantity and frequency of their substance use, as well as the accompanying medical and psychosocial sequelae.

(b) Clinical strategies to prevent and address relapse generally encompass the following steps:

1. Identify environmental cues and stressors that act as relapse triggers;

2. Help patients develop skills to cope with or manage negative emotional states;

3. Help the patient work toward a more balanced lifestyle;

4. Understand and manage craving;

5. Identify and interrupt lapses and relapses. Patients should have an emergency plan to address a lapse so that a full-blown relapse can be avoided. If relapse does occur, be prepared to intervene; and

6. Develop a recovery support system. Families are likely to provide such support if they are engaged in the treatment process and have an opportunity to ask questions, share their concerns and experiences, and learn practical coping strategies and behaviors to avoid.

(c) It should be noted that lack of adherence to pharmacologic regimens occurs in a substantial portion of patients being treated for addiction, with some studies reporting that a majority of patients fail to follow the treatment plan at some point in their care. Retention in treatment is also a problem. This is no different from the challenges encountered in managing any chronic disease, such as diabetes, hypertension, epilepsy, and other potentially life-threatening disorders, and is not an

indication to terminate treatment.

(d) Patients who continue to misuse opioids after sufficient exposure to buprenorphine and ancillary psychosocial services or who experience continued symptoms of withdrawal or craving at 32 mg of buprenorphine should be considered for therapy with methadone.

(11) Duration of Treatment.

(a) Available evidence does not support routinely discontinuing medication-assisted treatment once it has been initiated and the patient stabilized. However, this possibility frequently is raised by patients or family members. When it is, the physician and patient should carefully weigh the potential benefits and risks of continuing medication-assisted treatment and determine whether buprenorphine therapy can be safely discontinued.

(b) Studies indicate that opioid-dependent patients are at high risk for relapse when medication-assisted treatment is discontinued, even after long periods of stable maintenance. Research also shows that longer duration of treatment is associated with better treatment outcomes. Such long-term treatment, which is common to many medical conditions, should not be seen as treatment failure, but rather as a cost-effective way of prolonging life and improving the quality of life by supporting the natural and long-term process of change and recovery. Therefore, the decision to discontinue treatment should be made only after serious consideration of the potential consequences.

(c) As with other disease processes, the continuation of medication-assisted

treatment should be linked directly to the patient's response (for example, his or her attainment of treatment goals). Relapse risk is highest in the first six to 12 months after initiating abstinence, then diminishes gradually over a period of years. Therefore, it is reasonable to continue treatment for at least a year if the patient responds well.

(d) If buprenorphine is discontinued, the patient should be tapered off the medication through use of a safely structured regimen, and followed closely. It may be necessary to reinstate pharmacotherapy with buprenorphine or a different medication or other treatment services if relapse appears imminent or actually occurs. Such relapse poses a significant risk of overdose, which should be carefully explained to the patient. Patients also should be assured that relapse need not occur for them to be reinstated to medication-assisted treatment.

(12) Medical Records.

(a) Accurate and up-to-date medical records protect both the physician and the patient. In the event of a legal challenge, detailed medical records that document what was done and why are essential elements of the practitioner's defense.

(b) A written informed consent and a treatment agreement articulating measurable treatment goals are key documents. The treatment agreement should be updated as new information becomes available. Both the informed consent and treatment agreement should be carefully explained to the patient and signed by both the patient (or guardian) and the treating physician. The medical record should clearly reflect the decision-making process that resulted in any given treatment regimen.

(c) The patient's chart should contain a summary of the information needed to

understand the treatment plan, even without a thorough knowledge of the patient. This includes some demographic data, the names of other practitioners caring for the patient, all diagnoses, therapies employed, and a list of all medications prescribed. The name, telephone number, and address of the patient's pharmacy also should be recorded to facilitate contact as needed.

(d) Other documents that should be part of the medical record, where available, include:

1. Diagnostic assessments, including the patient history, physical examination, and any laboratory tests ordered, with their results;

2. Actual copies of, or references to, medical records of past hospitalizations or treatments by other providers;

3. The treatment plan, treatment agreement, and informed consent;

4. Authorization for release of information to other treatment providers;

5. Documentation of discussions with and consultation reports from other health care providers; and

6. Medications prescribed and the patient's response to them, including any adverse events.

(e) The medical record also must include all prescription orders, whether written or telephoned. In addition, written instructions for the use of all medications should be given to the patient and documented in the record.

(f) Monitoring visits should be carefully documented in the medical record, along with any subsequent changes to the treatment plan. The patient's record also

should contain documentation of steps taken to prevent the diversion of treatment medications, including any communications with other treating physicians and use of the PDMP to verify that all prescribed medicines have been obtained and that no other prescriptions for controlled drugs have been dispensed without the physician's knowledge.

(g) Records (including drug logs, if buprenorphine is dispensed in the office) should be up-to-date and maintained in an accessible manner, readily available for review. Good records demonstrate that a service was provided to the patient and establish that the service provided was medically necessary. Even if the outcome is less than optimal, thorough records protect the physician as well as the patient.

(h) Physicians who treat patients for addiction must observe the special confidentiality requirements of federal law found in 42 CFR, Part 2, Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR §§ 2.1 through 2.67), which addresses the confidentiality of patients being treated for alcohol or drug addiction. Title 42 CFR, Part 2, includes a prohibition against release of records or other information without the patient's consent or a valid court order, or in cases of a bona fide medical emergency, or in the course of mandatory reporting of child abuse.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Alabama §§ 34-24-53
History: Approved for publication: January 21, 2015. Effective Date: April 23, 2015.

540-X-21-.04 Definitions.

(1) Accurate use of terminology is essential to understanding office-based

treatment of opioid addiction. However, terminology in this area is changing. for many years, the most commonly used terms have been "drug abuse" and "drug dependence," with the latter indicating a severe condition considered synonymous with the term "addiction" (the chronic brain disease). The terms "abuse" and "dependence," in use since the third edition of the *Diagnostic and Statistical Manual of Mental Disorders*, were replaced in the fifth edition by the term "substance use disorder." Other new terms include "opioid use" for the activity of using opioids benignly or pathologically, and "opioid use disorder" for the disease associated with compulsive, out-of-control use of opioids.

(2) For the purposes of Chapter 540-X-21, the following terms are defined as shown.

(a) Abuse. The definition of "abuse" varies widely, depending on the context in which it is used and who is supplying the definition. For example, in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision* (DSM-IV-T), the American Psychiatric Association defines drug abuse as "a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by one or more behaviors." The *Diagnostic and Statistical Manual of Mental Disorders, Fifth* Edition (DSM-V), published in May 2013, replaces the term "abuse" with "misuse."

(b) Addiction.

1. Addiction is widely defined as a primary, chronic, neurobiologic disease, with genetic, psychosocial, and environmental factors influencing its development and manifestations. It is characterized by behaviors that include the following: impaired

control over drug use, craving, compulsive use, and continued use despite harm. (As discussed below, physical dependence and tolerance are normal physiological consequences of extended opioid therapy and are not the same as addiction.)

2. A recent definition of addiction, adopted by the American Society of Addiction Medicine in 2011, reads as follows: "Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death."

(c) Controlled Substance.

1. A controlled substance is a drug that is subject to special requirements under the CSA, which is designed to ensure both the availability and control of regulated substances. Under the CSA, availability of regulated drugs is accomplished through a system that establishes quotas for drug production and a distribution system that closely monitors the importation, manufacture, distribution, prescribing, dispensing, administering, and possession of controlled drugs. Civil and criminal sanctions for

serious violations of the statute are part of the government's drug control apparatus. Title 21, Chapter II of the Code of Federal Regulations (21 CFR. §§ 1300-1399) implements the CSA.

2. The CSA confers the responsibility for scheduling controlled substances on the FDA and the DEA. In granting regulatory authority to these agencies, the Congress noted that both public health and public safety needs are important and that neither takes primacy over the other, but that both are necessary to ensure the public welfare. To accomplish this, the Congress provided guidance in the form of factors that must be considered by the FDA and DEA when assessing public health and safety issues related to a new drug or one that is being considered for rescheduling or removal from control.

3. Most opioids are classified as Schedule II or III drugs under the CSA, indicating that they have a high potential for abuse and a currently accepted medical use in treatment in the U.S., and that abuse of the drug may lead to psychological or physical dependence. (Although the scheduling system provides a rough guide to abuse potential, it should be recognized that all controlled substances have some potential for abuse.)

(d) Dependence.

1. Physical dependence is a state of biologic adaptation that is evidenced by a class-specific withdrawal syndrome when the drug is abruptly discontinued or the dose rapidly reduced, and/or by the administration of an antagonist. It is important to distinguish addiction from the type of physical dependence that can and does occur

within the context of good medical care, as when a patient on long-term opioid analgesics for pain becomes physically dependent on the analgesic. The distinction is reflected in the two primary diagnostic classification systems used by health care professionals: the *International Classification of Mental and Behavioural Disorders, 10th Edition* (ICD-10) of the World Health Organization (WHO), and the *Diagnostic and Statistical Manual* of the American Psychiatric Association. In the DSM-IV-TR, a diagnosis of "substance dependence" meant addiction. In the DSM V, the term dependence is reestablished in its original meaning of physiological dependence; when symptoms are sufficient to meet criteria for substance misuse or addiction, the term "substance use disorder" is used, accompanied by severity ratings.

2. It may be important to clarify this distinction during the informed consent process, so that the patient understands that physical dependence and tolerance are likely to occur if opioids are taken regularly for a period of time, but the risk of addiction is relatively low unless the patient has additional risk factors. According to the World Health Organization, "The development of tolerance and physical dependence denote normal physiologic adaptations of the body to the presence of an opioid."

(e) Detoxification.

1. Detoxification (also termed "medically supervised withdrawal") refers to a gradual reduction, or tapering, of a medication dose over time, under the supervision of a physician, to achieve the elimination of tolerance and physical dependence.

2. "Detoxification" is a legal and regulatory term that has fallen into disfavor with some in the medical community; indeed, some experts view "detoxification" as a

misnomer because many abusable drugs are not toxic when administered in proper doses in a medical environment.

(f) Diversion.

1. The CSA establishes a closed system of distribution for drugs that are classified as controlled substances. Records must be kept from the time a drug is manufactured to the time it is dispensed. Health care professionals who are authorized to prescribe, dispense, and otherwise control access to such drugs are required to register with the DEA.

2. Pharmaceuticals that make their way outside this closed system are said to have been "diverted" from the system, and the individuals responsible for the diversion (including patients) are in violation of the law. The degree to which a prescribed medication is misused depends in large part on how easily it is redirected (diverted) from the legitimate distribution system.

(g) Maintenance Treatment. Maintenance treatment involves the dispensing or administration of an opioid medication (such as methadone or buprenorphine) at a stable dose and over a period of 21 days or more, for the treatment of opioid addiction. When maintenance treatment involves the use of methadone, such treatment must be delivered in an OTP. However, maintenance treatment with buprenorphine may be delivered in either an OTP or a medical office by a properly credentialed physician.

(h) Medication-Assisted Treatment (MAT). MAT is any treatment for opioid addiction that includes a medication (such as methadone, buprenorphine, or naltrexone) that is approved by the FDA for opioid detoxification or maintenance treatment. MAT

may be provided in a specialized OTP, or, for buprenorphine or naltrexone, in a physician's office or other health care setting.

(i) Misuse. The term misuse (also termed non-medical use) incorporates all uses of a prescription medication other than those that are directed by a physician and used by a patient within the law and the requirements of good medical practice.

(j) Opioid.

1. An opioid is any compound that binds to an opioid receptor. The class includes both naturally occurring and synthetic or semi-synthetic opioid drugs or medications, as well as endogenous opioid peptides. Most physicians use the terms "opiate" and "opioid" interchangeably, but toxicologists (who perform and interpret drug tests) make a clear distinction between them. "Opioid" is the broader, more appropriate term because it includes the entire class of agents that act as opioid receptors in the nervous system, whereas "opiates" refers to natural compounds derived from the opium plant but not semisynthetic opioid derivatives of opiates or completely synthetic agents. Thus, drug tests that are "positive for opiates" have detected one of these compounds or a metabolite of heroin, 6-monoacetyl morphine (MAM). Drug tests that are "negative for opiates" have found no detectable levels of opiates in the sample, even though other opioids that were not tested for, including the most common currently used and misused prescription opioids, may well be present in the sample that was analyzed.

2. *Opioid agonists* are compounds that bind to the mu opioid receptors in the brain, producing a response that is similar in effect to the natural ligand that would

activate it. With full mu opioid agonists, increasing the dose produces a more intense opioid effect. Most opioids that are misused, such as morphine and heroin, are full mu opioid agonists, as is methadone.

3. *Opioid partial agonists* occupy and activate the opioid receptors, but the activation they produce reaches a plateau, beyond which additional opioid doses do not produce a greater effect. It should be noted that the plateau (or "ceiling effect") may limit a partial agonist's therapeutic activity as well as its toxicity. Buprenorphine is a partial mu opioid agonist.

4. *Opioid antagonists* bind to and block the opioid receptors and prevent them from being activated by an opioid agonist or partial agonist. Naltrexone and naloxone both are opioid antagonists, and both can block the effect of opioid drugs.

(k) Opioid Treatment Program (OTP). (Sometimes referred to as a "methadone clinic" or "narcotic treatment program"). An OTP is any treatment program certified by SAMHSA in conformance with 42 CFR, Part 8, Certification of Opioid Treatment Programs (42 CFR §§ 8.1 through 8.34), to provide supervised assessment and medication-assisted treatment of patients who are addicted to opioids. An OTP can exist in a number of settings, including intensive outpatient, residential, and hospital facilities. Treatments offered by OTPs include medication-assisted treatment with methadone, buprenorphine or naltrexone, as well as medically supervised withdrawal or detoxification, accompanied by varying levels of medical and psychosocial services and other types of care. Some OTPs also can provide treatment for co-occurring mental disorders.

(l) Recovery. A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. As used in the ASAM Patient Placement Criteria, "recovery" refers to the overall goal of helping a patient achieve overall health and well-being. SAMHSA's 10 guiding principles recognize that recovery:

1. Emerges from hope;
2. Is person-driven;
3. Occurs via many pathways;
4. Is holistic;
5. Is supported by peers and allies;
6. Is supported through relationship and social networks;
7. Is culturally-based and influenced;
8. Is supported by addressing trauma;
9. Involves individual, family and community strengths and responsibility; and
10. Is based on respect.

(m) Relapse.

1. Relapse has been variously defined as "a breakdown or setback in a person's attempt to change or modify any target behavior" and as "an unfolding process in which the resumption of substance misuse is the last event in a long series of maladaptive responses to internal or external stressors or stimuli." Relapse rarely is caused by any single factor and often is the result of an interaction of physiologic and environmental factors.

2. The term *lapse* (often referred to as a *slip*) refers to a brief episode of drug use after a period of abstinence. A lapse usually is unexpected, of short duration, with relatively minor consequences, and marked by the patient's desire to return to abstinence. However, a lapse can also progress to a full-blown relapse, marked by sustained loss of control.

(n) Tolerance.

1. Tolerance is a sate of physiologic adaptation in which exposure to a drug induces changes that result in diminution of one or more of the drug's effects over time. Tolerance may occur both to an opioid's analgesic effects and to its unwanted side effects, such as respiratory depression, sedation, or nausea. Most investigators agree that absolute tolerance to the analgesic effects of opioids does not occur. In general, tolerance to the side effects of opioids develops more rapidly than does tolerance to the drug's analgesic effects.

2. Tolerance may or may not be evident during treatment with opioids and is not the same as addiction.

(o) Trial Period. A period of time, which can last weeks or even months, during which the efficacy of a medication or other therapy for the treatment of addiction is tested to determine whether the treatment goals can be met. If the goals are not met, the trial should be discontinued and an alternative approach (i.e, a different medication or non-pharmacologic therapy) adopted.

(p) Waiver. A documented authorization from the Secretary of Health and Human Services, issued by SAMHSA under the DATA 2000 regulations, that exempts a

qualified physician from the rules applied to OTPs and allows him or her to use buprenorphine for the treatment of addiction in office-based practice.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Alabama §§ 34-24-53
History: Approved for publication: January 21, 2015. Effective Date: April 23, 2015.

EXHIBIT E

ALABAMA STATE BOARD OF MEDICAL EXAMINERS
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MEMORANDUM

To: Medical Licensure Commission

From: Mandy Ellis

Date: March 16, 2023

Re: Administrative Rules Approved for Publication

The Board of Medical Examiners, at its meeting March 16, 2023, approved the following rules to be published for public comment in the *Alabama Administratively Monthly*:

- Administrative Rules, Chapter 540-X-11, *Guidelines for the Use of Lasers and Other Affecting Living Tissue*

In November 2022, after approval by a Board-designated laser rules workgroup consisting of Julia L. Boothe, M.D., Jane Weida, M.D., Elizabeth Jacobson, M.D., and Lauren Hughey, M.D., the Board promulgated a revision of the laser regulations for public comment.

In December 2022, Board staff received communications from representatives of the Alabama Dermatology Society and vascular and plastic surgeons articulating concerns with the rule proposals. In January 2023, Wilson Hunter, Board General Counsel, began working with the Alabama Dermatology Society, represented by Dr. Hughey, and the vascular and plastic surgeons, represented by Dr. Grady Gore, on revisions to the rules that would address their concerns.

The amended rules attached in this memo seek to meet the needs of the physicians most affected by laser regulations while meeting the Board's core goals of updating the regulations to reflect advances in technology; codifying scope of practice and training standards; and permitting physicians to safely delegate the use of lasers to licensed and unlicensed practitioners.

With an expected publication date of March 31, 2023, the public comment period ends May 5, 2023. The anticipated effective date is July 15, 2023.
Attachments:

RULES OF THE
ALABAMA BOARD OF MEDICAL EXAMINERS

CHAPTER 540-X-11
GUIDELINES FOR THE USE OF LASERS
AND OTHER MODALITIES AFFECTING LIVING TISSUE

Table of Contents

540-X-11-.01 Purpose.

(1) The use of lasers/pulsed light devices, or any energy source, chemical, or other modality that affects living tissue (when referring to the skin, anything below the stratum corneum), whether applied for surgical, therapeutic, or cosmetic purposes, is the practice of medicine.

(2) The purpose of these rules is to provide guidelines for the use of these devices for ablative and non-ablative treatment by physicians. Nothing in these rules

shall be construed to relieve the supervising physician of the professional or legal responsibility for the care and treatment of the physician's patients.

(3) These rules shall not apply to the following:

(a) Any person licensed to practice chiropractic if the laser/pulsed light device, energy source, chemical or other modality that affects living tissue is used exclusively for the practice of chiropractic;

(b) Any person licensed to practice dentistry if the laser/pulsed light device, energy source, chemical or other modality that affects living tissue is used exclusively for the practice of dentistry;

(c) Any person licensed to practice occupational therapy if the laser/pulsed light device, energy source, chemical or other modality that affects living tissue is used exclusively for the practice of occupational therapy;

(d) Any person licensed to practice optometry if the laser/pulsed light device, energy source, chemical or other modality that affects living tissue is used exclusively for the practice of optometry;

(e) Any person licensed to practice physical therapy if the laser/pulsed light device, energy source, chemical or other modality that affects living tissue is used exclusively for the practice of physical therapy.

(4) These rules shall apply to the removal of body art with LLBD but shall not apply to the practice of placing "body art," as defined in Chapter 420-3-23 of the Administrative Rules of the Alabama Department of Public Health, which is not a part of patient treatment; and which is performed with equipment specifically manufactured for performing body art procedures and specifically used according to the manufacturer's

instructions and standard professional practice; and which is otherwise regulated by the Alabama Department of Public Health.

(5) These rules shall not apply to the use of a laser/pulsed light device, energy source, chemical or other modality that affects living tissue which occurs in "hospitals" as defined in Ala. Code §22-21-20.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Alabama §§34-24-50, 34-24-51, 34-24-53
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540-X-11-.02 Definitions. For the purpose of these rules, the following definitions will apply:

(1) Ablative Treatment – Ablative treatment shall include any laser device, any energy-based device, any chemical, mechanical resection devices, or any modality that is expected or intended to remove, burn, or vaporize tissue extending below the dermal-epidermal junction, as well as any modality that causes coagulation necrosis or pure ablation at or below the dermal-epidermal junction.

(2) Direct Physician Supervision – Direct physician supervision shall mean that the physician is in the physical presence of the patient being treated and is directly observing the use of the modality by another practitioner.

(3) Energy Source – any therapeutic source which can affect or change living tissue, including varying levels of ability to cause trauma and/or scarring.

(4) LLBD - Lasers and Light/energy-Based Devices – lasers/pulsed light devices, or any energy source, chemical, or other modality that affects living tissue (when referring to the skin, anything below the stratum corneum), whether applied for surgical, therapeutic, or cosmetic purposes.

~~(5) Level 1 Practitioner – A Level 1 Practitioner is a physician authorized in a written job description or protocol to use a specific laser/pulsed light device or other energy source, chemical or other modality, as designated in the written job description or protocol, and who has met the educational requirements for a Level 1 Practitioner stated in these rules.~~

(5) Level 1 Delegate – A Level 1 Delegate is an assistant to physician (PA), as defined in Ala. Code § 34-24-290, a certified registered nurse practitioner, or registered nurse (RN) authorized in a written job description or protocol to use a specific laser/pulsed light device or other energy source, chemical or other modality for non-ablative procedures, as designated in the written job description or protocol, and who has met the educational requirements for a Level 1 Delegate stated in these rules.

(6) Level 2 Delegate – A Level 2 Delegate is a licensed practicing nurse (LPN) or medical assistant to include aestheticians, cosmetologists, and laser technicians authorized in a written job description or protocol to use a specific laser/pulsed light device or other energy source, chemical or other modality for non-ablative procedures, as designated in the written job description or protocol, and who has met the educational requirements for a Level 2 Delegate as stated in these rules.

(8) Non-ablative Treatment – Non-ablative treatment shall include any laser/intense pulsed light treatment or other energy source, chemical or modality that, although not expected or intended to remove, burn, or vaporize tissue, is intended to cause controlled heat-induced thermal change/injury to produce a result. This shall include treatments related to laser hair removal and other devices defined in these rules.

(9) On-site Supervision – On-site supervision shall mean continuous supervision in which the supervising physician is physically present in the same building as the appropriate, properly trained Level 1 or 2 delegate who is using an LLBD. All treatments and procedures must be performed under the physician's direction and immediate personal supervision, and the physician must be immediately available at all times that the Level 1 or 2 delegate is on duty. The physician retains full responsibility to patients and the Board for the manner and results of all services rendered.

(10) Locally remote Supervision – Locally remote supervision shall mean the geographic physical proximity of a delegating physician to a Level 1 Delegate who is performing a non-ablative procedure who is not providing on-site supervision but who is readily available for consultation, evaluation, referral, or direct medical intervention in person or by telemedicine. A locally remote physician's geographic physical proximity from the patient's treatment site must not exceed the usual and customary response time of emergency management services for the locality. Locally remote supervision may only be provided by American Board of Medical Specialties board-certified physicians who have completed post-graduate training in lasers, light-based devices, chemical peels, and any other modality that may be used to perform ablative treatment.

(11) Physician – A physician licensed by the Medical Licensure Commission of the State of Alabama.

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540-X-11-.03 Use of and Categories of Lasers and Other Modalities Affecting Living Tissue in the Practice of Medicine.

(1) The use of lasers/pulsed light devices, or other energy source, chemical, or modality that affects living tissue, for the purpose of treating a physical disease, disorder, deformity, injury, or other condition, including cosmetic, shall constitute the practice of medicine pursuant to Ala. Code §34-24-50.

(2) Categories of Procedures:

(a) Ablative Laser Skin Resurfacing – These procedures include the use of fractional (partially ablative) and non-fractional (fully ablative) CO2 lasers, fractional and non-fractional Erbium-type lasers (2940nm) used deeper than 100 microns, plasma, and any other laser/device that vaporizes or removes skin beyond the dermal-epidermal junction, both fractional and non-fractional types.

(b) Non-Ablative Laser Photorejuvenation – These procedures include the use of LLBD for skin resurfacing and rejuvenation that involves targeting certain chromophores with no purposeful vaporization or removal of skin.

(c) Intense Pulsed Light (IPL) and Broad Band Light (BBL) – These procedures include the use of devices with pulsed light instead of a laser beam to target chromophores (pigment, vascularity, water). IPL devices consist of different levels with a wide range of power/energy and variable settings.

(d) Photoepilation/Laser Hair Removal, and Vascular Conditions and Lesions, and Pigmentary Conditions ~~or Lesions~~.

1. Photoepilation/Laser Hair Removal procedures include the use of Ruby (694 nm), Alexandrite (755nm), Diode (800nm-810nm), ND:YAG (1064nm) lasers that target chromophore melanin, and IPL/BBL devices (when used solely for hair reduction in appropriate, fair-skinned patients).

2. Vascular Conditions and Lesions, and Pigmentary Conditions ~~or Lesions~~ procedures include the use of LLBDs that target a specific individual colored target and are used to treat spider veins, telangiectasias, small non-varicose vessels, rosacea, pigmented spots/lesions such as freckles, lentigines (sun/age spots), melasma, and hyperpigmentation., ~~and benign colored lesions (Seborrheic Keratosis, Actinic Keratosis, benign moles).~~ LLBDs include ND:YAG, IPL, BBL, Pulsed Dye Laser, KTP, Alexandrite, radiofrequency probe procedure and LLBD categories (a) and (b) listed above.

(e) Tattoo Removal – These procedures involve the treatment of all colors of tattoos with Q-switch ND:YAG, Q-switch Ruby, Q-switch Alexandrite, or other nano/picosecond devices used specifically for tattoo removal. These procedures carry a significant risk of complications, burns, and ulcerations.

(f) Non-Laser Skin Rejuvenation – These procedures use energy sources such as radiofrequency, ultrasound, infrared, and Class III lasers that work on heat-based targeting of skin and collagen. These procedures include any ultrasonic treatments, treatments for skin tightening/fat removal (including cryolipolysis and cryotherapy), and radiofrequency micro-needling.

(g) Endovascular Radiofrequency and Laser Ablation (EVLA) – These are surgical procedures that may only be performed by physicians.

(h) Laser-Assisted Liposuction (LAL) and Power-Assisted Liposuction – These procedures involve laser or energy-assisted invasive liposuction with the use of 1064nm, 1320nm, 1440nm, 1444nm, 924/975nm, 1319nm, and ultrasounds. These procedures include VaserLipo, Smart Lipo, Cellulaze, Cool Lipo, Tickle Lipo,

Accusculpt, Slim Lipo, ProLipo, CelluSmooth, BodyJet (water-assisted), and variations thereof, and may only be performed by physicians.

(i) Laser-Assisted Surgery – These procedures involve the use of lasers to assist surgeons with cutting, coagulation, tissue removal and ablation, and other surgical procedures, and may only be performed by physicians.

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540-X-11-.04 Delegation and Supervision

(1) A physician may delegate the performance of non-ablative treatments as defined in these rules through the use of written protocols to a properly trained Level 1 or 2 Delegate.

(2) A delegating physician shall supervise the performance of all non-ablative treatments delegated to a Level 1 or 2 Delegate. This supervision must include:

(a) Ensuring that patients are adequately informed and, prior to treatment, have signed consent forms that outline Risks, Benefits, Alternatives, and Complications, which includes disclosure of reasonably foreseeable side effects and complications which may result from the non-ablative treatment, as well as the name of the device and the procedure;

(b) Responsibility for the formulation or approval of a written protocol which meets the requirements of these rules and responsibility for any patient-specific deviation from the protocol;

(c) Substantive review and authorization, at least annually, of the written protocol and any patient-specific deviations from the protocol regarding care provided to a patient under the protocol on a schedule defined in the written protocol;

(d) Ensuring that any Level 1 or 2 Delegate has read and signed the facility's policies and procedures, written protocols for delegation, and these rules regarding the safe use of non-ablative devices;

(e) Prompt receipt of information from the Level 1 or 2 Delegate concerning any problem or complication encountered with any treatment; ~~Receipt, on a schedule defined in the written protocol, a periodic status report on the patient, including any problems or complications encountered;~~

(f) On-site or locally remote supervision for non-ablative treatments performed by Level 1 and 2 Delegates consistent with these rules, the training and experience of the delegate performing the procedure, and the risk of harm to the patient;

(g) Personal evaluation and care for complications that arise; and

(h) Evaluation of the technical skills of the Level 1 or 2 Delegate performing non-ablative treatment on an ongoing basis by formally documenting and reviewing at least annually the Level 1 or 2 Delegate's ability to perform the following:

(i) To properly operate the devices and provide safe and effective care; and

(ii) To respond appropriately to concerns, complaints, and complications and untoward effects of the procedures.

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Statutory Authority: Code of Alabama §§34-24-50, 34-24-51, 34-24-53

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540-X-11-.05 Written Protocols. Written protocols for the purpose of this section shall mean physician's order, standing delegation order, standing medical order, or other written order that is maintained on site. A written protocol must be provided to the Board upon request and must provide, at a minimum, the following:

(1) A statement identifying the individual physician authorized to utilize the specified device and responsible for the delegation of the performance of the specified procedure, including proof of the physician's training in accordance with these rules;

(2) A statement of the activities, decision criteria, and plan the Level 1 or 2 Delegate shall follow when performing delegated procedures;

(3) Selection criteria to screen patients for the appropriateness of non-ablative treatments;

(4) Identification of devices and settings to be used for patients who meet selection criteria;

(5) Methods by which the specified device is to be operated;

(6) A description of appropriate care and follow-up for common complications, serious injury, or emergencies as a result of the non-ablative treatment;

(7) Procedures for obtaining proper consent forms signed by the patient or legal guardian;

(8) Instructions for maintaining a patient's chart, which should include, at a minimum, the patient intake form, the executed informed consent, the treatment sheet and progress notes, and before & after instructions;

(9) Instructions for documentation of a patient's treatment, decisions made, and a plan for communication or feedback to the authorizing physician concerning specific decisions made. Documentation shall be recorded within a reasonable time after each procedure and may be performed on the patient's record or medical chart; and

(10) Instructions to contact the supervising physician immediately if complications or complaints from the patient arise.

(11) Written protocols should be signed by both the supervising physician and the corresponding Level 1 or 2 Delegate.

Author: Alabama Board of Medical Examiners
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540-X-11-.06 Initial Training Requirements for Practitioners. Physicians and delegates involved in the use of lasers/pulsed light devices, or any energy source, chemical, or other modality that affects living tissue, whether applied for surgical, therapeutic, or cosmetic purposes, must meet the following training requirements before utilizing a device:

(1) A physician must complete thirty (30) ~~sixteen (16)~~ hours of training. A Level 1 or 2 Delegate must complete forty (40) ~~twenty-four (24)~~ hours of training.

(2) Appropriate training for the use of any device covered by this Chapter shall include the following topics:

(a) Theory and physics of laser and light/energy-based devices and procedures, including their effect on living tissue, tissue interaction, clinical applications, and pre/post-treatment care;

(b) Education of skin anatomy and physiology, concerns, conditions, and diseases, including cancer, of the skin, skin type and color, chromophores, targets, general care for the skin, and recognition, management, and reporting of side effects and complications;

(c) Eight (8) hours of LLBD safety training, and

(d) Two (2) hours of training on the Board's rules and regulations, including this chapter.

(3) Appropriate training may be obtained through residency, fellowship, private courses, Board-approved self-study, training under another cosmetic practice, training on-site with a specialty board certified physician, and company-provided or in-service training by device representatives.

(4) These initial training requirements shall not apply to any physician who holds a current registration with the Board to use pulsed light devices, or any energy source, chemical, or other modality that affects living tissue, whether applied for surgical, therapeutic, or cosmetic purposes as of January 1, 2024. Any Level 1 or 2 Delegates currently using lasers/pulsed light devices, or any energy source, chemical, or other modality that affects living tissue, whether applied for surgical, therapeutic, or cosmetic purposes under supervision of a registered physician as set forth above as of January 1, 2024, shall not be required to complete the initial training requirements in this section. Any practitioners who register to use lasers/pulsed light devices, or any

energy source, chemical, or other modality that affects living tissue, whether applied for surgical, therapeutic, or cosmetic purposes after January 1, 2024, will be subject to the initial training requirements of this section.

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540-X-11-.07 Procedure and Device Training Requirements for Practitioners. Practitioners involved in the use of LLBDs must complete a minimum number of procedure/device-specific training hours, a minimum number of observed procedures, a minimum number of supervised procedures, and a minimum number of cases under supervision as set forth below.

(1) Ablative Laser Skin Resurfacing:

(a) Prior to performing procedures with any category of LLBD, physicians must complete eight (8) hours of training in the device or device category, unless the Practitioner received training on the device in residency, in which case only four (4) hours of training are required.

(b) Level 1 and 2 Delegates shall not perform these procedures.

(2) Non-Ablative Laser Photorejuvenation:

(a) Physicians must complete eight (8) hours of training on each device unless he or she received training on the device in residency, in which case only four (4) hours of training are required.

(b) Level 1 Delegates must complete twelve (12) hours of training on each device, which includes observing the procedure performed by a trained physician and performing ten (10) cases under the direct supervision of a trained physician. After

twenty (20) cases have been performed with a physician seeing a patient prior to the procedure, a Level 1 Delegate may treat a patient without a physician seeing the patient at each subsequent visit. ~~A physician must always see the patient for the initial consult and patient consent.~~

(c) ~~Level 2 Delegates must have at least six (6) months of LLBD experience under a trained physician and must have performed at least fifty (50) LLBD procedures under said physician to qualify for training in this category. After completion of these requirements,~~ A Level 2 Delegate must complete twenty (20) hours of training on each device, which includes observing the procedure performed by a trained physician or Level 1 Delegate and performing fifteen (15) cases under the direct supervision of a trained physician. After twenty (20) cases have been performed with a physician seeing a patient prior to the procedure, a Level 2 Delegate may treat a patient without a physician seeing the patient at each subsequent visit. ~~A trained physician must always see the patient for the initial consult and patient consent.~~

(3) Intense Pulsed Light (IPL) and Broad Band Light (BBL):

(a) Physicians must complete eight (8) hours of training on each device, unless he or she received training in residency, in which case only four (4) hours of training are required.

(b) Level 1 Delegates must complete twelve (12) hours of training on each device, which includes observing the procedure performed by a trained physician and performing ten (10) cases under the direct supervision of a trained physician. After performing twenty-five (25) supervised cases, a Level 1 Delegate may treat patients for subsequent patient visits without direct supervision by the physician after the physician

sees the patient in consult. After performing fifty (50) cases, a Level 1 Delegate may treat patients without direct supervision by the physician for the initial consult and patient consent.

(c) Level 2 Delegates must complete twenty (20) hours of training on each device, which includes observing the procedure performed by a trained physician and performing fifteen (15) cases under the direct supervision of a trained physician. After performing twenty-five (25) supervised cases, a Level 2 Delegate may treat patients for subsequent patient visits without direct supervision by the physician after the initial patient consult and consent, provided that the physician shall review the device settings for cases 26 through 50 prior to treatment. ~~and the initial treatment visit with the physician.~~ After performing fifty (50) cases, a Level 2 Delegate may treat patients for the initial treatment visit and subsequent visits without direct supervision by the physician after the physician has seen the patient in consult and consent.

(4) Photoepilation/Laser Hair Removal, Vascular Conditions and Lesions, and Pigmentary Conditions:

(a) Physicians must complete eight (8) hours of training on each device, unless he or she received training in residency, in which case only four (4) hours of training are required.

(b) Level 1 Delegates must complete twelve (12) hours of training on each device, which includes observing the procedure performed by a trained physician and performing ten (10) cases under the direct supervision of a trained physician. After performing twenty-five (25) supervised cases, a Level 1 Delegate may treat patients for subsequent patient visits without direct supervision by the physician after the physician

sees the patient in consult. After performing fifty (50) cases, a Level 1 Delegate may treat patients without direct supervision by the physician for the initial consult and patient consent.

(c) Level 2 Delegates must complete twenty (20) hours of training on each device, which includes observing the procedure performed by a trained physician and performing fifteen (15) cases under the direct supervision of a trained physician. After performing twenty-five (25) supervised cases, a Level 2 Delegate may treat patients for subsequent patient visits without direct supervision by the physician after the initial patient consult and consent, provided that the physician shall review the device settings for cases 26 through 50 prior to treatment. ~~and the initial treatment visit with the physician.~~ After performing fifty (50) cases, a Level 2 Delegate may treat patients for the initial treatment visit and subsequent visits without direct supervision by the physician after the physician has seen the patient in consult and consent.

(d) A solitary pigmented lesion shall be evaluated by a physician prior to any treatment with an LLBD device.

(5) Tattoo Removal:

(a) Physicians must complete eight (8) hours of training on each device, unless he or she received training in residency, in which case only four (4) hours of training are required.

(b) Level 1 Delegates must complete twelve (12) hours of training on each device, which includes observing the procedure performed by a trained physician and performing ten (10) cases under the direct supervision of a trained physician. After performing twenty-five (25) supervised cases, a Level 1 Delegate may treat patients for

subsequent patient visits without direct supervision by the physician after the physician sees the patient in consult. After performing fifty (50) cases, a Level 1 Delegate may treat patients without direct supervision by the physician for the initial consult and patient consent.

(c) Level 2 Delegates must complete twenty (20) hours of training on each device, which includes observing the procedure performed by a trained physician and performing fifteen (15) cases under the direct supervision of a trained physician. After performing twenty-five (25) supervised cases, a Level 2 Delegate may treat patients for subsequent patient visits without direct supervision by the physician after the initial patient consult and consent, provided that the physician shall review the device settings for cases 26 through 50 prior to treatment. ~~and the initial treatment visit with the physician.~~ After performing fifty (50) cases, a Level 2 Delegate may treat patients for the initial treatment visit and subsequent visits without direct supervision by the physician after the physician has seen the patient in consult and consent.

(6) Non-Laser Skin Rejuvenation:

(a) Physicians and Level 1 and 2 Delegates must complete official certifying training by the device manufacturer or be trained by a physician certified by the manufacturer to use the device.

(b) Level 1 and 2 Delegates must complete eight (8) hours of training on each device, which includes observation of five (5) area-specific treatments by a trained physician and performing ten (10) treatments under the direct supervision of a trained physician. After completing ten (10) treatments under direct supervision, a Level 1 or 2 Delegate may complete ten (10) additional treatments without direction supervision by

the physician, provided that the physician reviews the treatment plan and device settings prior to the treatment. After performing twenty-five (25) supervised cases, a Level 1 or 2 Delegate may consult, consent, and treat patients without direct supervision by the physician..

~~(a) Physicians must complete eight (8) hours of training on each device unless he or she received training on the device in residency, in which case only four (4) hours of training are required.~~

~~(b) Level 1 Delegates must complete eight (8) hours of training on each device, which includes observing the procedure performed by a trained physician and performing ten (10) cases under the direct supervision of a trained physician. After performing ten (10) supervised cases, a Level 1 Delegate may treat patients for subsequent patient visits after the initial patient consult and consent without direct supervision by the physician. After performing twenty five (25) cases, a Level 1 Delegate may treat patients for all visits without direct supervision by a physician.~~

~~(c) Level 2 Delegates must complete sixteen (16) hours of training on each device, which includes observing the procedure performed by a trained physician and performing ten (10) cases under the direct supervision of a trained physician. After performing twenty (20) supervised cases, a Level 2 Delegate may treat patients for subsequent patient visits without direct supervision by a physician after the initial patient consult and consent with the physician and the initial treatment visit. After performing fifty (50) cases, a Level 2 Delegate may treat patients for the initial treatment visit and subsequent visits without direct supervision by a physician after the physician has seen the patient in consult/consent.~~

~~(d) For cryotherapy only: Physicians and Level 1 and 2 Delegates may complete official certifying training by a device manufacturer or be trained by a physician certified under the aforementioned condition, including observation of five (5) area-specific treatments of a trained physician and performing five (5) treatments under the direct supervision of a trained physician. A physician must always see the patient and approve a complete treatment plan prior to the initial treatment being performed.~~ Thereafter, treatments may be performed under locally remote supervision.

(7) Endovascular Radiofrequency and Laser Ablation (EVLA):

(a) Physicians must complete eight (8) hours of training on each device within a residency or fellowship program.

(b) Level 2 and 3 Practitioners shall not perform these procedures.

(8) Laser-Assisted Liposuction (LAL) and Power-Assisted Liposuction:

(a) Physicians must complete eight (8) hours of training on each device within a residency or fellowship program.

(b) Level 2 and 3 Practitioners shall not perform these procedures

(9) Laser-Assisted Surgery

(a) Physicians must complete sixteen (16) hours of training on each device within a residency or fellowship program.

(b) Level 1 and 2 Delegates shall not perform these procedures.

~~(10) Any Physician registered to use lasers/pulsed light devices, or any energy source, chemical, or other modality that affects living tissue, whether applied for surgical, therapeutic, or cosmetic purposes as of January 1, 2024, shall not be required to complete the initial training requirements in this section. Any Level 1 or 2 Delegates~~

~~currently using lasers/pulsed light devices, or any energy source, chemical, or other modality that affects living tissue, whether applied for surgical, therapeutic, or cosmetic purposes under supervision of a registered Physician as set forth above as of January 1, 2024, shall not be required to complete the procedure and device training requirements in this section. Any practitioners who enter the practice of using lasers/pulsed light devices, or any energy source, chemical, or other modality that affects living tissue, whether applied for surgical, therapeutic, or cosmetic purposes after January 1, 2024, will be subject to the requirements of this section.~~

Author: Alabama Board of Medical Examiners
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540-X-11-.08 Remote Practice Site.

(1) For the purposes of the rules in this Chapter, a remote practice site is a practice site at which a Level 1 Delegate may, if authorized by these rules and a written job description or collaborative protocol, use LLBDs for non-ablative procedures under locally remote supervision.

(2) A Level 2 Delegate shall not use LLBDs at a remote practice site.

(3) The physician shall examine the patient, establish a treatment plan, perform informed consent of the patient, and sign the patient chart prior to a Level 1 Delegate performing the first non-ablative treatment of a patient for a particular disease or condition at a remote practice site. Subsequent non-ablative treatments which are a continuation of a treatment plan documented in the patient's chart may be performed by the Level 1 Delegate at a remote practice site without examination of the patient by the physician before each treatment. If any changes are made to the treatment plan or the

treatment plan ends, the physician must re-examine the patient prior to any updated treatment being performed.

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540-X-11-.09 Alternate Physicians.

(1) If a delegating physician will be unavailable to supervise a Level 1 or 2 Delegate as required by these rules, arrangements shall be made for an alternate physician to provide that supervision.

(2) An alternate physician must have the same training in performance of non-ablative treatments as the primary supervising physician.

(3) Any alternate physician providing supervision shall affirm in writing to the Board of Medical Examiners that he or she is familiar with the protocols or standing delegation orders in use at the site, will be accountable for adequately supervising the care provided pursuant to those protocols or standing delegation orders, and has the same training in the performance of non-ablative treatments as the primary supervising physician.

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540-X-11-.10 Quality Assurance. The physician must ensure that there is a quality assurance program for the facility where non-ablative procedures are performed for the purpose of continuously improving the selection and treatment of patients. An

appropriate quality assurance program shall consist of the elements listed in paragraphs (1) - (5) of this section.

(1) A mechanism to identify complications and untoward effects of treatment and to determine their cause.

(2) A mechanism to review the adherence of delegates to standing delegation orders, standing medical orders, and written protocols.

(3) A mechanism to monitor the quality of non-ablative treatments.

(4) A mechanism by which the findings of the quality assurance program are reviewed and incorporated into future standing delegation orders, standing medical orders, protocols, and supervising responsibility.

(5) Ongoing training to improve the quality and performance of delegates.

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Statutory Authority: Code of Alabama §§34-24-50, 34-24-51, 34-24-53
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540-X-11-.11 Equipment Safety. All equipment used for the purposes stated in this Chapter must be inspected, calibrated, and certified as safe to use according to the manufacturer's specifications.

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History: Approved for publication: February 21, 2007. Approved for publication: May 16, 2007. Final Adoption: August 15, 2007. Effective Date: September 20, 2007.

540-X-11-.12 Safe Use of Lasers.

In addition to the requirements of these rules, all practitioners who use or operate lasers must comply with any regulations, standards, directives and guidelines for laser

safety and use issued by the Occupational Safety and Health Administration, United States Department of Labor.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Alabama §§34-24-50, 34-24-51, 34-24-53
History: Approved for publication: February 21, 2007. Approved for publication: May 16, 2007. Final Adoption: August 15, 2007. Effective Date: September 20, 2007.

540-X-11-.13 Registration of Physicians Using Lasers in the Practice of Medicine.

(1) Every physician who proposes to perform any LLBD procedure in Alabama under these rules in Alabama shall register with the Board prior to performing any procedure.

(2) Registration shall be accomplished on a form provided by the Board.

(3) After initially registering, it shall be the obligation of the registrant to notify the Board in writing of any change or addition of facility location where LLBD procedures occur or are offered for use.

(4) Beginning January 2024, annual registration as a provider of LLBD procedures shall be required and shall be accomplished by electronic means.

(5) Annual registration as an LLBD provider shall be due by January 31 of each year.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Alabama §§34-24-50, 34-24-51, 34-24-53
History: Approved for publication: February 21, 2007. Approved for publication: May 16, 2007. Final Adoption: August 15, 2007. Effective Date: September 20, 2007.

540-X-11-.14 Reporting Requirement for Adverse Events. Every physician who performs or supervises the performance of a procedure covered under these rules shall report to the Board within three (3) business days the occurrence of all events related to

a procedure that resulted in an emergency transfer of a patient to a hospital, unscheduled hospitalization related to the procedure, third-degree dermal injury, or death.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Alabama §§34-24-50, 34-24-51, 34-24-53
History: Approved for publication: February 21, 2007. Approved for publication: May 16, 2007. Final Adoption: August 15, 2007. Effective Date: September 20, 2007.

540-X-11-.15 Effective Date. The deadline for compliance with the provisions of this section will be one year following the final adoption of this rule.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Alabama §§34-24-50, 34-24-51, 34-24-53
History: Approved for publication: February 21, 2007. Approved for publication: May 16, 2007. Final Adoption: August 15, 2007. Effective Date: September 20, 2007.

540-X-11-.16 Continuing Education and Minimum Annual Procedures Required.

(1) Level 1 and 2 Delegates must complete a minimum number of hours of continuing LLBD education and a minimum number of procedures to continue performing LLBD procedures under these guidelines. Physicians are exempt from continued LLBD education and an annual minimum number of procedures but must maintain proper training on any procedure or device a Level 1 or 2 Delegate is allowed to utilize. If a practitioner fails to meet these requirements, he or she must complete the initial training and procedure-specific training set forth in these guidelines.

(2) Level 1 Delegates must annually complete a minimum of four (4) hours of continuing LLBD education, and Level 2 Delegates must annually complete a minimum of six (6) hours of continuing LLBD education.

(3) Continuing LLBD education may include AMA PRA Category 1 CME hours, LLBD-specific medical conference hours, online study and courses, and self-

study through online webinars, lectures, CME courses, and hours lectured by a physician.

(4) Continuing LLBD education obtained may be general for all LLBD procedures and not specific to every procedure performed. Continuing education should include training on LLBD theory and physics; skin anatomy and conditions/diseases; LLBD safety; treatment of conditions; recognition, management, and reporting of side effects and complications; and overall use of LLBD procedures to treat patients.

(5) Level 1 Delegates must complete a minimum of ten (10) total LLBD procedures per year, and Level 2 Delegates must complete a minimum of thirty (30) total LLBD procedures per year.

(6) Level 1 Delegates must complete a minimum of ten (10) procedures in each procedure category they practice within, and Level 2 Delegates must complete a minimum of thirty (30) procedures in each procedure category they practice within.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Alabama §§34-24-50, 34-24-51, 34-24-53
History: Approved for publication:

EXHIBIT F

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **ALVIN MACON STINSON, III, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-116**

ORDER SETTING HEARING
For Contested Cases Initiated by Administrative Complaint

The Medical Licensure Commission has received the verified Administrative Complaint filed by the Alabama State Board of Medical Examiners in this matter. The Commission has determined that this matter is due to be set down for hearing under the provisions of Ala. Code § 34-24-361(e). This Order shall serve as the Notice of Hearing prescribed in Ala. Admin. Code r. 545-X-3-.03(3), (4). The Commission's legal authority and jurisdiction to hold the hearing in this matter are granted by Article 8, Chapter 24, Title 34 of the Code of Alabama (1975), and the particular sections of the statutes and rules involved are as set forth in the Administrative Complaint and in this Order.

1. **Service of the Administrative Complaint**

A copy of the Administrative Complaint and a copy of this Order shall be served forthwith upon the Respondent, by personally delivering the same to Respondent if he or she can be found within the State of Alabama, or, by overnight courier, signature required, to Respondent's last known address if he or she cannot be found within the State of Alabama. The Commission further directs that personal service of process shall be made by Hathaway Crenshaw, who is designated as the duly authorized agent of the Commission.

2. **Initial Hearing Date**

This matter is set for a hearing as prescribed in Ala. Code §§ 34-24-360, *et seq.*, and Ala. Admin. Code Chapter 545-X-3, to be held on Monday, November 20, 2023, at 10:00 a.m., at 848 Washington Avenue, Montgomery, Alabama, 36104. Unless otherwise specified by the Commission, the hearing will be held in person. All parties and counsel are expected to appear and to be prepared for the hearing at this date, time, and place.

3. **Appointment of Hearing Officer**

The Commission appoints the Honorable William R. Gordon, Circuit Judge (Ret.) as the Hearing Officer in this matter, pursuant to Ala. Admin. Code r. 545-X-3-.08. The Hearing Officer shall exercise general superintendence over all pre-hearing proceedings in this matter, and shall serve as the presiding officer at the

hearing, having and executing all powers described in Ala. Admin. Code r. 545-X-3-.08(1)(a)-(g).

4. **Answer**

Respondent shall file an Answer, as prescribed in Ala. Admin. Code r. 545-X-3-.03(6), within 20 calendar days of the service of the Administrative Complaint. If Respondent does not file such an Answer, the Hearing Officer shall enter a general denial on Respondent's behalf.

5. **Rescheduling/Motions for Continuance**

All parties and attorneys are expected to check their schedules immediately for conflicts. Continuances will be granted only upon written motion and only for good cause as determined by the Chairman of the Medical Licensure Commission. Continuances requested on grounds of engagement of legal counsel on the eve of the hearing will not be routinely granted.

6. **Case Management Orders**

The Hearing Officer is authorized, without further leave of the Commission, to enter such case management orders as he considers appropriate to the particular case. Among any other matters deemed appropriate by the Hearing Officer, the Hearing Officer may enter orders addressing the matters listed in Ala. Admin. Code

r. 545-X-3-.03(5)(a)-(f) and/or 545-X-3-.08(1)(a)-(g). All parties will be expected to comply with such orders.

7. **Manner of Filing and Serving Pleadings**

All pleadings, motions, requests, and other papers in this matter may be filed and served by e-mail. All filings should be e-mailed to:

- The Hearing Officer, William Gordon (wrgordon@charter.net);
- The Director of Operations of the Medical Licensure Commission, Rebecca Robbins (rrobbins@almlc.gov);
- General Counsel of the Medical Licensure Commission, Aaron Dettling (adettling@almlc.gov);
- General Counsel for the Alabama Board of Medical Examiners, Wilson Hunter (whunter@albme.gov); and
- Respondent/Licensee or his or her counsel, as appropriate.

The Director of Operations of the Medical Licensure Commission shall be the custodian of the official record of the proceedings in this matter.

8. **Discovery**

Consistent with the administrative quasi-judicial nature of these proceedings, limited discovery is permitted, under the supervision of the Hearing Officer. *See* Ala. Code § 41-22-12(c); Ala. Admin. Code r. 545-X-3-.04. All parties and attorneys

shall confer in good faith with one another regarding discovery. If disputes regarding discovery are not resolved informally, a motion may be filed with the Hearing Officer, who is authorized to hold such hearings as appropriate and to make appropriate rulings regarding such disputes.

9. Publicity and Confidentiality

Under Alabama law, the Administrative Complaint is a public document. The hearing itself is closed and confidential. The Commission's written decision, if any, will also be public. *See* Ala. Code § 34-24-361.1; Ala. Admin. Code r. 545-X-3-.03(10)(h), (11).

10. Stipulations

The parties are encouraged to submit written stipulations of matters as to which there is no basis for good-faith dispute. Stipulations can help to simplify and shorten the hearing, facilitate the Commission's decisional process, and reduce the overall costs of these proceedings. Written stipulations will be most useful to the Commission if they are submitted in writing approximately 10 days preceding the hearing. The Hearing Officer is authorized to assist the parties with the development and drafting of written stipulations.

11. Judicial Notice

The parties are advised that the Commission may take judicial notice of its prior proceedings, findings of fact, conclusions of law, decisions, orders, and judgments, if any, relating to the Respondent. *See* Ala. Code § 41-22-13(4); Ala. Admin. Code r. 545-X-3-.09(4).

12. Settlement Discussions

The Commission encourages informal resolution of disputes, where possible and consistent with public interest. If a settlement occurs, the parties should notify the Hearing Officer, the Commission's Director of Operations, and Commission's General Counsel. The terms of settlement are subject to the approval of the Commission. If approved, the Commission will generally incorporate the settlement terms into a Consent Decree.

13. Subpoenas

The Commission has the statutory authority to compel the attendance of witnesses, and the production of books and records, by the issuance of subpoenas. *See* Ala. Code §§ 34-24-363; 41-22-12(c); Ala. Admin. Code r. 545-X-3-.05. The parties may request that the Hearing Officer issue subpoenas for witnesses and/or documents, and the Hearing Officer is authorized to approve and issue such subpoenas on behalf of the Commission. Service of such subpoenas shall be the responsibility of the party requesting such subpoenas.

14. **Hearing Exhibits**

A. Parties and attorneys should, if possible, stipulate as to the admissibility of documents prior to the hearing.

B. The use of electronic technology, USB drives, CD's, DVD's, etc. is acceptable and encouraged for voluminous records. If the Commission members will need their laptop to view documents, please notify the Hearing Officer prior to your hearing.

C. If providing hard copies, voluminous records need not be copied for everyone but, if portions of records are to be referred to, those portions should be copied for everyone.

D. If a document is to be referred to in a hearing, copies should be available for each Commission member, the Hearing Officer, the Commission's General Counsel, opposing attorney, and the court reporter (12 copies).

E. Index exhibits/documents for easy reference.

F. Distribute exhibit/document packages at the beginning of the hearing to minimize distractions during the hearing.

15. **Administrative Costs**

The Commission is authorized, pursuant to Ala. Code § 34-24-381(b) and Ala. Admin. Code r. 545-X-3-.08(9) and (10), to assess administrative costs against the Respondent if he or she is found guilty of any of the grounds for discipline set forth in Ala. Code § 34-24-360. The Board of Medical Examiners **[X]has / [ ]has not** given written notice of its intent to seek imposition of administrative costs in this matter.

16. **Appeals**

Appeals from final decisions of the Medical Licensure Commission, where permitted, are governed by Ala. Code § 34-24-367.

DONE on this the 29th day of June, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-08-29 16:15:26 CDT

Craig H. Christopher, M.D.
its Chairman

Distribution:

- Honorable William R. Gordon (incl. Administrative Complaint)
- Rebecca Robbins
- Respondent/Respondent's Attorney
- E. Wilson Hunter
- Aaron L. Dettling

EXHIBIT G

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **ALBERT W. PEARSALL, IV, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2021-374**

CONSENT DECREE

This matter comes before the Medical Licensure Commission of Alabama ("the Commission") on the Administrative Complaint ("the Administrative Complaint") filed by the Alabama State Board of Medical Examiners ("the Board") on March 2, 2023. The Board and the Respondent, Albert W. Pearsall, IV, M.D. ("Respondent"), have entered into a Joint Settlement Agreement ("the Settlement Agreement"), and have asked the Commission to approve the Settlement Agreement and to embody it in this Consent Decree.

General Provisions

1. **Approval of the Settlement Agreement.** After review, the Commission finds that the Settlement Agreement represents a reasonable and appropriate disposition of the matters asserted in the Administrative Complaint. The Commission therefore approves the Settlement Agreement.

2. **Mutual Agreement and Waiver of Rights.** Respondent has consented and agreed to the entry of this Consent Decree, and has agreed to be bound by the findings of fact, conclusions of law, and terms and conditions stated herein. Respondent has validly waived his rights to an administrative hearing before the Commission, to be represented by an attorney at such hearing, and to further notice and formal adjudication by the Commission of the charges arising from the Administrative Complaint. Respondent has also validly waived any and all rights to judicial review of this Consent Decree pursuant to Ala. Code § 34-24-367, the Alabama Administrative Procedure Act, Ala. Code §§ 41-22-1, *et seq.*, by extraordinary writ, or otherwise.

3. **Public Documents.** The Settlement Agreement and this Consent Decree shall constitute public records under the laws of the State of Alabama. The Settlement Agreement and this Consent Decree may be published or disclosed by the Board and/or the Commission without further notice to Respondent.

4. **Additional Violations.** Any violation of the requirements of this Consent Decree, or any new violation of state or federal laws or regulations, may result in the Board filing a petition to discipline Respondent's medical license. Nothing in this Consent Decree precludes the Board from bringing new administrative charges against Respondent based upon events and circumstances not raised in the Administrative Complaint.

5. **Retention of Jurisdiction.** The Commission retains jurisdiction for the purpose of entering such other and further orders and directives as may be required to implement the provisions of this Consent Decree.

6. **Judicial Notice.** Pursuant to Ala. Code § 41-22-13(4), Respondent is informed that the Board and/or the Commission may at any time take judicial notice of this Consent Decree, and/or any of the Findings of Fact herein, and may deem any of the findings or conclusions set forth in this Consent Decree to be conclusively established, all without further notice to Respondent.

Findings of Fact

1. Respondent has been licensed to practice medicine in the State of Alabama since August 27, 1997, having been issued license no. MD.21279. Respondent was so licensed at all relevant times.

2. Respondent was arrested in Mobile County, Alabama, on September 2, 2021, and charged with aggravated stalking of his former girlfriend, who was also a former co-worker.

3. On or about October 8, 2021, Respondent submitted or caused to be submitted an Alabama medical license renewal application for calendar year 2022. On that application, Respondent answered "No" in response to Question 1, which asks: "SINCE YOUR LAST RENEWAL: Have you been 'charged' with 'any'

criminal offense (felony or misdemeanor) (this includes driving under the influence (DUI), even if you were convicted of a lesser offense)?"

4. Respondent's answer to Question 1 was untrue.

Conclusions of Law

1. The Commission has jurisdiction over the subject matter of the Administrative Complaint, and over the parties, pursuant to Ala. Code § 34-24-310, *et seq.*

2. The Commission finds, as a matter of law, that the determined facts constitute violations of Ala. Code §§ 34-24-360(2), (17), and Ala. Admin. Code r. 545-X-4-.06.

Order/Discipline

Based upon the foregoing Findings of Fact and Conclusions of Law, it is ORDERED, ADJUDGED, AND DECREED:

1. That Respondent is assessed an administrative fine in the amount of two hundred fifty dollars ($250.00). In accordance with Ala. Admin. Code r. 545-X-3-.08(8)(d)(i), Respondent is ordered to pay the administrative fine within 30 days of this Order.[1]

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[1] "The refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission" may be a separate instance of "unprofessional conduct." *See* Ala. Admin. Code r. 545-X-4-.06(6).

2. That no costs of this proceeding are assessed against Respondent at this time.

DONE on this the 30th day of June, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-06-30 11:33:29 CDT

Craig H. Christopher, M.D.
its Chairman

EXHIBIT H

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **KIMBERLY LYNN BALASKY, D.O.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-151**

CONSENT DECREE

This matter comes before the Medical Licensure Commission of Alabama ("the Commission") on the Administrative Complaint ("the Administrative Complaint") filed by the Alabama State Board of Medical Examiners ("the Board") on June 22, 2023. The Board and the Respondent, Kimberly Lynn Balasky, D.O. ("Respondent"), have entered into a Joint Settlement Agreement ("the Settlement Agreement"), and have asked the Commission to approve the Settlement Agreement and to embody it in this Consent Decree.

General Provisions

1. **Approval of the Settlement Agreement.** After review, the Commission finds that the Settlement Agreement represents a reasonable and appropriate disposition of the matters asserted in the Administrative Complaint. The Commission therefore approves the Settlement Agreement.

2. **Mutual Agreement and Waiver of Rights.** Respondent has consented and agreed to the entry of this Consent Decree, and has agreed to be bound by the findings of fact, conclusions of law, and terms and conditions stated herein. Respondent has validly waived her rights to an administrative hearing before the Commission, to be represented by an attorney at such hearing, and to further notice and formal adjudication by the Commission of the charges arising from the Administrative Complaint. Respondent has also validly waived any and all rights to judicial review of this Consent Decree pursuant to Ala. Code § 34-24-367, the Alabama Administrative Procedure Act, Ala. Code §§ 41-22-1, *et seq.*, by extraordinary writ, or otherwise.

3. **Public Documents.** The Settlement Agreement and this Consent Decree shall constitute public records under the laws of the State of Alabama. The Settlement Agreement and this Consent Decree may be published or disclosed by the Board and/or the Commission without further notice to Respondent.

4. **Additional Violations.** Any violation of the requirements of this Consent Decree, or any new violation of state or federal laws or regulations, may result in the Board filing a petition to discipline Respondent's medical license. Nothing in this Consent Decree precludes the Board from bringing new administrative charges against Respondent based upon events and circumstances not raised in the Administrative Complaint.

5. **Retention of Jurisdiction.** The Commission retains jurisdiction for the purpose of entering such other and further orders and directives as may be required to implement the provisions of this Consent Decree.

6. **Judicial Notice.** Pursuant to Ala. Code § 41-22-13(4), Respondent is informed that the Board and/or the Commission may at any time take judicial notice of this Consent Decree, and/or any of the Findings of Fact herein, and may deem any of the findings or conclusions set forth in this Consent Decree to be conclusively established, all without further notice to Respondent.

Findings of Fact

1. Respondent has been licensed to practice medicine in the State of Alabama since May 26, 2004, having been issued license no. DO.859. Respondent was so licensed at all relevant times.

2. On or about December 27, 2022, Respondent submitted or caused to be submitted an Alabama medical license renewal application for calendar year 2023. On that application, Respondent certified that the annual minimum continuing medical education requirement of 25 credits had been met or would be met by December 31, 2022. Respondent further represented that, if audited, she would have supporting documents.

3. Respondent did not earn any valid continuing medical education credits during 2022.

Conclusions of Law

1. The Commission has jurisdiction over the subject matter of the Administrative Complaint, and over the parties, pursuant to Ala. Code § 34-24-310, *et seq.*

2. The Commission finds, as a matter of law, that the determined facts constitute violations of Ala. Code § 34-24-360(23) and Ala. Admin. Code r. 545-X-5-.02.

Order/Discipline

Based upon the foregoing Findings of Fact and Conclusions of Law, it is ORDERED, ADJUDGED, AND DECREED:

1. That Respondent is assessed an administrative fine in the amount of two thousand five hundred dollars ($2,500.00). In accordance with Ala. Admin. Code r. 545-X-3-.08(8)(d)(i), Respondent is ordered to pay the administrative fine within 30 days of this Order.[1]

2. That Respondent is ORDERED to obtain 25 ***additional*** credits of AMA PRA Category 1™ or equivalent continuing medical education, in addition to the 25

[1] "The refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission" may be a separate instance of "unprofessional conduct." *See* Ala. Admin. Code r. 545-X-4-.06(6).

credits already required for calendar year 2023, for a combined total of 50 credits, no later than December 31, 2023.

3. That no costs of this proceeding are assessed against Respondent at this time.

DONE on this the 30th day of June, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-06-30 11:34:07 CDT

Craig H. Christopher, M.D.
its Chairman

EXHIBIT I

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **JAMES STEVEN ST. LOUIS, D.O.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-148**

ORDER SETTING HEARING
For Contested Cases Initiated by Administrative Complaint

The Medical Licensure Commission has received the verified Administrative Complaint filed by the Alabama State Board of Medical Examiners in this matter. The Commission has determined that this matter is due to be set down for hearing under the provisions of Ala. Code § 34-24-361(e). This Order shall serve as the Notice of Hearing prescribed in Ala. Admin. Code r. 545-X-3-.03(3), (4). The Commission's legal authority and jurisdiction to hold the hearing in this matter are granted by Article 8, Chapter 24, Title 34 of the Code of Alabama (1975), and the particular sections of the statutes and rules involved are as set forth in the Administrative Complaint and in this Order.

1. **Service of the Administrative Complaint**

A copy of the Administrative Complaint and a copy of this Order shall be served forthwith upon the Respondent, by personally delivering the same to Respondent if he or she can be found within the State of Alabama, or, by overnight courier, signature required, to Respondent's last known address if he or she cannot be found within the State of Alabama. The Commission further directs that personal service of process shall be made by FedEx/Nicole Hardy, who is designated as the duly authorized agent of the Commission.

2. **Initial Hearing Date**

This matter is set for a hearing as prescribed in Ala. Code §§ 34-24-360, *et seq.*, and Ala. Admin. Code Chapter 545-X-3, to be held on Monday, November 20, 2023, at 10:00 a.m., at 848 Washington Avenue, Montgomery, Alabama, 36104. Unless otherwise specified by the Commission, the hearing will be held in person. All parties and counsel are expected to appear and to be prepared for the hearing at this date, time, and place.

3. **Appointment of Hearing Officer**

The Commission appoints the Honorable William R. Gordon, Circuit Judge (Ret.) as the Hearing Officer in this matter, pursuant to Ala. Admin. Code r. 545-X-3-.08. The Hearing Officer shall exercise general superintendence over all pre-hearing proceedings in this matter, and shall serve as the presiding officer at the

hearing, having and executing all powers described in Ala. Admin. Code r. 545-X-3-.08(1)(a)-(g).

4. **Answer**

Respondent shall file an Answer, as prescribed in Ala. Admin. Code r. 545-X-3-.03(6), within 20 calendar days of the service of the Administrative Complaint. If Respondent does not file such an Answer, the Hearing Officer shall enter a general denial on Respondent's behalf.

5. **Rescheduling/Motions for Continuance**

All parties and attorneys are expected to check their schedules immediately for conflicts. Continuances will be granted only upon written motion and only for good cause as determined by the Chairman of the Medical Licensure Commission. Continuances requested on grounds of engagement of legal counsel on the eve of the hearing will not be routinely granted.

6. **Case Management Orders**

The Hearing Officer is authorized, without further leave of the Commission, to enter such case management orders as he considers appropriate to the particular case. Among any other matters deemed appropriate by the Hearing Officer, the Hearing Officer may enter orders addressing the matters listed in Ala. Admin. Code

r. 545-X-3-.03(5)(a)-(f) and/or 545-X-3-.08(1)(a)-(g). All parties will be expected to comply with such orders.

7. **Manner of Filing and Serving Pleadings**

All pleadings, motions, requests, and other papers in this matter may be filed and served by e-mail. All filings should be e-mailed to:

- The Hearing Officer, William Gordon (wrgordon@charter.net);
- The Director of Operations of the Medical Licensure Commission, Rebecca Robbins (rrobbins@almlc.gov);
- General Counsel of the Medical Licensure Commission, Aaron Dettling (adettling@almlc.gov);
- General Counsel for the Alabama Board of Medical Examiners, Wilson Hunter (whunter@albme.gov); and
- Respondent/Licensee or his or her counsel, as appropriate.

The Director of Operations of the Medical Licensure Commission shall be the custodian of the official record of the proceedings in this matter.

8. **Discovery**

Consistent with the administrative quasi-judicial nature of these proceedings, limited discovery is permitted, under the supervision of the Hearing Officer. *See* Ala. Code § 41-22-12(c); Ala. Admin. Code r. 545-X-3-.04. All parties and attorneys

shall confer in good faith with one another regarding discovery. If disputes regarding discovery are not resolved informally, a motion may be filed with the Hearing Officer, who is authorized to hold such hearings as appropriate and to make appropriate rulings regarding such disputes.

9. Publicity and Confidentiality

Under Alabama law, the Administrative Complaint is a public document. The hearing itself is closed and confidential. The Commission's written decision, if any, will also be public. *See* Ala. Code § 34-24-361.1; Ala. Admin. Code r. 545-X-3-.03(10)(h), (11).

10. Stipulations

The parties are encouraged to submit written stipulations of matters as to which there is no basis for good-faith dispute. Stipulations can help to simplify and shorten the hearing, facilitate the Commission's decisional process, and reduce the overall costs of these proceedings. Written stipulations will be most useful to the Commission if they are submitted in writing approximately 10 days preceding the hearing. The Hearing Officer is authorized to assist the parties with the development and drafting of written stipulations.

11. Judicial Notice

The parties are advised that the Commission may take judicial notice of its prior proceedings, findings of fact, conclusions of law, decisions, orders, and judgments, if any, relating to the Respondent. *See* Ala. Code § 41-22-13(4); Ala. Admin. Code r. 545-X-3-.09(4).

12. Settlement Discussions

The Commission encourages informal resolution of disputes, where possible and consistent with public interest. If a settlement occurs, the parties should notify the Hearing Officer, the Commission's Director of Operations, and Commission's General Counsel. The terms of settlement are subject to the approval of the Commission. If approved, the Commission will generally incorporate the settlement terms into a Consent Decree.

13. Subpoenas

The Commission has the statutory authority to compel the attendance of witnesses, and the production of books and records, by the issuance of subpoenas. *See* Ala. Code §§ 34-24-363; 41-22-12(c); Ala. Admin. Code r. 545-X-3-.05. The parties may request that the Hearing Officer issue subpoenas for witnesses and/or documents, and the Hearing Officer is authorized to approve and issue such subpoenas on behalf of the Commission. Service of such subpoenas shall be the responsibility of the party requesting such subpoenas.

14. **Hearing Exhibits**

A. Parties and attorneys should, if possible, stipulate as to the admissibility of documents prior to the hearing.

B. The use of electronic technology, USB drives, CD's, DVD's, etc. is acceptable and encouraged for voluminous records. If the Commission members will need their laptop to view documents, please notify the Hearing Officer prior to your hearing.

C. If providing hard copies, voluminous records need not be copied for everyone but, if portions of records are to be referred to, those portions should be copied for everyone.

D. If a document is to be referred to in a hearing, copies should be available for each Commission member, the Hearing Officer, the Commission's General Counsel, opposing attorney, and the court reporter (12 copies).

E. Index exhibits/documents for easy reference.

F. Distribute exhibit/document packages at the beginning of the hearing to minimize distractions during the hearing.

15. **Administrative Costs**

The Commission is authorized, pursuant to Ala. Code § 34-24-381(b) and Ala. Admin. Code r. 545-X-3-.08(9) and (10), to assess administrative costs against the Respondent if he or she is found guilty of any of the grounds for discipline set forth in Ala. Code § 34-24-360. The Board of Medical Examiners **[X]has / [ ]has not** given written notice of its intent to seek imposition of administrative costs in this matter.

16. **Appeals**

Appeals from final decisions of the Medical Licensure Commission, where permitted, are governed by Ala. Code § 34-24-367.

DONE on this the 29th day of June, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-06-29 16:16:40 CDT

Craig H. Christopher, M.D.
its Chairman

Distribution:

- Honorable William R. Gordon (incl. Administrative Complaint)
- Rebecca Robbins
- Respondent/Respondent's Attorney
- E. Wilson Hunter
- Aaron L. Dettling

EXHIBIT J

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **GARY ROYCE WISNER, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2018-155**

ORDER

This matter is before the Medical Licensure Commission of Alabama on Respondent's Motion to Continue, filed on June 16, 2023. The Board of Medical Examiners does not object to the motion.

Upon due consideration, the Motion to Continue is granted, and the hearing in this matter is continued and re-set for Monday, November 20, 2022, at 10:00 a.m., at 848 Washington Avenue, Montgomery, Alabama, 36104.

DONE on this the 30th day of June, 2023.

THE MEDICAL LICENSURE COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-06-30 11:41:14 CDT

Craig H. Christopher, M.D.
its Chairman

EXHIBIT K

STATE OF ALABAMA)
)
MONTGOMERY COUNTY)

VOLUNTARY SURRENDER

I, SCOTT WILLIAM SMITH, M.D., do voluntarily surrender my license to practice medicine or osteopathy in the State of Alabama, identified by license number MD.43125, under the provisions of Ala. Code § 34-24-361(g). I acknowledge that this action is taken by me while under investigation by the Alabama State Board of Medical Examiners ("the Board").

I acknowledge that I sign this document willingly, that I execute it as my free and voluntary act for the purposes herein expressed, and that I am of sound mind and under no constraint or undue influence.

I understand that I have a right to a hearing in this matter, and I hereby freely, knowingly, and voluntarily waive such right to a hearing. I also understand that both the Board and Medical Licensure Commission ("Commission") shall have access to any investigative file in this matter should I request reinstatement of my medical license, and that the Board has the right to contest my reinstatement. I understand that the Commission may summarily deny any petition for reinstatement of my medical license for two (2) years from the effective date of this surrender. I further understand that upon applying for reinstatement, it shall be my burden to prove by sufficient evidence that I satisfy the criteria for reinstatement as provided for in the Commission's rules, which include, but are not limited to, demonstrating to the satisfaction of the Commission that I am able to practice medicine with reasonable skill and safety to patients.

I understand that this surrender shall become effective upon acceptance by

the Commission. I further acknowledge that this voluntary surrender constitutes a public record of the Board and Commission and will be reported by the Commission to the National Practitioner Data Bank and to the Federation of State Medical Boards. I understand that this voluntary surrender may be released by the Board or Commission to any person or entity requesting information concerning the licensure status in Alabama of the physician named herein.

EXECUTED this 7th day of June, 2023.

Scott William Smith M.D.

SCOTT WILLIAM SMITH, M.D.

Witnessed by:

Catherine M. Smith

(Print)

Catherine M Smith

(Sign)

EXHIBIT L

STATE OF ALABAMA)
)
MONTGOMERY COUNTY)

VOLUNTARY SURRENDER

I, ROBERT EARL TAYLOR, M.D., do voluntarily surrender my certificate of qualification and license to practice medicine or osteopathy in the State of Alabama, identified by license number MD.21262, under the provisions of Ala. Code § 34-24-361(g). I acknowledge that this action is taken by me while under investigation by the Alabama State Board of Medical Examiners ("the Board")

I acknowledge that I sign this document willingly, that I execute it as my free and voluntary act for the purposes herein expressed, and that I am of sound mind and under no constraint or undue influence.

I understand that I have a right to a hearing in this matter, and I hereby freely, knowingly, and voluntarily waive such right to a hearing. I also understand that both the Board and Medical Licensure Commission shall have access to any investigative file in this matter should I request reinstatement of my certificate of qualification and medical license, and that the Board has the right to contest my reinstatement. I understand that the Board may summarily deny any petition for reinstatement of my certificate of qualification for two (2) years from the effective date of this surrender. I further understand that upon applying for reinstatement, it

shall be my burden to prove by sufficient evidence that I satisfy the criteria for reinstatement as provided for in the Board's rules, which include, but are not limited to, demonstrating to the satisfaction of the Board that I am able to practice medicine with reasonable skill and safety to patients.

I understand that this surrender shall become effective upon acceptance by the Board. I further acknowledge that this voluntary surrender constitutes a public record of the Board and will be reported by the Board to the National Practitioner Data Bank and to the Federation of State Medical Boards. I understand that this voluntary surrender may be released by the Board to any person or entity requesting information concerning the licensure status in Alabama of the physician named herein.

EXECUTED this 5th day of May, 2023.

R Taylor MD

ROBERT EARL TAYLOR, M.D.

Witnessed by:

Lori M. Barnett
(Print)

Lori Barnett

EXHIBIT M

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **JOHN MCKENZIE HENDERSON, D.O.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2021-112**

ORDER

This matter is before the Medical Licensure Commission of Alabama on the "Joint Status Report" filed by the parties on May 16, 2023. Upon consideration, this matter is set for a final hearing to be held on Wednesday, September 27, 2023, at 10:00 a.m., at 848 Washington Avenue, Montgomery, Alabama 36104.

DONE on this the 5th day of July, 2023.

THE MEDICAL LICENSURE COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-07-05 11:41:25 CDT

Craig H. Christopher, M.D.
its Chairman

EXHIBIT N

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **THOMAS PAUL ALDERSON, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-138**

ORDER

At the request of the Respondent, the hearing in this matter is continued and re-set for Wednesday, August 9, 2023, at 9:30 a.m., at 3300 Cahaba Road, Suite 320, Birmingham, Alabama, 35203.

DONE on this the 30th day of June, 2023.

THE MEDICAL LICENSURE COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-06-30 11:35:14 CDT

Craig H. Christopher, M.D.
its Chairman

EXHIBIT O

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **RODNEY LOWELL DENNIS, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-139**

ORDER

At the request of the Respondent, the hearing in this matter is continued and re-set for Wednesday, August 9, 2023, at 9:30 a.m., at 3300 Cahaba Road, Suite 320, Birmingham, Alabama, 35203.

DONE on this the 30th day of June, 2023.

THE MEDICAL LICENSURE COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-06-30 11:35:43 CDT

Craig H. Christopher, M.D.
its Chairman

EXHIBIT P

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **COSMIN DOBRESCU, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-054**

ORDER (AMENDED)

This matter is before the Medical Licensure Commission of Alabama on Respondent's Motion to Continue, submitted via e-mail on June 7, 2023. The Board of Medical Examiners does not object to the motion. Respondent has also executed and submitted a waiver of the 120-day limitation on the summary suspension imposed by Ala. Code § 41-22-19(d) and Ala. Admin. Code r. 545-X-3-.13(2).

Upon due consideration, the Motion to Continue is granted, and the hearing in this matter is continued and re-set for Wednesday, December 20, 2023, at 10:00 a.m., at 848 Washington Avenue, Montgomery, Alabama, 36104.

DONE on this the 7th day of July, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-07-07 12:15:46 CDT

Craig H. Christopher, M.D.
its Chairman

EXHIBIT Q

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **SHAKIR RAZA MEGHANI, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-061**

ORDER

This matter is before the Medical Licensure Commission of Alabama on Respondent's Motion to Continue, filed on June 23, 2023. The Board of Medical Examiners does not object to the motion. Upon due consideration, the Motion to Continue is granted, and the hearing in this matter is continued and re-set for Thursday, October 26, 2023, at 10:00 a.m., at 848 Washington Avenue, Montgomery, Alabama 36104.

DONE on this the 30th day of June, 2023.

THE MEDICAL LICENSURE COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-06-30 11:37:10 CDT

Craig H. Christopher, M.D.
its Chairman

EXHIBIT R

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **v.** **VANESSA ANN RAGLAND-PAYNE, D.O.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-100**

ORDER

This matter is before the Medical Licensure Commission of Alabama on the Recommended Findings of Fact and Conclusions of Law entered by Commissioners Christopher, Nagrodzki, and Aldridge on May 30, 2023. Upon consideration, the recommended findings of the three-member panel, attached hereto as Exhibit "A," are ratified and entered as the final judgment of the Commission. *See* Ala. Code § 34-24-366; Ala. Admin. Code r. 545-X-3-.14(3).

DONE on this the 30th day of June, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-06-30 11:40:47 CDT

Craig H. Christopher, M.D.
its Chairman

EXHIBIT S

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **v.** **CARLOS A. LIOTTA, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-097**

ORDER

This matter is before the Medical Licensure Commission of Alabama on the Recommended Findings of Fact and Conclusions of Law entered by Commissioners Christopher, Nagrodzki, and Aldridge on May 30, 2023. Upon consideration, the recommended findings of the three-member panel, attached hereto as Exhibit "A," are ratified and entered as the final judgment of the Commission. *See* Ala. Code § 34-24-366; Ala. Admin. Code r. 545-X-3-.14(3).

DONE on this the 30th day of June, 2023.

THE MEDICAL LICENSURE COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-06-30 11:36:44 CDT

Craig H. Christopher, M.D.
its Chairman

EXHIBIT T

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **v.** **SHARON G. GRIFFITTS, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-124**

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter came before the Medical Licensure Commission of Alabama for a contested case hearing on June 28, 2023. After receiving and considering all of the relevant evidence and argument, we find the Respondent, Sharon G. Griffitts, M.D., guilty of the disciplinary charges presented by the Board, and impose professional discipline as set out below.

I. Introduction and Statement of the Case

The respondent in this case is Sharon G. Griffitts, M.D. ("Respondent"). Respondent was first licensed by the Commission on January 1, 1998, having been issued license No. MD.21438. The disciplinary charges in this case arise out of Respondent's alleged failure to earn a total of 75 AMA PRA Category 1 Credits™ ("CME") during 2022, as required by a Consent Order entered by the Commission.

II. Procedural History

This is Respondent's third CME violation. Respondent earned zero CME credits during 2019. To resolve the first CME violation, Respondent agreed to a Consent Order, which we entered on November 23, 2020. Under this first Consent Order, Respondent's license was reprimanded, Respondent was fined $2,500.00, and Respondent was ordered to earn a total of 50 CME credits during 2021.

Respondent again earned zero valid CME credits during 2021. To resolve the second CME violation, we entered another Consent Order on September 28, 2022. In this Consent Order, we reprimanded Respondent's license, fined her $5,000.00, and ordered her to earn 50 "additional" CME credits (*i.e.*, a total of 75 credits) during 2022.

On May 8, 2023, the Board filed an Administrative Complaint ("the Administrative Complaint"), alleging that Respondent failed to earn 75 CME credits during 2022, as required by the September 28, 2022 Consent Order. The Administrative Complaint contains three counts. Count One alleges that Respondent committed unprofessional conduct in violation of Ala. Code § 34-24-360(2) and Ala. Admin. Code r. 545-X-4-.06, by failing to comply with the Consent Orders described above. Count Two charges Respondent with making fraudulent or untrue statements to the Board in violation of Ala. Code § 34-24-360(17), because Respondent promised in her license renewal application for

2023 that she had completed, or would complete, her 2022 CME requirement, and that she would have documents to prove up her compliance. In Count Three, the Board alleges that Respondent failed to maintain and produce documentary evidence of CME compliance as required by Ala. Admin. Code r. 545-X-5-.10.

On June 28, 2023, we conducted an evidentiary hearing on these charges as prescribed in Ala. Admin. Code r. 545-X-3. The case for disciplinary action was presented by the Board through its attorneys E. Wilson Hunter and Alicia M. Harrison. Respondent did not appear, and the hearing was held *in absentia* as authorized by Ala. Code §§ 34-24-361(e)(10) and 41-22-12(d).[1] Pursuant to Ala. Admin. Code r. 545-X-3-.08(1), the Honorable William R. Gordon presided as Hearing Officer. Each side was offered the opportunity to present evidence and argument in support of its respective contentions, and to cross-examine the witnesses presented by the other side (though Respondent, as noted above, declined this opportunity). In accordance with Ala. Code § 41-22-16, we enter the following Findings of Fact and Conclusions of Law.

[1] Respondent was offered the opportunity to attend the hearing by remote means. She expressly declined this invitation.

III. Findings of Fact

1. Respondent failed to controvert any allegation of the Administrative Complaint. Therefore, the factual allegations of paragraphs 1 through 11 of the Administrative Complaint are deemed to be conclusively established as true for purposes of these proceedings, and are incorporated herein by reference.

2. Respondent was first licensed by the Commission on January 1, 1998, having been issued license No. MD.21438.

3. The Consent Order of September 28, 2022 required Respondent to earn 50 "additional" AMA PRA Category 1 Credits™ during calendar year 2022. The 50 "additional" credits were in addition to the 25 CME credits required each year by Ala. Admin. Code r. 545-X-5-.02(1). The September 28, 2022 Consent Order thus required Respondent to earn a total of 75 CME hours during 2022.

4. Respondent does not dispute that she failed to comply with the Consent Order of September 28, 2022.

5. On December 26, 2022, Respondent submitted an application for renewal of her license to practice medicine in Alabama for 2023. In that application, Respondent promised that she had met or would meet the annual minimum CME requirement of 25 AMA PRA Category 1 Credits™ or equivalent, and that, if audited, she would have supporting documentation to substantiate this attestation.

6. The Board asked Respondent at least two times, in writing, to produce documents substantiating her compliance with her CME requirements for 2022. Respondent produced no such documents.

IV. Conclusions of Law

1. The Commission has jurisdiction over the subject matter of this cause pursuant to Act No. 1981-218, Ala. Code §§ 34-24-310, *et seq*.

2. Respondent was properly notified of the time, date, and place of the administrative hearing and of the charges against her in compliance with Ala. Code §§ 34-24-361(e) and 41-22-12(b), and Ala. Admin. Code r. 545-X-3-.03(3), (4). At all relevant times, Respondent was a licensee of this Commission and was and is subject to the Commission's jurisdiction.

3. Under certain conditions, the Commission "shall have the power and duty to suspend, revoke, or restrict any license to practice medicine or osteopathy in the State of Alabama or place on probation or fine any licensee." Ala. Code § 34-24-360.

4. It is "unprofessional conduct" within the meaning of Ala. Code § 34-24-360(2) for any physician to violate "an order entered by the Medical Licensure Commission ... issued pursuant to ... Code of Ala. 1975, Section 34-24-361(h)." Ala. Admin. Code r. 545-X-4-.06(6). The Consent Orders of November 23, 2020

and September 28, 2022 are, of course, "order[s] entered by the Medical Licensure Commission ... issued pursuant to ... Code of Ala. 1975, Section 34-24-361(h)."

5. The evidence presented at the hearing establishes that Respondent engaged in unprofessional conduct in violation of Ala. Code § 34-24-360(2) and Ala. Admin. Code r. 545-X-4-.06(6), in that she violated the requirement of the September 28, 2022 Consent Order that she obtain a total of 75 AMA PRA Category 1 Credits™ during the 2022 calendar year.

6. A physician is subject to professional discipline if she makes "any fraudulent or untrue statement to the commission or to the State Board of Medical Examiners." Ala. Code § 34-24-360(17).

7. The evidence presented at the hearing establishes that Respondent did make a fraudulent and untrue statement to the Board when she filed her license renewal application for the 2023 calendar year.

8. Rule 545-X-5-.10 provides as follows:

> **Record Keeping Requirement.** Every physician subject to the minimum continuing medical education requirement established in this Chapter shall maintain records of attendance or certificates of completion demonstrating compliance with the minimum continuing medical education requirement. . . . Every physician subject to the continuing medical education requirement of this Chapter shall, upon request, submit a copy of such records to the State Board of Medical Examiners for verification. Failure to maintain records documenting that a physician has met the minimum continuing medical education requirement, and/or failure to provide such records upon request to the State Board of Medical Examiners is hereby declared to be

> unprofessional conduct and may constitute grounds for discipline of the physician's license to practice medicine, within the discretion of the Medical Licensure Commission and in accordance with the statutes and regulations governing the disciplining of a physician's license.

9. The evidence presented at the hearing establishes that Respondent failed to produce documentary evidence that she complied with the 2022 CME requirements, in violation of Ala. Admin. Code r. 545-X-5-.10.

V. Decision

Therefore, it is **ORDERED, ADJUDGED, AND DECREED:**

1. That the Respondent, Sharon G. Griffitts, M.D., is adjudged **GUILTY** of unprofessional conduct in violation of Ala. Code § 34-24-360(2) and Ala. Admin. Code r. 545-X-4-.06, as charged in Count One of the Administrative Complaint.

2. That the Respondent, Sharon G. Griffitts, M.D., is adjudged **GUILTY** of making a fraudulent or untrue statement to the Board in violation of Ala. Code § 34-24-360(17), as charged in Count Two of the Administrative Complaint.

3. That the Respondent, Sharon G. Griffitts, M.D., is adjudged **GUILTY** of failing to maintain and produce records of CME credits in violation of Ala. Admin. Code r. 545-X-5-.10, as charged in Count Three of the Administrative Complaint.

4. That Respondent's license to practice medicine in Alabama is **REPRIMANDED.**

5. That in addition to all other fines and costs previously assessed and remaining unpaid, Respondent is **ASSESSED** an administrative fine in the amount of ten thousand dollars ($10,000.00) as to each of Counts One, Two, and Three, but imposed concurrently, for a total administrative fine of ten thousand dollars ($10,000.00). In accordance with Ala. Admin. Code r. 545-X-3-.08(8)(d)(i), Respondent is **ORDERED** to pay the administrative fine within 30 days of this Order.[2] In compliance with Ala. Code § 34-24-383, Respondent's annual certificate of registration shall not be renewed for 2024 unless and until this administrative fine, and all other fines and costs previously assessed, are paid in full.

6. That the Respondent is **ORDERED** to earn a total of 75 AMA PRA Category 1 Credits™ during the 2023 calendar year, representing the standard 25 hours required by Ala. Admin. Code r. 545-X-5-.02(1), plus 50 additional "make-up" hours.

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[2] "The refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission" may be a separate instance of "unprofessional conduct." *See* Ala. Admin. Code r. 545-X-4-.06(6).

7. That Respondent's annual certificate of registration shall not be renewed for 2024 based on an attestation that she has complied, or will comply, with the CME requirements imposed by the Commission's rules and by this Order. To the contrary, Respondent's annual certificate of registration shall be renewed for 2024 only if she first presents documented evidence that she has fully complied with all requirements of this Order.

8. That Respondent's compliance with the Continuing Medical Education requirements imposed by Ala. Admin. Code r. 545-X-5 should be audited by the Board for the next five years.

DONE on this the 7th day of July, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-07-07 12:13:38 CDT

Craig H. Christopher, M.D.
its Chairman

EXHIBIT U

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **v.** **ANDRÉ VONTRAL HAYNES, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-044**

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This is a contested reinstatement proceeding under Ala. Code § 34-24-337. The Medical Licensure Commission of Alabama held a hearing in this matter on June 28, 2023. After receiving and considering all of the relevant evidence and argument, we find that the Alabama Board of Medical Examiners ("the Board") proved up three of its four counts, and that Dr. Haynes' license to practice medicine in Alabama should be reinstated to full and unrestricted status and simultaneously disciplined as set out below.

I. Introduction and Statement of the Case

The respondent in this case is André Vontral Haynes, M.D. (hereinafter "Respondent"). Respondent was first licensed by the Commission on or about September 12, 2008, having been issued license no. MD.29119. The Board's

opposition to the reinstatement of Respondent's license centers on Respondent's failure to renew his license at the end of 2021, his continuing to practice medicine and prescribe controlled substances in Alabama for at least the ensuing year, and on alleged misrepresentations Respondent made on his annual license renewal applications from 2014 through 2021.

II. Procedural History

Respondent failed to renew his license to practice medicine in Alabama in late 2021. His license therefore became inactive on December 31, 2021. On or about January 23, 2023, Respondent applied for reinstatement pursuant to Ala. Code § 34-24-337. On March 27, 2023, the Board, as prescribed in Ala. Code § 34-24-337(e), filed its "Notice of Intent to Contest Reinstatement." On April 26, 2023, as prescribed in Ala. Code § 34-24-337(g), the Board filed its Administrative Complaint setting forth the specific grounds for its opposition to reinstatement of Respondent's license (the "Administrative Complaint").

The Administrative Complaint contains four counts. Count One alleges that Respondent is guilty of fraud in applying for or procuring a license to practice medicine in Alabama in violation of Ala. Code § 34-24-360(1), in that, from 2014 through 2021, he denied the existence of criminal charges against him on his annual license renewal applications. Count Two—based on the same operative facts as Count One—similarly alleges that Respondent made fraudulent or untrue statements

in violation of Ala. Code § 34-24-360(17). In Count Three, the Board alleges that Respondent is guilty of unprofessional conduct, in violation of Ala. Code § 34-24-360(2) and -51, because he practiced medicine in Alabama during 2022 without a valid medical license. And in Count Four, the Board alleges that Respondent committed unprofessional conduct by "knowingly and intentionally" continuing to write prescriptions for patients in Alabama between February 7 and February 24, 2023—a period of time in which Respondent not only lacked a license to practice medicine in Alabama, but also had been warned by the Board to stop doing so.

On June 28, 2023, we conducted a full evidentiary hearing on these charges as prescribed in Ala. Admin. Code r. 545-X-3. The case opposing reinstatement was presented by the Board through its attorneys Wilson Hunter and Alicia Harrison. Respondent appeared without counsel. Pursuant to Ala. Admin. Code r. 545-X-3-.08, the Honorable William R. Gordon presided as Hearing Officer. Each side was offered the opportunity to present evidence and argument in support of its respective contentions, and to cross-examine the witnesses presented by the other side. After careful review, we have made our own independent judgments regarding the weight and credibility to be afforded to the evidence, and the fair and reasonable inferences to be drawn from it. Having done so, and as prescribed in Ala. Code § 41-22-16, we enter the following Findings of Fact and Conclusions of Law.

III. Findings of Fact

We find the following facts to be established by the preponderance of the admissible and probative evidence presented at the hearing.

1. Respondent was first licensed by the Commission on or about September 12, 2008, having been issued license no. MD.29119.

2. Respondent lives in a suburb of Atlanta, Georgia. To the extent relevant to these proceedings, Respondent's medical practice primarily consists of providing telemedicine-based addiction medicine services to patients suffering from opioid dependency.

3. Respondent failed to renew his license to practice medicine in Alabama at the end of 2021. As a result, Respondent's medical license and his Alabama Controlled Substances Certificate ("ACSC") became inactive by operation of law on December 31, 2021.

4. Respondent continued to provide treatment to patients located in Alabama during 2022, even though he did not have an active license to do so. Respondent also continued to write prescriptions for patients in Alabama during 2022, including prescriptions for controlled substances, although he did not have an active ACSC. Specifically, during 2022, Respondent's Prescription Drug Monitoring Program ("PDMP") Prescriber Activity Report shows—and Respondent

admits—that he wrote over 200 prescriptions for controlled substances to approximately 20 different patients in Alabama during 2022. (BME Exhibit 13.)

5. On February 7, 2023, a representative of the Board contacted Respondent by phone and informed him that he did not have a license to practice medicine in Alabama, and that he should adapt his behavior accordingly.

6. It appears that, between February 7 and 24, 2023, Respondent limited his provision of telemedicine services to fewer than 10 Alabama residents.

7. On November 9, 2013, Respondent was arrested by the Chattanooga, Tennessee Police Department, and was charged with domestic assault, a misdemeanor under Tennessee law.[1] (BME Exhibit 2.)

8. On January 2, 2014, Respondent was arrested in Cobb County, Georgia, and was charged with violation of a family violence order, a misdemeanor under Georgia law. The January 2, 2014 charge—later amended to disorderly conduct—arose out of Respondent's alleged violation of a no-contact order that was allegedly entered as part of the Chattanooga arrest. (BME Exhibit 3.)

9. In Alabama, a license to practice medicine must be renewed every year. *See* Ala. Code § 34-24-337(a) ("Every person licensed to practice medicine or

[1] This case involves only Respondent's *failure to disclose* these arrests and charges. The Board has made no allegations, and we make no determinations, about the verity of these charges, nor about the extent to which these incidents reflect upon Respondent's ability to practice medicine with reasonable skill and safety to patients.

osteopathy in the State of Alabama shall, on or before December 31 of each succeeding year, apply to the commission for renewal of a certificate of registration which shall be effective during the next calendar year.").

10. In each annual license renewal application for license renewal years 2014, 2015, 2016, and 2017, Respondent was asked the question, "Have you been charged with any offense (felony/misdemeanor) within the past year?" (BME Exhibits 4, 5, 6, 7.) In response to each such question, Respondent answered "No." (*Id.*)

11. For license renewal years 2018, 2019, 2020, and 2021, Respondent was asked the question, "Since your last renewal: Have you been 'charged' with 'any' criminal offense (felony or misdemeanor) (This includes driving under the influence (DUI), even if you were convicted of a lesser offense)?" (BME Exhibits 8, 9, 10, 11.) In response to each such question, Respondent answered "No." (*Id.*)

12. Respondent's negative answers for the years 2014 and 2015 were untrue. When Respondent applied for renewal of his Alabama medical license for 2014, he had just recently been arrested and charged with domestic assault in Hamilton County, Tennessee. And when Respondent applied for renewal of his license for 2015, he had been charged during the preceding year with disorderly conduct in Cobb County, Georgia.

IV. Conclusions of Law

1. The Medical Licensure Commission of Alabama has jurisdiction over the subject matter of this cause pursuant to Act No. 1981-218, Ala. Code §§ 34-24-310, *et seq*. Under certain conditions, the Commission "shall have the power and duty to suspend, revoke, or restrict any license to practice medicine or osteopathy in the State of Alabama or place on probation or fine any licensee." Ala. Code § 34-24-360.

2. The Commission also has power to order reinstatement, or, in appropriate circumstances, to deny reinstatement, of licenses to practice medicine in Alabama. In a contested reinstatement proceeding such as this one, the Commission has discretion to reinstate, deny reinstatement, or to reinstate a license and simultaneously impose disciplinary conditions on the license:

> The commission may deny reinstatement of a license upon a finding that the applicant has committed any of the acts or offenses set forth in Sections 34-24-360, 34-24-57, 16-47-128, or any other provision of law establishing grounds for the revocation, suspension, or discipline of a license to practice medicine. **In addition, the commission may reinstate the license and impose any penalty, restriction, or condition of probation provided for in subsection (h) of Section 34-24-361 and Section 34-24-381 as the commission deems necessary to protect the public health and the patients of the applicant.** If, at the conclusion of the hearing, the commission determines that no violation has occurred, the license of the applicant shall be reinstated.

Ala. Code § 34-24-337(h) (emphasis added).

3. Respondent was properly notified of the time, date and place of the administrative hearing and of the charges against him in compliance with Ala. Code §§ 34-24-361(e) and 41-22-12(b)(1), and Ala. Admin. Code r. 545-X-3-.03(3), (4). At all relevant times, Respondent was a licensee of this Commission (or was practicing medicine without a license) and was and is subject to the Commission's jurisdiction.

4. Under Alabama law, the practice of medicine occurs where the patient is physically located. *See* Ala. Code § 34-24-703(c) ("The provision of telehealth medical services is deemed to occur at the patient's originating site within this state.").

5. A license to practice medicine in Alabama is subject to discipline when it is shown that the licensee has engaged in "[f]raud in applying for or procuring a certificate of qualification to practice medicine or osteopathy or a license to practice medicine or osteopathy in the State of Alabama." Ala. Code § 34-24-360(1). The evidence presented at the hearing establishes that Respondent violated Ala. Code § 34-24-360(1), in that, on his 2014 and 2015 license renewal applications, Respondent falsely denied the existence of criminal charges against him during the preceding years.

6. A license to practice medicine in Alabama is subject to discipline when it is shown that the licensee has "[made] any fraudulent or untrue statement to the

commission or to the State Board of Medical Examiners." Ala. Code § 34-24-360(17). The evidence presented at the hearing similarly establishes that Respondent violated Ala. Code § 34-24-360(17), in that, on his 2014 and 2015 license renewal applications, Respondent falsely denied the existence of criminal charges against him during the preceding years.

7. A license to practice medicine in Alabama is subject to discipline when it is shown that the licensee has engaged in "[u]nprofessional conduct as defined herein or in the rules and regulations promulgated by the commission." Ala. Code § 34-24-360(2). Any violation of the rules of the Board or Commission *prima facie* constitutes "unprofessional conduct," Ala. Admin. Code r. 545-X-4-.06(22), and our rules require that "[e]very person licensed to practice medicine shall apply to the Commission, on or before December 31 of each succeeding year for a certificate of registration." Ala. Admin. Code r. 545-X-2-.03(1). Moreover, it is a Class C felony to practice medicine in Alabama without a license. *See* Ala. Code § 34-24-51. The evidence presented at the hearing establishes that Respondent violated Ala. Code § 34-24-360(2), in that, from approximately January 1, 2022 through at least February 7, 2023, he practiced medicine and prescribed controlled substances in the State of Alabama at least 200 times without a valid license to do so.

8. Based on the evidence presented at the hearing, the Commission is unable to conclude that Respondent violated Ala. Code § 34-24-360(2) by practicing medicine in Alabama between February 7 and February 24, 2023.

V. Decision

Based on all of the foregoing, it is **ORDERED, ADJUDGED, AND DECREED:**

1. That the Respondent, André Vontral Haynes, M.D., is adjudged **GUILTY** of violating Ala. Code § 34-24-360(1) as charged in Count One of the Administrative Complaint.

2. That the Respondent, André Vontral Haynes, M.D., is adjudged **GUILTY** of violating Ala. Code § 34-24-360(17) as charged in Count Two of the Administrative Complaint.

3. That the Respondent, André Vontral Haynes, M.D., is adjudged **GUILTY** of violating Ala. Code §§ 34-24-51 and -360(2) as charged in Count Three of the Administrative Complaint.

4. That the Respondent, André Vontral Haynes, M.D., is adjudged **NOT GUILTY** of violating Ala. Code § 34-24-360(2), as charged in Count Four of the Administrative Complaint.

5. That Respondent's license to practice medicine in the State of Alabama is hereby **REINSTATED** to full and unrestricted status, and is simultaneously disciplined as follows:

a. Respondent's license to practice medicine in the State of Alabama is **REPRIMANDED.**

b. Respondent is **ASSESSED** an administrative fine in the amount of five thousand dollars ($5,000.00) as to Count One, five thousand dollars ($5,000.00) as to Count Two, and five thousand dollars ($5,000.00) as to Count Three, separately and severally, for a total administrative fine of fifteen thousand dollars ($15,000.00). In accordance with Ala. Admin. Code r. 545-X-3-.08(8)(d)(i), Respondent is ordered to pay the administrative fine within 30 days of this Order.[2]

c. Respondent is **ORDERED** to complete the following online courses of continuing education offered by the American Society of Addiction Medicine, and shall exhibit proof of completion to the Commission within 90 days of the date of this Order:

[2] "The refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission" may be a separate instance of "unprofessional conduct." *See* Ala. Admin. Code r. 545-X-4-.06(6).

- Evaluation and Treatment of Opioid Use Disorders in Remote Areas with Telemedicine[3]
- Lessons Learned from Buprenorphine Telehealth During COVID-19: A Guide for Providers[4]
- Buprenorphine Bridges: Telehealth Solutions to Mitigate Buprenorphine Barriers[5]
- Engaging Patients & Maximizing Visits through Telemedicine[6]

6. That within 30 days of this Order, the Board shall file its bill of costs as prescribed in Ala. Admin. Code r. 545-X-3-.08(10)(b), and Respondent shall file any objections to the cost bill within 10 days thereafter, as prescribed in Ala. Admin. Code r. 545-X-3-.08(10)(c). The Commission reserves the issue of imposition of costs until after full consideration of the Board's cost bill and Respondent's objections, and this reservation does not affect the finality of this Order. *See* Ala. Admin. Code r. 545-X-3-.08(10)(e).

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[3] https://elearning.asam.org/products/evaluation-and-treatment-of-opioid-use-disorders-in-remote-areas-with-telemedicine

[4] https://elearning.asam.org/products/lessons-learned-from-buprenorphine-telehealth-during-covid-19-a-guide-for-providers

[5] https://elearning.asam.org/products/buprenorphine-bridges-telehealth-solutions-to-mitigate-buprenorphine-barriers

[6] https://elearning.asam.org/products/engaging-patients-maximizing-visits-through-telemedicine

DONE on this the 14th day of July, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-07-14 07:43:27 CDT

Craig H. Christopher, M.D.
its Chairman

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **v.** **MARK A. MURPHY, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2020-248**

FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter came before the Medical Licensure Commission of Alabama for a contested case hearing on June 28, 2023. After receiving and considering all of the relevant evidence and argument, we find the Respondent, Mark A. Murphy, M.D., guilty of the disciplinary charges presented by the Board, and impose professional discipline as set out below.

I. Introduction and Statement of the Case

The respondent in this case is Mark A. Murphy, M.D. ("Respondent"). Respondent was first licensed by the Commission on June 25, 1998, having been issued license No. MD.21871. The disciplinary charges in this case arise out of Respondent's felony criminal convictions for conspiracy to distribute controlled substances and for related health care fraud.

II. Procedural History

On May 8, 2023, the Board filed an Administrative Complaint ("the Administrative Complaint"). The Administrative Complaint contains five counts, each of which alleges that Respondent has been convicted of specified felony criminal offenses in the United States District Court for the Northern District of Alabama, all in violation of Ala. Code § 34-24-360(4).

On June 28, 2023, we conducted an evidentiary hearing on these charges as prescribed in Ala. Admin. Code r. 545-X-3. The case for disciplinary action was presented by the Board through its attorneys E. Wilson Hunter and Alicia M. Harrison. Respondent did not appear, and the hearing was held *in absentia* as authorized by Ala. Code §§ 34-24-361(e)(10) and 41-22-12(d). Pursuant to Ala. Admin. Code r. 545-X-3-.08(1), the Honorable William R. Gordon presided as Hearing Officer. Each side was offered the opportunity to present evidence and argument in support of its respective contentions, and to cross-examine the witnesses presented by the other side (though Respondent, as noted above, declined this opportunity). In accordance with Ala. Code § 41-22-16, we enter the following Findings of Fact and Conclusions of Law.

III. Findings of Fact

1. Respondent failed to controvert any allegation of the Administrative Complaint. Therefore, the factual allegations of paragraphs 1 through 10 of the

Administrative Complaint are deemed to be conclusively established as true for purposes of these proceedings, and are incorporated herein by reference.

2. Respondent was first licensed by the Commission on June 25, 1998, having been issued license No. MD.21871. Respondent's license to practice medicine in Alabama has been inactive since January 1, 2017.

3. On or about March 7, 2023, Respondent was convicted of conspiracy to distribute controlled substances in violation of 21 U.S.C. § 846, a felony, in the case of *United States v. Mark Murphy*, No. 5:20-CR-291-LSC (N.D. Ala.).

4. On or about March 7, 2023, Respondent was convicted of attempt and conspiracy to commit health care fraud in violation of 18 U.S.C. § 1349, a felony, in the case of *United States v. Mark Murphy*, No. 5:20-CR-291-LSC (N.D. Ala.).

5. On or about March 7, 2023, Respondent was convicted of five counts of health care fraud in violation of 18 U.S.C. §§ 1347, 2, all felonies, in the case of *United States v. Mark Murphy*, No. 5:20-CR-291-LSC (N.D. Ala.).

6. On or about March 7, 2023, Respondent was convicted of conspiracy to defraud the United States in violation of 18 U.S.C. § 371, a felony, in the case of *United States v. Mark Murphy*, No. 5:20-CR-291-LSC (N.D. Ala.).

7. On or about March 7, 2023, Respondent was convicted of illegal remunerations involving federal health care programs in violation of 42 U.S.C.

§ 1320a-7b(b)(1) and 18 U.S.C. § 2, a felony, in the case of *United States v. Mark Murphy*, No. 5:20-CR-291-LSC (N.D. Ala.).

IV. Conclusions of Law

1. The Commission has jurisdiction over the subject matter of this cause pursuant to Act No. 1981-218, Ala. Code §§ 34-24-310, *et seq*.

2. Respondent was properly notified of the time, date, and place of the administrative hearing and of the charges against him in compliance with Ala. Code §§ 34-24-361(e) and 41-22-12(b), and Ala. Admin. Code r. 545-X-3-.03(3), (4). At all relevant times, Respondent was a licensee of this Commission and was and is subject to the Commission's jurisdiction.

3. Under certain conditions, the Commission "shall have the power and duty to suspend, revoke, or restrict any license to practice medicine or osteopathy in the State of Alabama or place on probation or fine any licensee." Ala. Code § 34-24-360.

4. Section 34-24-360(4) provides that a physician's license to practice medicine may be suspended, revoked, or otherwise disciplined if the physician is convicted of any felony criminal offense. In such a case, "a copy of the record of conviction, certified to by the clerk of the court entering the conviction, shall be conclusive evidence." Ala. Code § 34-24-360(4).

V. Decision

Therefore, it is **ORDERED, ADJUDGED, AND DECREED:**

1. That the Respondent, Mark A. Murphy, M.D., is adjudged **GUILTY** of conviction of a felony in violation of Ala. Code § 34-24-360(4), as charged in Count One of the Administrative Complaint.

2. That the Respondent, Mark A. Murphy, M.D., is adjudged **GUILTY** of conviction of a felony in violation of Ala. Code § 34-24-360(4), as charged in Count Two of the Administrative Complaint.

3. That the Respondent, Mark A. Murphy, M.D., is adjudged **GUILTY** of conviction of a felony in violation of Ala. Code § 34-24-360(4), as charged in Count Three of the Administrative Complaint.

4. That the Respondent, Mark A. Murphy, M.D., is adjudged **GUILTY** of conviction of a felony in violation of Ala. Code § 34-24-360(4), as charged in Count Four of the Administrative Complaint.

5. That the Respondent, Mark A. Murphy, M.D., is adjudged **GUILTY** of conviction of a felony in violation of Ala. Code § 34-24-360(4), as charged in Count Five of the Administrative Complaint.

6. That, separately and severally as to each of Counts One through Five, the license to practice medicine of Respondent, Mark A. Murphy, M.D., is **REVOKED.**

7. That, separately and severally as to each of counts One through Five, Respondent is **ASSESSED** an administrative fine in the amount of ten thousand dollars ($10,000.00) for each count, for a total administrative fine of fifty thousand dollars ($50,000.00). In accordance with Ala. Admin. Code r. 545-X-3-.08(8)(d)(i), Respondent is **ORDERED** to pay the administrative fine within 30 days of this Order.[1]

8. That within 30 days of this Order, the Board shall file its bill of costs as prescribed in Ala. Admin. Code r. 545-X-3-.08(10)(b), and Respondent shall file any objections to the cost bill within 10 days thereafter, as prescribed in Ala. Admin. Code r. 545-X-3-.08(10)(c). The Commission reserves the issue of imposition of costs until after full consideration of the Board's cost bill and Respondent's objections, and this reservation does not affect the finality of this Order. *See* Ala. Admin. Code r. 545-X-3-.08(10)(e).

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[1] "The refusal or failure by a physician to comply with an order entered by the Medical Licensure Commission" may be a separate instance of "unprofessional conduct." *See* Ala. Admin. Code r. 545-X-4-.06(6).

DONE on this the 7th day of July, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-07-07 12:14:45 CDT

Craig H. Christopher, M.D.
its Chairman