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

October 31, 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
Nina Nelson-Garrett, M.D.
Pamela Varner, M.D.
Howard J. Falgout, M.D.
Paul M. Nagrodzki, M.D.

MEMBERS NOT PRESENT

MLC STAFF

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

BME STAFF

Rebecca Daniels, Investigator
Randy Dixon, Investigator
Amy Dorminey, Operations Director
Greg Hardy, Investigator
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 Lavendar, Investigator
Tiffany Seamon, Director of Credentialing
Christy Stewart, Paralegal

Call to Order: 9:07 a.m.

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

OLD BUSINESS

Minutes September 27, 2023

Commissioner Nagrodzki made a motion that the Minutes of September 27, 2023, be approved. A second was made by Commissioner Alsip. The motion was approved by unanimous vote.

NEW BUSINESS

Full License Applicants

	Name	Medical School	Endorsement
1.	Dylana Moore Adams	University of Alabama School of Medicine Birmingham	USMLE
2.	Charles Zachary Aggen	University of South Alabama College of Medicine	USMLE
3.	Lauren Haley Anderson	Saint Louis University School of Medicine	USMLE
4.	Mitchell Keegan Arbogast	SUNY at Buffalo School of Medicine & Biomedical Science	USMLE/NC
5.	Nadia Bakor	Ross University	USMLE/TX
6.	Ryan Alexander Bear	Alabama College of Osteopathic Medicine	COMLEX
7.	Jullian Stanley Beau	Florida Atlantic Univ Charles E. Schmidt College of Medicine	USMLE/GA
8.	Ron Simon Ben-Meir	Touro U College of Osteopathic Medicine	COMLEX/TX
9.	Christina Mills Birsan	Loma Linda University School of Medicine	USMLE/CA
10.	Sydney B Blankenship	University of Alabama School of Medicine Birmingham	USMLE
11.	Meera S Boppana	Guntur Medical College, Nagarjuna University	FLEX/MA
12.	Sarah Elizabeth Bowman	Florida State University College of Medicine	USMLE
13.	Michaela B McDonald	Charles University the First Faculty of Medicine	USMLE
14.	Richard Joseph Camara	Loma Linda University School of Medicine	USMLE/WI
15.	Yamil Ramon Cardel	Ponce School of Medicine	USMLE/FL
16.	Jeffrey Chris Chang	St Georges University of London	USMLE
17.	Queendaleen Chukwurah	Ebonyi State University College of Health Sciences	USMLE
18.	Jena Lauren Clementi	St Georges University of London	USMLE
19.	Lani Kai Clinton	John A Burns School of Medicine, Univ of Hawaii	USMLE/OR
20.	Roderica Elise Cottrell	University of Louisville School of Medicine	USMLE/GA
21.	Dylan Jon Dangerfield	University of North Dakota School of Medicine & Health Sciences	USMLE
22.	Eric Anthony DeGeare	University of Louisville School of Medicine	USMLE
23.	Madeleine V Dehner	Tulane University School of Medicine	USMLE

	Name	Medical School	Endorsement
24.	Trent Walker Dietsche	Nova Southeastern University College of Medicine	COMLEX/SC
25.	Kendra Mims Douglas	Alabama College of Osteopathic Medicine	COMLEX
26.	Katelyn Ducker	Edward Via College of Osteopathic Medicine, Auburn	COMLEX
27.	Laviel A Fernandez	SUNY at Stony Brook School of Medicine	USMLE/MO
28.	Michael Shay Ferrell	Virginia Commonwealth University School of Medicine	USMLE/NC
29.	Daryl Lee Figa	University of Louisville School of Medicine	NBME/GA
30.	Nathalie Francis	Medical University of the Americas, Nevis	USMLE
31.	Mina M Arnist Ghaly	Ain Shams University Faculty of Medicine	USMLE
32.	Emily Taylor Gullette	University of South Carolina School of Medicine	USMLE
33.	Victoria Maria Hammond	University of Miami Miller School of Medicine	USMLE/MD
34.	Avneet Hans	University of Texas Southwestern Medical Center at Dallas	USMLE
35.	Reagan Haley Hattaway	University of Alabama School of Medicine Birmingham	USMLE
36.	Alicia Carole Hereford	University of South Alabama College of Medicine	USMLE
37.	Amy Jeanette Holland	Brody School of Medicine at East Carolina University	FLEX/NC
38.	John Michael Hoyle	University of Alabama School of Medicine Birmingham	USMLE
39.	Andrew David Hubbs	University of Louisville School of Medicine	USMLE
40.	Patricia JeNell Hughes	Alabama College of Osteopathic Medicine	COMLEX
41.	William Carlisle Jacobs	Augusta University	USMLE/MA
42.	Jasanjeet Jawanda	Dayanand Medical College & Hospital, Punjab University	USMLE/CT
43.	Ciara Corban Jenkins	Eastern Virginia Medical School	USMLE
44.	Sterling McBride Jones	Virginia Commonwealth University School of Medicine	USMLE
45.	Lainie Joffrion Jorns	Louisiana State University Medical Center in Shreveport	USMLE/FL
46.	David Charles Judge	University of Massachusetts Medical School	USMLE/NY
47.	Abdulaziz S A A Khurshed	Univ of Manchester / Univ of St. Andrews School of Medicine	USMLE
48.	Natalie Summers King	University of Alabama School of Medicine Birmingham	USMLE
49.	Pranayraj Kondapally	University of South Alabama College of Medicine	USMLE
50.	Nicole Elaine Lally	St. George's University School of Medicine, Grenada	USMLE
51.	Aaron Robert Landis	University of Alabama School of Medicine Birmingham	USMLE
52.	Nivie V Lasevski	Medical University of the Americas (Nevis)	USMLE
53.	Jacob Garrison Lawing	Augusta University	USMLE
54.	Andrew Ryan Lenzie	University of Alabama School of Medicine Birmingham	USMLE
55.	Yesenia Lopez	University of Alabama School of Medicine Birmingham	USMLE
56.	Jose A Lulli Cantoni	Cayetano Heredia University, Peru	USMLE
57.	Kyle Logan Meggison	Touro Univ College of Osteopathic Medicine	COMLEX/FL
58.	Adam N Miller	Alabama College of Osteopathic Medicine	COMLEX
59.	Paul Jackson Morris	University of Alabama School of Medicine Birmingham	USMLE
60.	Vinay Nagaraj	University of South Carolina School of Medicine	USMLE/GA
61.	Syed Ali Shawn Naqvi	Edward Via Virginia College of Osteopathic Medicine	COMLEX/DE
62.	John Anthony Norton	Chicago College of Osteopathic Medicine	COMLEX/OH
63.	Kevin J Thomas O'Keefe	University of Florida College of Medicine	USMLE
64.	Renu Pandit	University of Alabama School of Medicine Birmingham	USMLE
65.	Madison Brooke Peoples	University of Alabama School of Medicine Birmingham	USMLE

	Name	Medical School	Endorsement
66.	Shelby Swede Phung	University of Mississippi School of Medicine	USMLE
67.	Valeria A Pierluissi Rivera	University of Medicine and Health Sciences, St. Kitts	USMLE
68.	Andrew Stephen Podley	Florida International Univ Herbert Wertheim College of Medicine	USMLE/NV
69.	Christopher Allen Price	University of Mississippi School of Medicine	USMLE
70.	Margaret Rose Puelle	University of Michigan Medical School	USMLE/PA
71.	Shareena Akhi Rahman	University of Virginia School of Medicine	USMLE/NC
72.	Grace Catherine Raines	University of Alabama School of Medicine Birmingham	USMLE/VA
73.	Carl Scott Ramsey	Loma Linda University School of Medicine	USMLE/CA
74.	Priscilla Perez Roberts	University of South Alabama College of Medicine	USMLE
75.	Isaiah Jarell Rolle	Ohio University College of Osteopathic Medicine	COMLEX/GA
76.	Chintan Rupareliya	Smolensk State Medical Academy	USMLE/KY
77.	Neil Robert Seeley	University of Colorado School of Medicine	NBME/CA
78.	Dennis Sehgal	Windsor University	USMLE/IL
79.	Thomas James Shakar	Florida State University College of Medicine	USMLE/NC
80.	Gary B Sinensky	Albert Einstein College of Med of Yeshiva / Rosalind Franklin Univ	NBME/NY
81.	Adia Yasmeen Stokes	Morehouse School Of Medicine	USMLE/AZ
82.	Jon Christian Storey	St Georges University of London	USMLE
83.	Soterios Channing Stroud	Idaho College of Osteopathic Medicine	COMLEX
84.	Tyler Briant Sullivan	University of Mississippi School of Medicine	USMLE
85.	John William Summerville	University of Wisconsin Medical School	NBME/VA
86.	Muhammad Tahir	Shandong Medical University	USMLE
87.	Benjamin J. Taylor	Edward Via College of Osteopathic Medicine-Auburn campus	COMLEX
88.	Amy Theriault	University of Pikeville Kentucky College of Osteopathic Medicine	COMLEX
89.	Abraham M Titus	Avalon University School of Medicine	USMLE
90.	Enrique Vazquez Mendez	University of Medicine and Health Sciences, St. Kitts	USMLE
91.	Gregory Ventrelli	University of Connecticut School of Medicine	USMLE
92.	Devon Gerhard Wade	Univ of Tennessee Health Science Center College of Medicine	USMLE
93.	Samuel Waling	Lincoln Memorial Univ Debusk College of Osteopathic Medicine	COMLEX/GA
94.	Sarah Elizabeth Waling	Lincoln Memorial Univ Debusk College of Osteopathic Medicine	COMLEX/GA
95.	Gisella A M Ward	University of South Alabama College of Medicine	USMLE
96.	David Mark Warnky	University of Kansas School of Medicine Wichita	USMLE
97.	Philip Samir Wasef	Florida International Univ Herbert Wertheim College of Medicine	USMLE/FL
98.	Jocelyn Denise Wilson	University of North Carolina School at Chapel Hill	USMLE/WA
99.	William Alan Woolery	Oklahoma State University College of Osteopathic Medicine Tulsa	COMLEX/MI
100.	Amia Elizabeth Yamane	Mahidol University, Faculty of Medicine, Siriraj Hospital	USMLE
101.	Jenifer Lin Yeh	Alabama College of Osteopathic Medicine	COMLEX
102.	Benjamin C. Akosa	University of Nigeria College of Medicine	USMLE/GA
103.	Michael E. Minev	Ben-Gurion University of Negev	USMLE/AZ
104.	*Maxfield W. Delap	Alabama College of Osteopathic Medicine	COMLEX
105.	*Omar L. Hamada	Univ of Tennessee Health Science Center College of Med	NBME/TN
106.	*Rebecca L. Massey	University of Alabama School of Medicine Birmingham	USMLE
107.	*Aaron B. Stuber	University of Alabama School of Medicine Birmingham	USMLE

Name	Medical School	Endorsement
108.Ethan Kellum	Univ of Tennessee Health Sciences Center College of Med	USMLE/MA
109.Jane T. Ly	University of Arizona College of Medicine	USMLE/CA
110.Nawaf A. Al-Hashemi	Gulf Medical College Ajman	USMLE/MO
111.*Steven H. Randolph	Chicago College of Osteopathic Medicine	COMLEX/NJ
112.Donald Lee Miller	University of Iowa Carver College of Medicine	FLEX

**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 one hundred twelve (1-112) for full licensure. The motion was approved by unanimous vote.

Limited License Applicants

	Name	Medical School	Endorsement	Location	License
1.	Ammar A Al Heyasat	Hashemite Univ Faculty of Medicine	LL/AL	Crestwood IM	R
2.	Humna Ellahi	University of Health Sciences Lahore	LL/AL	North AL Shoals Psychiatry	R
3.	David L Goldblatt	UT Medical School at Galveston	LL/AL	Thomas Hospital IM	R
4.	Donald Kosol Groves	U of Miami Miller School of Medicine	LL/AL	UAB Birmingham Surgery	F
5.	Juan Hernandez Segura	Francisco Marroquin University	LL/AL	USA Health Pediatrics	R
6.	Kristen Gail Hunt	Lincoln Mem U Debusk C of Osteo Med	LL/AL	UAB Huntsville IM	R
7.	Sally Hussein Hussein	Ain Shams Univ Faculty of Medicine	LL/AL	Crestwood IM	R
8.	Fadi Ibrahim	American University of Antigua	LL/AL	Baptist Montgomery FM	R
9.	Iyare Idiakhoa	University of Lagos	LL/AL	Thomas Hospital IM	R
10.	Sudhir Suggala	Mysore Medical College, Mysore Univ	LL/AL	USA Complex Spine Fellowship	F
11.	Kaushal A Upadhyay	BJ Medical College, Ahmedabad	LL/AL	UAB Birmingham Ortho Surg	VP

A motion was made by Commissioner Alsip with a second by Commissioner Morris to approve applicant numbers one through eleven (1-11) for limited 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 September 1, 2023, through September 30, 2023. A copy of this report is attached as Exhibit "A".

APPLICANTS FOR REVIEW

Kristin Dobay, M.D.

A motion was made by Commissioner Alsip with a second by Commissioner Morris to defer any action on Dr. Dobay's application until the November 20, 2023 Commission meeting. The motion was approved by unanimous vote.

Richard Mesco, D.O.

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

REPORTS

Physician Monitoring Report

The Commission received as information the physician monitoring report dated October 24, 2023. A copy of the report is attached as Exhibit "B".

DISCUSSION ITEMS

2024 MLC Meeting Calendar

A motion was made by Commissioner Aldridge with a second by Commissioner Morris to adopt the proposed 2024 MLC meeting calendar with the following amendments: the March 27, 2024 meeting date changed to March 28, 2024, and the May 22, 2024 meeting date changed to May 29, 2024. The motion was approved by unanimous vote. A copy of the adopted meeting calendar is attached hereto as Exhibit "C".

BME Rule for Publication: 540-X-1-.16, 540-X-7-.15, 540-X-7, Appendix A; Rules for Collaborative Practice

The Commission received as information the BME Rule for Publication: 540-X-1-.16, 540-X-7-.15, 540-X-7, Appendix A; Rules for Collaborative Practice. A copy of the rule is attached hereto as Exhibit "D".

FSMB Call for Comments: Strategies for Prescribing Opioids for the Management of Pain

The Commission received as information the FSMB Call for Comments: Strategies for Prescribing Opioids for the Management of Pain. Commission Chairman Christopher requested this

item be placed on the November 20, 2023 agenda for further consideration. A copy of the memorandum is attached hereto as Exhibit "E".

FSMB Call for Nominations

The Commission received as information the FSMB Call for Nominations memorandum. A copy of the memorandum is attached hereto as Exhibit "F".

FSMB Call for Award Nominations

The Commission received as information the FSMB Call for Award Nominations memorandum. A copy of the memorandum is attached hereto as Exhibit "G".

ADMINISTRATIVE FILINGS

Steven Wayne Powell, M.D.

The Commission received as information the Administrative Suspension of Dr. Powell's Alabama medical license. Pursuant to provisions of Section 10(d) of the Interstate Medical Licensure Compact and codified at Ala. Code §34-24-529(d), Dr. Powell's Alabama medical license was administratively suspended for a period of 90 days beginning August 28, 2023. A copy of the Administrative Suspension is attached hereto as Exhibit "H".

John Butler Blalock, Jr., M.D.

The Commission received as information the Notice of Intent to Contest Reinstatement filed by the Alabama State Board of Medical Examiners. A copy of the Notice of Intent to Contest Reinstatement is attached hereto as Exhibit "I".

The Commission received as information the Motion to Withdraw Notice of Intent to Contest Reinstatement filed by the Alabama State Board of Medical Examiners. A copy of the motion is attached hereto as Exhibit "J".

Carl Edward Albertson, M.D.

The Commission received a Joint Settlement Agreement and Consent Order between Dr. Albertson and the Alabama State Board of Medical Examiners. A motion was made by Commissioner Alsip with a second by Commissioner Aldridge 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 "K".

Keith M. Harrigill, M.D.

The Commission received a Joint Settlement Agreement and Consent Order between Dr. Harrigill 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 "L".

Brian J. Tierney, M.D.

The Commission received a Joint Settlement Agreement and Consent Order between Dr. Tierney 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 "M".

Nefertiti Durant, M.D.

The Commission received as information a Motion to Continue Hearing regarding the Administrative Complaint filed by the Alabama State Board of Medical Examiners. A copy of the Motion to Continue Hearing is attached hereto as Exhibit "N".

Richard Jones, M.D.

The Commission received as information Dr. Jones' answer to the Administrative Complaint filed by the Alabama State Board of Medical Examiners. A copy of the Answer is attached hereto as Exhibit "O".

At 9:40 a.m., the Commission entered closed session pursuant to Alabama Code § 34-24-361.1 to hear and consider the following matters:

CAK

HEARINGS

Nefertiti Durant, M.D.

The Commission received a proposed Joint Settlement Agreement filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Nagrodzki with a second by Commissioner Morris to approve 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 "P".

Shakir Raza Meghani, M.D.

The Commission received a proposed Joint Settlement Agreement filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Alsip with a second by Commissioner Aldridge to defer action until the Commission's November 20, 2023 meeting to allow time to receive and review additional information. The motion was approved by unanimous vote.

Thomas Paul Alderson, M.D.

A motion was made by Commissioner Nelson-Garrett with a second by Commissioner Falgout to approve the Three-Member Panel's Recommended Findings of Fact and Conclusions of Law. The motion was approved by unanimous vote, with Commissioner Alsip abstaining from the vote. A copy of the Commission's order is attached hereto as Exhibit "Q".

Rodney Lowell Dennis, M.D.

A motion was made by Commissioner Alsip with a second by Commissioner Morris 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 hereto as Exhibit "R".

Tarik Y. Farrag, M.D.

A motion was made by Commissioner Alsip with a second by Commissioner Aldridge to enter an order directing the court reporter to complete and correct the transcripts from the Commission's August 23, 2023 hearing of Case No. 2023-023. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "S".

Lauren Elizabeth Duensing, M.D.

A motion was made by Commissioner Aldridge with a second by Commissioner Morris to approve the proposed Consent Decree drafted by Aaron Dettling, MLC General Counsel, and endorsed by both Dr. Duensing and the Board. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "T".

Meeting adjourned at 10:54 p.m.

PUBLIC MEETING NOTICE: The next meeting of the Alabama Medical Licensure Commission was announced for Monday, November 20, 2023, beginning at 9:00 a.m.

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

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

11/20/2023
Date Signed

EXHIBIT A

IMLCC Licenses Issued September 1, 2023 - September 30, 2023 (98)

Name	License Type	License Number	Status	Issue Date	Expiration Date	State of Principal Licensure
Jimmy Y Saade	MD	47277	Active	9/6/2023	12/31/2023	Arizona
Robert Murphy Portley	MD	47280	Active	9/6/2023	12/31/2023	Arizona
Homan Mostafavi	DO	3422	Active	9/20/2023	12/31/2023	Arizona
Ronald Joseph Boucher	MD	47325	Active	9/21/2023	12/31/2023	Arizona
Glen Joseph McCracken	MD	47329	Active	9/21/2023	12/31/2023	Arizona
Andrew Douglas Schatzki	MD	47330	Active	9/21/2023	12/31/2023	Arizona
Carl Bronitsky	MD	47341	Active	9/26/2023	12/31/2024	Arizona
Husain Haiderali Danish	MD	47282	Active	9/6/2023	12/31/2023	Colorado
Meredith McDermott	MD	47292	Active	9/8/2023	12/31/2023	Colorado
Leslie R Pickens	MD	47308	Active	9/18/2023	12/31/2023	Colorado
Alex Foxman	MD	47312	Active	9/18/2023	12/31/2023	Colorado
Melissa R Coomes	MD	47404	Active	9/27/2023	12/31/2023	Colorado
Nyabilondi Huguette Ebama	MD	47278	Active	9/6/2023	12/31/2023	Georgia
Kenneth MacLeod Rice	MD	47284	Active	9/7/2023	12/31/2024	Georgia
Toni Kim	MD	47297	Active	9/13/2023	12/31/2023	Georgia
Ilene April Grossman	MD	47302	Active	9/14/2023	12/31/2023	Georgia
Kimberlynn Rochelle Richards	MD	47318	Active	9/19/2023	12/31/2024	Georgia
Marshall Lawrence Nash	MD	47323	Active	9/20/2023	12/31/2024	Georgia
Emily Janine Ross	MD	47332	Active	9/26/2023	12/31/2023	Georgia
Taniqua Alexander Miller	MD	47348	Active	9/27/2023	12/31/2023	Georgia
Mark Gerald Neerhof	DO	3415	Active	9/11/2023	12/31/2023	Illinois
Arooba Khalid Almas	DO	3419	Active	9/18/2023	12/31/2023	Illinois
Preyanshu Mukesh Parekh	DO	3421	Active	9/19/2023	12/31/2023	Illinois
Jenna Christine Goeckner	MD	47320	Active	9/19/2023	12/31/2023	Illinois
Daniel Philip Owens	MD	47327	Active	9/21/2023	12/31/2023	Illinois
Sepideh Farzin Moghadam	MD	47285	Active	9/7/2023	12/31/2024	Indiana
Kyla Renae Pyko	DO	3416	Active	9/14/2023	12/31/2023	Indiana
Toihunta Stubbs	MD	47305	Active	9/15/2023	12/31/2023	Kentucky
Jonathan Daniel Mizrahi	MD	47275	Active	9/6/2023	12/31/2023	Louisiana
William Andrew Loe	MD	47290	Active	9/8/2023	12/31/2023	Louisiana
Nabeel Saghir	MD	47322	Active	9/20/2023	12/31/2023	Louisiana

Dawit Mihretie Wubie	MD	47300	Active	9/14/2023	12/31/2023	Maryland
Jennifer Parnaz Huckabee	MD	47303	Active	9/14/2023	12/31/2023	Maryland
Jamil S Muasher	MD	47309	Active	9/18/2023	12/31/2023	Maryland
Yuyang Zhang	MD	47324	Active	9/20/2023	12/31/2024	Maryland
Govind Jivanda Seth	MD	47416	Active	9/27/2023	12/31/2023	Maryland
Nicholaus Arthur Josey	MD	47296	Active	9/12/2023	12/31/2023	Michigan
Michelle Marie Keeley	MD	47307	Active	9/15/2023	12/31/2023	Michigan
Kevin Paul Gerlach	DO	3417	Active	9/18/2023	12/31/2024	Michigan
Nasser Lakkis	MD	47314	Active	9/18/2023	12/31/2024	Michigan
Kevin Lee Sijansky	MD	47286	Active	9/7/2023	12/31/2023	Mississippi
Michael Timur Salman	MD	47326	Active	9/21/2023	12/31/2023	Mississippi
Scott Haddon McLeod	MD	47342	Active	9/26/2023	12/31/2023	Mississippi
Dabbs Curley	MD	47350	Active	9/27/2023	12/31/2023	Mississippi
Rajesh Laxmi Gade	MD	47328	Active	9/21/2023	12/31/2023	Montana
Abhishek Singh	MD	47281	Active	9/6/2023	12/31/2023	Nebraska
Minden Catherine Collamore	DO	3411	Active	9/6/2023	12/31/2023	Ohio
Thomas Richard Murray	DO	3412	Active	9/6/2023	12/31/2023	Ohio
Joel Simon David	DO	3414	Active	9/8/2023	12/31/2023	Ohio
Rebecca R Schlachet	DO	3420	Active	9/19/2023	12/31/2023	Ohio
Robert Stanley Burcham	MD	47273	Active	9/1/2023	12/31/2023	Tennessee
Michelle Cowden Sharpe	MD	47288	Active	9/7/2023	12/31/2024	Tennessee
Travis Scott Shivers	MD	47291	Active	9/8/2023	12/31/2023	Tennessee
Andrea A Birch	MD	47321	Active	9/20/2023	12/31/2024	Tennessee
Steven Groke	MD	47331	Active	9/25/2023	12/31/2023	Tennessee
Rohan Vidyadhar Chitale	MD	47333	Active	9/26/2023	12/31/2024	Tennessee
Brad R Cohen	MD	47420	Active	9/28/2023	12/31/2023	Tennessee
Christina Lynn Roland	MD	47276	Active	9/6/2023	12/31/2023	Texas
Rebecca A Snyder	MD	47279	Active	9/6/2023	12/31/2023	Texas
Michelle K Horton	DO	3413	Active	9/6/2023	12/31/2023	Texas
Jeaneen Antoinette Chappell	MD	47283	Active	9/6/2023	12/31/2023	Texas
Blake Henchcliffe	MD	47287	Active	9/7/2023	12/31/2023	Texas
Brian Dean Badgwell	MD	47289	Active	9/8/2023	12/31/2023	Texas
Syed Farrukh Hasan Jafri	MD	47293	Active	9/11/2023	12/31/2023	Texas
Larissa Alejandra Meyer	MD	47294	Active	9/11/2023	12/31/2023	Texas

Karin Hoang Woodman	MD	47295	Active	9/11/2023	12/31/2023	Texas
DiAnne Sherill Davis	MD	47298	Active	9/13/2023	12/31/2023	Texas
Nizar Chafic Charafeddine	MD	47304	Active	9/15/2023	12/31/2023	Texas
Karen Marie Moody	MD	47313	Active	9/18/2023	12/31/2023	Texas
Jean-Bernard Durand	MD	47315	Active	9/18/2023	12/31/2023	Texas
John Michael Skibber	MD	47316	Active	9/18/2023	12/31/2023	Texas
Gwyn Richardson	MD	47319	Active	9/19/2023	12/31/2023	Texas
Maureen Handoko-Yang	MD	47334	Active	9/26/2023	12/31/2023	Texas
Bilal Mustafa	MD	47335	Active	9/26/2023	12/31/2023	Texas
Amin Majid Alousi	MD	47336	Active	9/26/2023	12/31/2023	Texas
Mehmet Altan	MD	47337	Active	9/26/2023	12/31/2023	Texas
Sarah Baxter Fisher	MD	47338	Active	9/26/2023	12/31/2023	Texas
Qaiser Bashir	MD	47339	Active	9/26/2023	12/31/2023	Texas
John Warren Davis	MD	47340	Active	9/26/2023	12/31/2023	Texas
Natalie Janine Miriam Dailey Garnes	MD	47343	Active	9/27/2023	12/31/2023	Texas
Uday Rameshchandra Popat	MD	47344	Active	9/27/2023	12/31/2023	Texas
Anne Szu I Tsao	MD	47345	Active	9/27/2023	12/31/2023	Texas
Steven Jay Frank	MD	47346	Active	9/27/2023	12/31/2023	Texas
Timothy Newhook	MD	47347	Active	9/27/2023	12/31/2023	Texas
Rafael Nicholas Favela IV	MD	47349	Active	9/27/2023	12/31/2023	Texas
Fareed Khawaja	MD	47429	Active	9/28/2023	12/31/2023	Texas
Jennifer Ann Wargo	MD	47430	Active	9/28/2023	12/31/2023	Texas
Richard Eugene Champlin	MD	47431	Active	9/28/2023	12/31/2023	Texas
Mustafa Tai	MD	47432	Active	9/29/2023	12/31/2023	Texas
Susan Lynne McGovern	MD	47434	Active	9/29/2023	12/31/2023	Texas
Elie Mouhayar	MD	47435	Active	9/29/2023	12/31/2023	Texas
Ronald Stephen Beloy Doria	MD	47310	Active	9/18/2023	12/31/2023	Utah
Jessica Carolyn Schlicher	MD	47301	Active	9/14/2023	12/31/2023	Washington
Pavel Conovalciuc	MD	47306	Active	9/15/2023	12/31/2023	Washington
Rana Nauman Ahmad	MD	47311	Active	9/18/2023	12/31/2024	Washington
Daniel L Christensen	MD	47433	Active	9/29/2023	12/31/2023	Washington
Kelly Elizabeth Allen-Lopez	DO	3418	Active	9/18/2023	12/31/2023	West Virginia
Grace Elizabeth Hunter	MD	47299	Active	9/14/2023	12/31/2023	Wyoming

**Total licenses issued since April 2017 - 3,343*

EXHIBIT B

STATE *of* ALABAMA
MEDICAL LICENSURE COMMISSION

To: Medical Licensure Commission

From: Nicole Hardy

Subject: October Physician Monitoring Report

Date: 10/24/2023

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

Physician:	**Scott Hull Boswell, M.D.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	12/1/2014
License Status:	Active
Requirements:	Therapist Report Check PDMP
Received:	Therapist Report PDMP Compliant

Physician:	**Dylan E. Caggiano, D.O.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	12/3/2021
License Status:	Active
Requirements:	APHP Report
Received:	Report from Rob Hunt with supporting documents

Physician:	**Ronald Edwin Calhoun, M.D.**
Order Type:	BME/MLC
Due Date:	Quarterly
Order Date:	3/25/2014
License Status:	Active
Requirements:	APHP Report
Received:	Report from Rob Hunt with supporting documents

Physician:	**Daniel Clanton Clower, M.D.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	1/22/2015
License Status:	Active
Requirements:	Limited Prescribing
	Worksite report from Dr. Park T. Chittom
Received:	PDMP Complaint
	Report from Dr. Chittom

Physician:	**Ran Halleluyan, M.D.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	9/28/2022
License Status:	Active-Restricted
Requirements:	Psychiatrist Report
Received:	Report from Dr. Harold Veits

Physician:	**Mark Koch, D.O.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	10/25/2022
License Status:	Active-Restricted
Requirements:	APHP Report
	CPEP Compliance Report
Received:	Report from Rob Hunt with supporting documents
	Compliance Email from CPEP

Physician:	**Barry Neal Lumpkins, M.D.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	No order in place
License Status:	Active
Requirements:	Check PDMP Quarterly
Received:	PDMP Compliant

Physician:	**Edith Helga Gubler McCreadie, M.D.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	9/10/2019
License Status:	Active-Probation
Requirements:	Limited Prescribing
Received:	PDMP Complaint

Physician:	**Frances Delaine Salter, M.D.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	10/4/2005
License Status:	Active
Requirements:	APHP Report
Received:	Report from Rob Hunt with supporting documents

Physician:	**Hobert James Sharpton, D.O.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	No order in place
License Status:	Active
Requirements:	Check PDMP Quarterly
Received:	PDMP Compliant

Physician:	**Colin G. Stafford, M.D.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	2/24/2021
License Status:	Active
Requirements:	APHP Report
Received:	Report from Rob Hunt with supporting documents

Physician:	**Janie T. Bush Teschner, M.D.**
Order Type:	BME/MLC
Due Date:	Other
Order Date:	4/19/2023
License Status:	Active-Probation
Requirements:	APHP Report Practice Plan Limited Practice (Pending practice place approval) Therapist Report AA/NA Meetings CME
Received:	Report from Rob Hunt with supporting documents

Physician:	**Charles R. Thompson, M.D.**
Order Type:	MLC
Due Date:	Quarterly
Order Date:	10/27/2021
License Status:	Active
Requirements:	Check PDMP Quarterly
Received:	PDMP Compliant

EXHIBIT C

Alabama Medical Licensure Commission

2024

Medical Licensure Commission meetings begin at 9:00 a.m. in Montgomery.

All dates are subject to change.

Important Dates
MLC Meeting Days
BME Meeting Days
BME/MLC Holiday Schedule

January

S	M	T	W	T	F	S
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

February

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11	12	13	14	15	16	17
18	19	20	21	22	23	24
25	26	27	28	29		

March

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24	25	26	27	28	29	30
31						

April

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28	29	30				

May

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26	27	28	29	30	31	

June

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23	24	25	26	27	28	29
30						

July

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28	29	30	31			

August

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25	26	27	28	29	30	31

September

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15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

October

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13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

November

S	M	T	W	T	F	S
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17	18	19	20	21	22	23
24	25	26	27	28	29	30

December

S	M	T	W	T	F	S
1	2	3	4	5	6	7
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15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	31				

Adopted: 10/31/2023

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: October 19, 2023

Re: Administrative Rules Approved for Publication

The Board of Medical Examiners, at its meeting October 19, 2023, approved the following rules to be published for public comment in the *Alabama Administratively Monthly*:

- Administrative Rule 540-X-1-.16, *Fees Associated with Collaborative Practices*
- Administrative Rule 540-X-7-.15, *Registration – Physician Assistant*
- Administrative Rule 540-X-7, Appendix A, *Application for Registration of Physician Assistant*

The Advanced Practice Providers Department identified needed changes to rules to elicit information regarding a collaborating/supervising physician's board certification and postgraduate education information in order to determine eligibility.

Additionally, a change is requested to the P.A. registration agreement to ask whether there will be practice under a limited protocol, and if so, to request submission of the applicable limited protocol form.

With an expected publication date of October 31, 2023, the public comment period ends December 5, 2023. The anticipated effective date is February 12, 2024.

Attachments:

Administrative Rule 540-X-1-.16, *Fees Associated with Collaborative Practices*
Administrative Rule 540-X-7-.15, *Registration – Physician Assistant*
Administrative Rule 540-X-7, Appendix A, *Application for Registration of Physician Assistant*

540-X-1-.16 Fees Associated with Collaborative Practices.

(1) Fee for New Collaborative Practice:

(a) At the time a physician enters into a collaborative practice agreement with a Certified Registered Nurse Practitioner (CRNP) or a Certified Nurse Midwife (CNM), for the purpose of registering the collaborative practice, an initial commencement fee in the amount of Two Hundred Dollars ($200.00) and a completed collaborative practice commencement form shall be submitted to the Board.

(b) The collaborative practice commencement form will request the following:

1. Physician name, license number, primary practice specialty, primary practice address, whether the physician is board certified, the physician's residency completion date, and the name of program and completion date of any fellowship, or other supervised training program, if applicable.

2. CRNP/CNM name, RN license number, national certification specialty, practice address.

3. Number of hours per week to practice in collaborative agreement.

4. Whether the practice is a remote practice, the physician's primary practice, patient homes, hospital, skilled nursing facility, or other.

5. Whether the collaborative practice will be solely by telemedicine. If yes, additional information may be solicited, including but not limited to:

i. Plan for providing required medical oversight and direction to the CRNP/CNM.

ii. Plan for completing required quality assurance reviews;

iii. If no covering physician is named on the application, plan for being readily available at all times.

iv. Detailed plan to meet requirement of meeting face to face no less than twice annually.

v. Detailed plan to meet requirement of being physically present no less than 10% of the CRNP/CNM's scheduled hours if the CRNP/CNM has fewer than two years/4,000 hours of experience since being certified.

6. Whether the practice will be under a limited protocol for comprehensive physical exams or a limited protocol for long term care.

7. Physician's certification of understanding the responsibilities described in Board Rules Chapter 540-X-8.

8. Physician's certification that all covering physicians listed in the application have knowledge of their addition to the collaborative agreement, an understanding of Board Rules Chapter 540-X-8, and an awareness of their responsibilities in the collaborative agreement.

9. Physician's attestation of understanding of all quality assurance requirements contained in Board Rules Chapter 540-X-8.

(c) Payment of the initial fee and submission of the completed commencement form is established by the Board as a qualification for the physician to participate and engage in the collaborative practice.

(d) If the physician has not paid the initial fee and submitted a completed commencement form, the Board shall not approve the physician to participate in the collaborative practice.

Author: Alabama Board of Medical Examiners

Statutory Authority: §§ 34-24-53 and 34-24-340(b)
History: Approved New Rule: August 15, 2007. Emergency Rule Effective: September 4, 2007. Amended/Approved for Publication: January 21, 2015. Effective Date: June 25, 2015. Amended: Filed May 22, 2018. Certified: Filed July 19, 2018. Effective Date: September 4, 2018. Amended/Approved for Publication: September 16, 2020. Certified Rule Filed January 20, 2021. Effective Date: March 15, 2021.

540-X-7-.15 Registration - Physician Assistant (P.A.).

(1) Registration of a physician assistant by the Board to perform medical services under the supervision of a physician approved by the Board to supervise the assistant shall be accomplished in the following manner:

(~~1~~a) A completed application for registration in the form specified in Appendix A to Chapter 7 shall be submitted to the Board and shall include a list of each practice site, including the address and phone number where the registration and core duties shall be utilized, and shall list the name and designated working hours of the physician assistant at each practice site;

(~~2~~b) A non-refundable, non-transferable registration fee in the amount of $100.00 shall accompany the application; and

(~~3~~c) A detailed job description signed by the physician and physician assistant shall accompany the application. The job description shall set forth those functions and procedures for which the physician assistant qualified by formal education, clinical training, area of certification, and experience, and which sets forth the anticipated functions and activities of the physician assistant. The job description shall include the formulary for prescribing non-controlled drugs that are authorized by the supervising physician to be prescribed by the physician assistant and shall include the authorized dosages, quantities, and number of refills for each drug type to be prescribed.

(2) If the physician assistant intends to practice under a limited protocol, a limited protocol form must be completed and accompany the application.

(~~4~~3) The physician and the physician assistant may be personally interviewed, at the discretion of the Board, prior to final action on the application for registration.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §§34-24-290, et. seq.
History: Repealed and Replaced: Filed September 21, 1998; effective October 26, 1998. **Repealed and New Rule:** Filed August 22, 2002; effective September 26, 2002. **Repealed and New Rule:** Filed September 19, 2002; effective October 24, 2002. Amended/Approved July 21, 2021. Certified Rule Filed October 20, 2021. Effective Date: December 13, 2021.

ALABAMA BOARD OF MEDICAL EXAMINERS
P.O. Box 946/Montgomery, AL 36101-0946/(334) 242-4116

APPLICATION FOR REGISTRATION OF PHYSICIAN ASSISTANT

PHYSICIAN:
Supervising Physician Name in Full
AL Medical License Number
Medical Specialty
Board Certified
~~Board Eligible~~
Residency Completion Date
If applicable, name of program and completion date of any fellowship, or other supervised training program.

Practice Address
County
Street
Apt/Suite
State
Zip
Telephone Number

1. Is the physician assistant for whom registration is sought employed by you or by your group, partnership or professional corporation?

You answered No, a Supplemental Certificate must be submitted.

PHYSICIAN ASSISTANT

Physician Assistant Name in Full
AL P. A. License Number

2. **Covering Physicians**
If you would like to add covering physicians to this registration agreement, please submit covering physician agreements.

3. **Limited Protocols**
If the P.A. intends to practice under a limited protocol, please submit the applicable limited protocol form.

~~3~~4. **Core Duties and Scope Of Practice**
Please submit the core duties and scope of practice form.

~~4~~5. List each practice site where the core duties and scope of practice will be utilized and the number of hours this P.A. will be working weekly in each site. Must include name, address, and phone number of each site:
Remote site: Yes* No
Practice Name
Address

Phone
Hours Per Week
*If yes, provide a plan describing the practice location, facilities, and arrangements for appropriate communication, consultation, and review.

~~5~~6. Specify a plan for quarterly quality assurance management with defined quality outcome measures for evaluation of the clinical practice of the physician assistant and include review of a meaningful sample of medical records plus all adverse outcomes. The term "medical records" includes, but is not limited to, electronic medical records.
Documentation of quality assurance review shall be readily retrievable, identify records that were selected for review, include a summary of findings conclusions, and, if indicated, recommendations for change.

Supervising Physician Initials
Physician Assistant Initials

~~6~~7. Will this P. A. be authorized to have prescriptive privileges?
You answered Yes, complete the Formulary which is a list of the legend drugs which are authorized by the Physician to be prescribed by the P. A. The formulary approved under the rules of the Board of Medical Examiners should be utilized and attached as the authorized legend drugs to be prescribed. The medication categories chosen should reflect the needs of the supervising physician's medical practice.

~~7~~8. Will this P. A. be authorized to have prescriptive privileges to prescribe controlled substances as allowed under Alabama Code Section 20-2-60, et. seq.? (Prerequisites for controlled substances prescribing by P.A.s are stated in Board Rules, Chapter 540-X-12)
If yes, the application for a Qualified Alabama Control Substance Certificate can be found at our web site, www.albme.gov~~rg~~.

We hereby certify under penalty of law of the State of Alabama that the foregoing information in this Physician Assistant Job Description is correct to the best of our knowledge and belief. We certify that we have reviewed the current rules of the Alabama Board of Medical Examiners pertaining to assistants to physicians and understand our responsibilities. We understand that we are equally responsible for the actions of the Assistant to the Physician.

Under Alabama law, this document is a public record and will be provided upon request

I understand and agree that by typing my name, I am providing an electronic signature that has the same legal effect as a written signature pursuant to Ala. Code §§ 8-1A-2 and 8-1A-7. I attest that the foregoing information has been provided by me and is true and correct to the best of my knowledge, information and belief.

Knowingly providing false information to the Alabama Board of Medical Examiners or Medical Licensure Commission of Alabama could result in disciplinary action.

EXHIBIT E

STATE *of* ALABAMA

MEDICAL LICENSURE COMMISSION

MEMORANDUM

To: Medical Licensure Commission

From: Rebecca Robbins

Subject: FSMB Call for Comments: Strategies for Prescribing Opioids for the Management of Pain

Date: October 20, 2023

The FSMB Workgroup on Opioid and Addiction Treatment was previously charged with conducting a comprehensive review of the existing FSMB policies related to opioids and to revise them as appropriate. Earlier this year, the Workgroup provided a draft copy of the revised policies to member medical boards seeking comment to the revisions.

Due to the number of comments that were received, the Workgroup was directed to review all the comments and consider modification of the draft based upon those comments. The Workgroup has completed its revisions and is redistributing the draft policy for additional feedback.

Following consideration of any comments received, a final document will be presented to the House of Delegates at the 2024 Annual Meeting.

Comments are due by **December 1, 2023**. If the Commission has no comments, this item should be received as information.

Rebecca Robbins

From: April Evans <aevans@fsmb.org> on behalf of Lisa A. Robin (FSMB) <LRobin@fsmb.org>
Sent: Friday, October 20, 2023 1:27 PM
To: Lisa A. Robin (FSMB); Kandis McClure
Subject: FSMB Requests Comments on Draft Report

Dear Colleagues,

You will recall that the FSMB Workgroup on Opioid and Addiction Treatment, created in May 2022, was charged with doing a comprehensive review of existing FSMB policies related to opioids and revise them as appropriate. In completing its work, the Workgroup conducted a thorough review and analysis of FSMB's existing opioid-related policies, related state and federal guidelines and policies, guidance documents from selected medical specialty organizations and a targeted literature review. A draft policy, *Strategies for Prescribing Opioids for the Management of Pain,* was shared for comment with member boards and other interested parties in February 2022. Because of the number of comments received, the Board of Directors directed the Workgroup to review all the comments received and consider modification of the draft based on those comments.

The Workgroup met in June and September 2023 and discussed all of the comments received. The Workgroup has completed its revision and is distributing to you for any additional feedback you may have.

The draft may be accessed at the following link: https://www.fsmb.org/siteassets/communications/draft-strategies-for-prescribing-opioids-for-the-management-of-pain-2023.pdf

You may submit comments by **December 1, 2023,** by using this link: https://form.jotform.com/232904944749165

A final draft will be considered by the FSMB House of Delegates at its Annual Business Meeting in April 2023.

Best regards,
Lisa

Lisa Robin
Chief Advocacy Officer
Federation of State Medical Boards
1775 Eye Street NW | Suite 410 | Washington, DC 20006
o. 202-463-4006 | lrobin@fsmb.org | www.fsmb.org

Strategies for Prescribing Opioids for the Management of Pain

INTRODUCTION

Since 2017, when the Federation of State Medical Boards (FSMB) adopted the document entitled *Guidelines for the Chronic Use of Opioid Analgesics,* new evidence has emerged regarding the risks and benefits associated with prescription opioid therapy, as well as the value of risk mitigation strategies to limit patient harm through tapering and discontinuation of opioid therapy. Although overall prescriptions by clinicians for opioids (including long-acting and extended-release formulations) have decreased by more than 44% between 2011 and 2020, the epidemic of deaths from drug-related overdoses continues to be a leading public health priority in the United States, with overdose deaths rising to more than 107,000 in 2022. This is due in large part to a marked increase in the use of illicit and synthetic opioids, most notably fentanyl, shifting the focus among many stakeholders and policymakers on harm-reduction strategies.

Pain remains one of the most common reasons patients present to healthcare providers, with national surveys highlighting that one in five adults in the U.S. suffers from chronic pain, underscoring the public health importance of evidence-based pain care.[1] Furthermore, recent data have emerged revealing disparities in access to pain care, particularly affecting historically minoritized and marginalized populations, women, and patients living in rural and underserved areas. Certain patients may also be at risk for inadequate pain treatment, including older patients, patients with cognitive impairment, those with substance use and mental disorders, sickle cell disease, cancer and patients at the end of life.[2] Despite efforts to improve pain management and mitigate associated risks, responsible and appropriate prescribing of opioids continues to be a lingering challenge for state medical boards, clinicians and patients.

To address these issues, in April 2022, FSMB Chair Sarvam P. TerKonda, MD, appointed the Workgroup on Opioid and Addiction Treatment to conduct a comprehensive review of FSMB recommendations related to opioids and to update this guidance, as appropriate, with the goal of advancing pain care and improving the safe and appropriate prescribing of opioids for pain, eliminating stigmatizing language, and emphasizing that decisions regarding pain care should be shared between the clinician and patient and individualized. In completing its work, the Workgroup conducted a thorough review and analysis of FSMB's existing opioid-related policies, related state and federal guidelines and policies, guidance documents from selected medical

[1] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1. *See also* Zelaya CE, Dahlhamer JM, Lucas JW, Connor EM, *Chronic pain and high-impact chronic pain among U.S. adults*, NCHS Data Brief; 390:1–8 PMID:33151145 (2020).

[2] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

specialty organizations (e.g., the American Society of Addiction Medicine, American College of Obstetricians and Gynecologists) and a targeted review of the medical literature. Workgroup members included board members and staff who serve on state medical and osteopathic boards, health professionals from academia, and representatives of the National Association of Boards of Pharmacy, the National Council of State Boards of Nursing, the American Association of Dental Boards, the Centers for Disease Control and Prevention, the American Medical Association and the American Osteopathic Association.

The Workgroup sought input from a diverse group of medical and health policy stakeholders that included experts in pain medicine and addiction treatment, government officials, patients living with pain, and thought leaders. Subsequently, a meeting was held in September 2022 with experts on a variety of topics related to pain management. The Workgroup met on several additional occasions to examine and explore key elements required to ensure that FSMB's recommendations remain timely and sufficiently comprehensive to serve as a meaningful guidance and resource for state medical and osteopathic boards, physicians and other clinicians.

Policy makers and clinicians are working to maintain a balance between curbing the nation's epidemic of drug overdoses and ensuring that appropriate access to evidence-based care is available to patients with pain. The recommendations in this document have been revised to reflect the paramount importance of individualized, patient-centered, equitable care in the management of pain, regardless of the patient's age, race, ethnicity, gender, disability, or socioeconomic status. The guidelines also reflect a more comprehensive inclusion of non-opioid, non-pharmacologic and non-invasive treatment options, as well as additional information about patient populations not previously addressed in FSMB guidance. The definitions have also been updated to reflect current terminology and to remove stigmatizing language.

The strategies and recommendations in this document are intended as a helpful resource to provide overall guidance to state medical and osteopathic boards in assessing clinicians' management of pain in their patients and whether opioids are or were used in a medically appropriate manner. While this guidance is intended for use by state medical boards, it may also be a resource for other health professional regulatory boards responsible for the oversight of clinicians who prescribe opioids.

The guidance that follows is not meant to establish a standard of care, but rather to encourage a responsible, patient-centered and compassionate approach to caring for patients with pain.

GUIDELINES FOR PRESCRIBING OPIOIDS FOR THE MANAGEMENT OF PAIN

Section 1 – PREAMBLE Opioids may be appropriate for the management of pain; however, they carry considerable potential risks, including misuse and the development of opioid use disorder

(OUD), among others.[3] To implement best practices for opioid prescribing, medical students, residents and practicing clinicians must understand the relevant pharmacologic and clinical issues in the use of opioids and should obtain sufficient targeted continuing education and training about the safe prescribing of opioids and other controlled substances, as well as training in multimodal treatments for pain. The clinical determination of whether opioids are used as part of a treatment protocol is one that should be made between the individual and clinician based on the factors and considerations unique to that individual as discussed in these guidelines.

Section 2 – FOCUS OF GUIDELINES

The focus of the guidelines that follow is on the overall safe and evidence-based treatment of pain but **are not intended to establish a specific standard of care.**[4] The provision of care should be individualized, patient-centered and equitable, with the goal of optimizing function and quality of life. Effective means of achieving the goals of these guidelines vary widely depending on the type and causes of the patient's pain, the preferences of the clinician and the patient, the resources available at the time of care, patient demographics, and other concurrent issues that are beyond the scope of these guidelines.

The guidelines that follow are not intended to influence the prescribing of opioids over other means of treatment, but rather to recognize the responsibility of clinicians to view pain management as essential to the quality of medical practice and to the quality of life for patients living with pain.

While all care should be individualized and patient-centered, the guidelines that follow are applicable to the prescribing of opioids for the management of pain not generally associated with urgent or emergency care, cancer care, sickle cell-related care, palliative care or end of life care. Although these guidelines apply most directly to the use of opioids in the treatment of pain, many of the strategies described may also be relevant to responsible prescribing and the mitigation of risks associated with other controlled substances that carry increased risks, including, but not limited to, overdose and misuse.

Section 3 – DEFINITIONS

For the purposes of these guidelines, the following terms are defined as shown.

Aberrant Behaviors: Aberrant behavior is irregular behavior that deviates from what is considered proper, appropriate or normal to maintain or improve care. Suspected aberrant behavior should be discussed directly with the patient.

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[3] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95.
DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[4] For additional information on standards of care, see FSMB's Considerations for Identifying Standards of Care.

Abuse: Abuse is an older, stigmatizing term[5] used to describe a pattern of drug use that exists despite awareness of, or experience with, adverse consequences or risk of consequences. Abuse of a prescription medication includes its use in a manner that deviates from accepted medical, legal and social standards, generally to achieve a euphoric state ("high") or that is other than the purpose for which the medication was prescribed. The term "misuse" is now preferred over "abuse."

Addiction: Addiction is a treatable, chronic medical disease involving complex interactions among brain circuits, genetics, the environment and an individual's life experiences. Individuals with addiction use substances or engage in behaviors that become compulsive and often continue despite harmful consequences.[6]

Controlled Substance: A controlled substance is a drug that is subject to special requirements under the federal Controlled Substances Act of 1970 (CSA), which was designed to ensure both the availability and control of regulated substances. [7] Under the CSA, availability of regulated drugs for medical purposes 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 control apparatus. The Code of Federal Regulations (Title 21, Chapter 2) implements the CSA. The CSA provides that responsibility for scheduling controlled substances is shared between the Food and Drug Administration (FDA) and the Drug Enforcement Administration (DEA). In granting regulatory authority to these agencies, Congress noted that both public health and public safety needs are important and that neither takes primacy over the other. To accomplish this, 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 a drug that is being considered for rescheduling or removal from control.

Most potent opioids are classified in Schedule II under the CSA,[8] indicating that they have a significant potential for misuse and a currently accepted medical use in treatment in the U.S. (with certain restrictions). Although the scheduling system provides a rough guide to misuse potential, all controlled medications have some potential for misuse.

Corresponding Responsibility: A prescription for a controlled substance to be effective must be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of

[5] *See* Kelly, John F. and Westerhoff, Cassandra, "Does it matter how we refer to individuals with substance-related condition? A randomized study of two commonly used terms." *International Journal of Drug Policy*, Vol. 21, Issue no.3, pages 202-207 (2010). Retrieved from: https://www.sciencedirect.com/science/article/abs/pii/S0955395909001546?via%3Dihub.

[6] American Society of Addiction Medicine, *The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder 2020 Focused Updated*

[7] Controlled Substance Act of 1970(CSA). Federal Register (CFR). Public Law 91-513, 84 Stat. 1242.

[8] 21 USC 812: Schedules of controlled substances

his or her professional practice. The responsibility for the proper prescribing and dispensing of controlled substances is upon the prescribing practitioner, but a corresponding responsibility also rests with the pharmacist who fills the prescription. An order purporting to be a prescription issued not in the usual course of professional treatment, or in legitimate and authorized research, is not a prescription within the meaning and intent of section 309 of the Act (21 U.S.C. 829) and the person knowingly filling such a purported prescription, as well as the person issuing it, shall be subject to the penalties provided for violations of the provisions of law relating to controlled substances.[9]

Dependence: Used in different ways:

- Physical dependence is a state of neurological adaptation that is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist.
- Psychological dependence is a subjective sense of need for a specific psychoactive substance, either for its positive effects or to avoid negative effects associated with its abstinence.[10]

Diversion: Distribution of a controlled substance outside of the closed system of distribution.[11]

Harm Reduction: A comprehensive set of policies and initiatives to help prevent death, injury, disease, overdose and substance misuse. Harm reduction has been seen as effective in addressing the public health epidemic involving substance use as well as infectious disease and other harms associated with drug use. Specifically, harm reduction services can:

- Connect individuals to overdose education, counseling and referral to treatment for infectious diseases and substance use disorders.
- Distribute opioid overdose reversal medications (e.g., naloxone) to individuals at risk of overdose, or to those who might respond to an overdose.
- Lessen harms associated with drug use and related behaviors that increase the risk of infectious diseases, including HIV, viral hepatitis, and bacterial and fungal infections.
- Reduce infectious disease transmission among individuals who use illicit drugs, including those who inject drugs, by equipping them with accurate information and facilitating referral to resources.
- Reduce overdose deaths, promote linkages to care and facilitate co-location of services as part of a comprehensive, integrated approach.
- Reduce stigma associated with substance use and co-occurring disorders.
- Promote a philosophy of hope and healing by utilizing those with "lived experience" of recovery in the management of harm reduction services, and connecting those who

[9] 21 C.F.R. Section 1306.04.

[10] American Society of Addiction Medicine, *The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder 2020 Focused Updated*

[11] *See* Controlled Substances Act of 1970 (CSA). Federal Register (CFR). Public Law 91-513, 84 Stat. 1242.

have expressed interest to treatment, peer support workers and other recovery support services.[12]

Misuse: The use of illegal drugs and/or the use of prescription drugs in a manner other than as directed by the prescriber, such as use in greater amounts, more frequently, or longer than told to take a drug, or using someone else's prescription.[13] While misuse may be a reason to discontinue or alter a course of therapy or treatment, it should not by itself be a reason to discharge a patient from a practice.

Opioid: A current term for any psychoactive chemical that resembles morphine in pharmacological effects, and which includes opiates and synthetic/semisynthetic agents that exert their effects by binding to highly selective receptors in the brain, where morphine and endogenous opioids affect their actions.[14]

Opioid Use Disorder: A problematic pattern of opioid use that causes significant impairment or distress. A diagnosis of opioid use disorder is based on specific criteria such as unsuccessful efforts to decrease or control use, or use resulting in social problems and a failure to fulfill obligations at work, school, or home, among other criteria. Opioid use disorder (OUD) is preferred over older terms with similar definitions, such as "opioid abuse or dependence" or "opioid addiction."[15]

Pain: An unpleasant and potentially disabling sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage.

- Acute Pain**:** Pain that is usually sudden in onset and time limited (having a duration of less than one (1) month) and often is caused by injury, trauma or medical treatments such as surgery.
- Subacute Pain**:** Unresolved acute pain or subacute pain (pain that has been present for one to three (1–3) months) that can evolve into chronic pain.
- Chronic Pain**:** Pain that typically lasts more than three (3) months and can be the result of an underlying medical disease or condition, injury, medical treatment, inflammation or unknown cause[16]

[12] *Harm Reduction*, Substance Abuse and Mental Health Services Administration, U.S. Department of Health & Human Services (last updated Apr. 4, 2023) https://www.samhsa.gov/find-help/harm-reduction.

[13] *Commonly Used Terms*, Center for Disease Control and Prevention (last reviewed Jan. 26, 2021) available at: https://www.cdc.gov/opioids/basics/terms.html

[14] *See* American Society of Addiction Medicine, *The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder 2020 Focused Updated* (2020).

[15] *Commonly Used Terms*, Center for Disease Control and Prevention (last reviewed Jan. 26, 2021) available at: https://www.cdc.gov/opioids/basics/terms.html

[16] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

Prescription Drug Monitoring Program: Prescription Drug Monitoring Programs (PDMPs) offer information about controlled prescription medications, including opioids, that are dispensed to an individual. They can serve as important resources for clinicians in completing fuller patient clinical assessments of opioid and other controlled substance use history.[17] A PDMP history or report should not, by itself, be used as the basis for discontinuing care, discharging a patient or non-consensually changing a course of treatment.

Substance Use Disorder: Substance use disorder (SUD) is a health condition marked by a cluster of cognitive, behavioral and physiological symptoms indicating that the individual continues to use alcohol, nicotine and/or other drugs despite significant related problems.[18] Individuals with an SUD also may have pain, which should be assessed and treated. Coordination of care with a clinician specializing in SUD care may be appropriate.

Tolerance: A decrease in response to a drug dose that occurs with continued use. If an individual is tolerant to a drug, increased doses are required to achieve the effects originally produced by lower doses. Both physiological and psychosocial factors may contribute to the development of tolerance.

Section 4 - GUIDELINES

State medical boards may use the following criteria for use in evaluating a clinician's management of a patient with pain, including the clinician's prescribing of opioid analgesics. Such use is subject to the **Guidelines, Limitations and Restrictions** previously set forth.

Patient Evaluation and Risk Stratification

The medical record should document the presence of one or more recognized medical indications in consideration of relevant psychosocial contraindications for prescribing an opioid and reflect an appropriately detailed patient evaluation.[19] An evaluation should be completed and documented concurrent with the decision of whether to prescribe an opioid. Evaluation of the patient is critical to appropriate management. Evaluation can identify reversible causes of pain and underlying etiologies with potentially serious sequelae that require urgent action. To guide patient-specific selection of therapy, clinicians should evaluate patients and establish or confirm the diagnosis.

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[17] *See* American Society of Addiction Medicine, *The ASAM National Practice Guideline For the Treatment of Opioid Use Disorder 2020 Focused Updated (2020).*

[18] *Diagnostic and statistical manual of mental disorders,* American Psychiatric Association (5th Ed., Text Rev.) (2022) https://doi.org/10.1176/appi.books.9780890425787.

[19] See U.S. Department of Health and Human Services (2019, May). Pain Management Best Practices Inter-Agency Task Force Report: Updates, Gaps, Inconsistencies, and Recommendations. Retrieved from U. S. Department of Health and Human Services website: https://www.hhs.gov/sites/default/files/pmtf-final-report-2019-05-23.pdf; *See also* Douglas L. Gourlay, et. al., Universal Precautions in Pain Medicine*: A Rational Approach to the Treatment of Chronic Pain*, Pain Medicine Vol. 6, Issue 2 (Mar. 2005).

Clinicians are encouraged to maximize the use of nonopioid therapies if benefits outweigh the risks, and consider nonpharmacological, noninvasive approaches to managing pain.[20] Patients may not have affordable or ready access to all forms of pain treatment due to insurance or other payer limitations as well as barriers due to social determinants of health, including employment, child care, transportation and other concerns.

The nature and extent of the evaluation depends on the type of pain and the context in which it occurs, including identifying potentially reversible causes of pain. Assessment of the patient's pain should include the nature and intensity of the pain, past and current treatments for the pain, any underlying or co-occurring disorders and conditions (including underlying mental and substance use disorders), social determinants of health, and the effect of the pain on the patient's physical and psychological functioning. [21] Racial bias has been shown to result in the undertreatment of pain in certain patient populations.[22] Clinicians should be aware of the impact of bias when evaluating patients with pain and strive to achieve equity fluency in care.[23]

For every patient, the initial assessment and evaluation should include a systems review (e.g., cardiovascular, pulmonary, neurologic) and relevant physical examination, as well as objective markers of disease or diagnostic markers as indicated. Also, functional assessment, including social and vocational assessment, is useful in identifying potential supports and obstacles to treatment and rehabilitation. Clinicians should, to the extent possible, provide culturally and linguistically appropriate communications, including communications that are accessible to persons with disabilities.[24]

Assessment of the patient's personal and family history and relative risk for substance use disorder should be part of the initial evaluation and considered prior to a decision as to whether to prescribe opioids.[25] Assessment can be performed through a careful clinical interview, which should also inquire into any history of physical or emotional abuse, or other adverse events which

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[20] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1; *See also* Chou R, Hartung D, Turner J, et al. Opioid treatments for chronic pain. Comparative effectiveness review no. 229. Rockville, MD: Agency for Healthcare Research and Quality; 2020.

[21] *Treatment Improvement Protocol (TIP) 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders*, Center for Substance Abuse Treatment (CSAT) and Substance Abuse and Mental Health Services Administration (SAMHSA) DHHS Pub. No. (SMA) 12-4671 (2012).

[22] Hoffman KM, Trawalter S, Axt JR, Oliver MN. *Racial bias in pain assessment and treatment recommendations, and false beliefs about biological differences between blacks and whites.* Proc Natl Acad Sci U S A. 2016 Apr 19;113(16):4296-301. doi: 10.1073/pnas.1516047113. Epub 2016 Apr 4. PMID: 27044069; PMCID: PMC4843483.

[23] For additional information, see the Final Report of the FSMB Workgroup on Diversity, Equity and Inclusion in Medical Regulation and Patient Care (2023).

[24] Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[25] *Recommendation 8*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

are potential risk factors for substance use disorder.[26] Use of validated screening tools for substance use disorder may be useful to supplement the collecting and evaluating of information in determining the patient's level of risk.[27] The presence of a prior, adverse experience should not by itself constitute a reason to deny a particular therapy.

Patients with substance use disorders are likely to experience greater risks for opioid use disorder and overdose than persons without these conditions.[28] Treatment of a patient who has a history of substance use disorder may involve consultation with an addiction specialist before opioid therapy is initiated, as well as follow-up, as needed. Although substance use disorders can alter the expected benefits and risks of opioid therapy for pain, patients with co-occurring pain and substance use disorder require ongoing pain management that maximizes benefits relative to risks. All clinicians, particularly those who treat patients with chronic pain, are encouraged to be knowledgeable about the identification and treatment of substance use disorder, including the role of medications for treatment of opioid use disorder, such as methadone, buprenorphine and naltrexone.

Assessment of the patient's personal and family history of mental disorders should be part of the initial evaluation, and ideally should be completed prior to a decision as to whether to prescribe opioids. All patients should be screened for depression and other mental disorders as part of a risk evaluation and to determine an appropriate course of treatment. Patients with untreated depression and other mental disorders may be at increased risk for opioid use disorder and drug overdose. Additionally, untreated depression and psychological distress can interfere with the resolution of pain.[29]

The evaluation of the patient may include information from family members and/or significant others consistent with appropriate patient privacy requirements. The state's PDMP should be reviewed prior to initiating opioid therapy and at appropriate intervals thereafter to determine whether the patient is receiving prescriptions from other clinicians, and the results obtained from the PDMP should be reviewed. Information obtained from the PDMP could indicate a need for referral to a treatment provider.

In working with a patient who is prescribed opioids by another clinician—particularly a patient already on high doses—the evaluation and risk stratification assumes even greater importance.

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[26] *Treatment Improvement Protocol (TIP) 54: Managing Chronic Pain in Adults With or in Recovery From Substance Use Disorders*, Center for Substance Abuse Treatment (CSAT) and Substance Abuse and Mental Health Services Administration (SAMHSA) DHHS Pub. No. (SMA) 12-4671 (2012). CSAT, SAMHSA, 2012.

[27] *See Recommendation 8 and Recommendation 12*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[28] *See Recommendation 8*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[29] *See Recommendation 8*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

Therefore, to ensure appropriate care, clinicians should collaborate with the primary prescriber for a clear understanding of the indications for the high dosage and strategies to mitigate risk associated with the current dosage, including whether tapering is clinically appropriate, in collaboration with the patient.

Pregnant, postpartum and parenting persons should receive compassionate, evidence-based care for pain and/or opioid use disorder.[30] A cautious approach to prescribing opioids should be balanced with the need to address pain, and pregnancy should not be a reason to avoid treating acute pain.[31] Prescribing opioid medication during pregnancy should include a discussion of treatment goals and the benefits and risks of opioid use, including the risk of becoming physiologically dependent on opioids or possibility of an infant developing neonatal opioid withdrawal syndrome (NOWS). However, NOWS is treatable, and obstetricians/gynecologists (OB-GYN) and other obstetric care clinicians (OCCs) should not hesitate to prescribe opioids based on a concern for opioid withdrawal in the neonate alone.[32]

For pregnant persons already receiving opioids, clinicians should access appropriate expertise if tapering is being considered because of possible risks to the pregnant patient and the fetus if the patient goes into withdrawal.[33]

Specific to postpartum pain management, pharmacologic and nonpharmacologic therapies can be useful. Therefore, OB-GYNs and other OCCs should be familiar with effective pain management options for individuals under their care, including understanding the risks and benefits of each option, with a goal of avoidance of under-, over-, or inequitable treatment of pain. OB-GYNs and other OCCs should engage in shared decision making with individuals regarding their preferences for pain management; doing so may improve satisfaction, decrease opioid use, and potentially reduce misuse and diversion.[34]

When opioid therapy is used for patients above the age of 65, clinicians should use additional caution and increase the frequency and extent of monitoring to ensure pain is addressed and to

[30] *See Recommendation 8*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[31] The American College of Obstetricians and Gynecologists, Committee Opinion, Opioid Use and Opioid Use Disorder in Pregnancy, Number 711, August 2017, Reaffirmed 2021; *See also* Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[32] The American College of Obstetricians and Gynecologists, Committee Opinion, Opioid Use and Opioid Use Disorder in Pregnancy, Number 711, August 2017, Reaffirmed 2021.

[33] *See Recommendation 5 and Recommendation 8* of Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[34] For additional information on opioid use in pregnant patients, please see American College of Obstetrics and Gynecologists, Committee Opinion Number 711, Opioid Use and Opioid Use Disorder in Pregnancy, available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy

minimize risks of opioids prescribed.[35] Clinicians should review all current medications, over-the-counter drugs and any natural or other remedies before prescribing any new drugs.[36]

Patients at risk for sleep-disordered breathing are at increased risk for harm with the use of opioid therapy.[37] Clinicians should consider the use of a screening tool for obstructive sleep apnea and refer patients for proper evaluation and treatment when indicated.

The patient evaluation should include most of the following elements:

- Medical history, review of systems, and physical examination targeted to the pain condition
- A review of current medications, including over the counter drugs and natural remedies
- A description of the nature and intensity of the pain
- A review of current and past treatments, including interventional treatments, with response to each treatment
- Underlying condition(s) or disease(s) thought to be causing pain and co-existing disease(s) or condition(s), including those which could complicate treatment (e.g., obesity, renal disease, sleep apnea, COPD, etc.)
- The effect of pain on physical and psychological functioning
- Personal and family history of substance use disorder
- History of behavioral health disorders
- Medical indication(s) for use of opioids
- A review of PDMP results
- Consultation with other clinicians, including specialists, when applicable
- Tests of urine, blood or other types of biological samples, and diagnostic markers

Development of a Treatment Plan and Goals

The goals of pain treatment include reasonably attainable improvement in pain to decrease suffering and increase functionality and quality of life; improvement in pain-associated symptoms such as sleep disturbance, depression and anxiety; treating potentially reversible causes of pain; screening for side effects of treatment; and avoidance of unnecessary or excessive

[35] *See Recommendation 7 and Recommendation 8,* Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[36] *See Recommendation 8*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[37] *See Recommendation 8*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1

use of medications.[38] Although improvement in function is a primary goal, function can improve even when pain is not substantially reduced or eliminated. There should be a balance between monitoring for efficacy and side effects with the use of medications for the shortest duration appropriate.

The treatment plan and goals should be established as early as possible in the treatment process and revisited regularly, to provide clear-cut, individualized objectives to guide the choice of therapies through shared decision-making for both the clinician and the patient.

The treatment plan may contain information supporting the selection of therapies, both pharmacologic (including medications other than opioids, such as non-steroidal anti-inflammatory drugs, acetaminophen and selected antidepressants and anticonvulsants) interventional, and non-pharmacologic therapies (such as cognitive behavioral therapy, massage, exercise, multimodal pain treatment and osteopathic manipulative treatment.) Clinicians are encouraged to recognize the role that social determinants of health have on an individual patient's access to specific therapies and to help identify effective strategies and other options to help individuals obtain treatment. The treatment plan should document any further diagnostic evaluations, consultations or referrals, or additional therapies that have been considered, to the extent they are available. The plan should also include discussions regarding tapering, reducing, or discontinuing opioid therapy when clinically appropriate and thoughtful consideration of the potential risks and benefits for opioid tapering, should opioid therapy be unsuccessful.[39]

Informed Consent and Treatment Agreement

The decision whether to initiate opioid therapy, like the decision about how to treat an individual's substance use disorder or opioid use disorder, is a shared decision between the clinician and the patient. The clinician should discuss the risks and benefits of the treatment plan (including any proposed use of opioid analgesics or other pharmacologic or nonpharmacologic modalities) with the patient. If opioids are prescribed, the patient (and possibly family members or caregivers) should be counseled on the potential risks and anticipated benefits, adverse effects of opioids, including but not limited to dependence, substance use disorder, overdose and overdose mitigation strategies, and death, as well as the safe methods to store and dispose of medications.

[38] *See Recommendation 2*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1; *See also Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education and Research*, Institute of Medicine (IOM) of the National Academy of Sciences (NAS), National Academies Press (2011).

[39] *See Recommendation 6 and Recommendation 7*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

Documentation of informed consent and treatment agreement is recommended for subacute and chronic opioid therapy.[40] Treatment agreements outline the joint responsibilities of the clinician and patient. In addition, the clinician should discuss with the patient how and when the PDMP will be reviewed as part of the patient's care and how that information will be used.

Informed consent may address:

- Potential risks and benefits of initiating opioid therapy
- Potential risks and benefits of non-opioid pharmacologic therapies
- Potential side effects (both short and long term), such as cognitive impairment and constipation
- The likelihood that tolerance to, and physical dependence on, the medication will develop
- Risk of drug interactions and over-sedation
- Risk of impaired motor skills (i.e., affecting driving and other tasks)
- Risk of substance use disorder, overdose and death
- The clinician's prescribing policies and expectations, including the number and frequency of prescription refills, early refills and replacement of lost or stolen medications
- Reasons for which drug therapy may be changed or discontinued (including violation of the treatment agreement)
- Reasons for which treatment may be discontinued without agreement by the patient under certain circumstances
- Education of the patient that the complete elimination of pain may not occur
- The possible impact of therapeutic opioid use on toxicology testing in the workplace or for other purposes
- Risks for household members and other persons if opioids are intentionally or unintentionally shared with others for whom they are not prescribed

Treatment agreements outline the joint responsibilities of the clinician and patient and are indicated for opioid or other medications with potential for substance use disorder. It is strongly recommended that treatment agreements include:

- Treatment goals in terms of pain management, restoration of function and safety, quality of life, however, treatment may not result in the elimination of pain
- Patient's responsibility for safe medication use (not taking more than prescribed; dangers of using in combination with alcohol, cannabis, or other substances like benzodiazepines unless closely monitored by the prescriber, overdose prevention and naloxone use, etc.)
- Secure storage and safe disposal
- Patient's responsibility to obtain prescribed opioids from only one clinician or practice, if possible (recognizing that this may not be possible for all patients)

[40] *See* Douglas L. Gourlay, et. al., *Universal Precautions in Pain Medicine: A Rational Approach to the Treatment of Chronic Pain*, Pain Medicine Vol. 6, Issue 2 (Mar. 2005).

- Patient's responsibility of getting the prescriptions filled at only one pharmacy, if possible (recognizing that this may not be possible for all patients)
- Patient's agreement to periodic drug testing, when clinically appropriate
- Clinician's responsibility to be available or to have a covering clinician available to care for unforeseen problems and to prescribe scheduled refills

Clinicians are recommended to refrain from referring patients to the emergency department to obtain prescriptions for opioids for chronic pain that are not related to cancer, sickle cell crisis, or as part of palliative or end-of-life care.

Initiating an Opioid Trial

Non-opioid, non-pharmacologic and non-invasive treatments (such as cognitive behavioral therapy, massage, exercise, multimodal pain treatment and osteopathic manipulative treatment) should be considered before initiating opioid therapy for subacute and chronic pain.[41] However, patients should not be required to sequentially fail nonpharmacologic and nonopioid pharmacologic therapy or be required to use any specific treatments before proceeding to opioid therapy.[42] Patients may not have affordable or ready access to all forms of pain treatment due to insurance or other payer limitations as well as barriers due to social determinants of health, including employment, child care, transportation and other concerns.

When a decision is made to initiate opioid therapy, it should be presented to the patient as a "therapeutic trial" or as a "test for a defined period of time" and with specified evaluation points, including those to assess changes in pain and function.

The clinician should explain that progress will be carefully monitored for both benefit and harm, in terms of the effects of opioids on the patient's level of pain, function, and quality of life, as well as to identify any adverse events or risks to safety.[43] When initiating opioid therapy for acute, sub-acute, or chronic pain, clinicians should prescribe immediate-release opioids instead of extended-release and long-acting (ER/LA) opioids.[44]

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[41] *See* Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. (See Recommendations 1 & 2) DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[42] *See Recommendation 2*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95.DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[43] *See Recommendation 2 and Recommendation 7,* Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. (See Recommendations 1 & 2) DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1; Nicolaidis C, Chianello T & Gerrity M, *Development and preliminary psychometric testing of the Centrality of Pain Scale*., Pain Medicine. 612-617 (Apr. 2011).

[44] *See Recommendation 3,* Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

The concurrent use of benzodiazepines and opioids is included as a boxed warning by the FDA as it greatly increases the risk of adverse events, including death. Clinicians should use caution when prescribing opioid pain medication and benzodiazepines (or other central nervous system depressants) concurrently and consider whether benefits outweigh risks.[45]

While there is clinical variation in response by patients to opioid therapy at any given dosage and there is need for patient flexibility and individualization with respect to opioid dosages, some states have specific dosing guidelines for opioids that are statutory in nature. The CDC has removed numeric thresholds from its recommendations due to reports of patient harm and to support individualized, patient-centered care. When considering whether to increase opioid dosage, a clinician should clearly state in the medical record the rationale for using higher dosages and monitor those patients prescribed such a dose with increased vigilance to assure that the medication is helping patients achieve their pain and functional goals and that risks of diversion and/or overdose are minimized. The clinician should also be aware that maximum benefit to the patient may have already been obtained and increasing the dosage may not result in further therapeutic benefit and can result in harm to the patient. Referral to, or consultation with, a pain specialist for patients on higher opioid dosages, may be considered, and dosages should not be escalated without re-evaluation of the benefits and risks in consultation with the patient.

Before prescribing methadone for its analgesic effect, clinicians are strongly recommended to have specific training and/or experience as individual responses to methadone vary widely increasing the risk of overdose. There is a complex relationship between dose, half-life, duration of analgesic effect, and duration of respiratory depression. Specifically, the duration of analgesic effect is generally shorter than the duration of respiratory depression. The long half-life of methadone and the longer duration of respiratory depression relative to analgesia places patients at risk for overdose, particularly when titrating methadone dose for pain management.

Clinicians should recommend naloxone for home use where appropriate and include education for all patients with opioid prescriptions as a potential life-saving tool in case of unintentional poisoning or intentional overdose by the patient or household contacts. One version of naloxone is available over the counter as of September 2023 and other versions are available without a prescription through pharmacies and community-based groups.

Ongoing Monitoring and Adapting the Treatment Plan

The clinician should regularly review the patient's clinical progress, including any new information about the etiology of the pain or the patient's overall health and level of functioning. When possible, additional information about the patient's response to opioid therapy may be obtained from family members or other close contacts, as well as by a review of the state PDMP.

[45] *See Recommendation 11,* Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

The frequency of patient visits may increase during the initiation of the treatment plan and the adjustment of the opioid dosage. As the patient is stabilized in the treatment regimen, follow-up visits may be scheduled as indicated by stability and risk level. Monitoring strategies for a specific patient should take into account the elevated risk of dependence and the potential development of a substance use disorder or misuse over an extended period of opioid therapy. This may involve referring the patient to treatment programs or harm-reduction services when deemed clinically appropriate.

Clinicians should not dismiss patients from their practice based solely on PDMP information. Doing so may adversely affect patient safety and result in missed opportunities to provide potentially lifesaving information (e.g., about risks of prescription opioids and about overdose prevention) and interventions (e.g., safer prescriptions, nonopioid pain treatment, opioid overdose reversal medication, and effective treatment for substance use disorders).[46]

Continuation, modification or termination of opioid therapy for pain should be discussed with the patient and is contingent on the clinician's evaluation of (1) evidence of the patient's progress toward treatment objectives and (2) the absence of substantial risks or adverse events, such as signs of substance use disorder and/or diversion.[47] A satisfactory response to treatment would be indicated by a reduced level of pain, increased level of function, improved quality of life, or a reduction in the further decline of the patient. Information from family members or other caregivers may be considered in evaluating the patient's response to treatment. Use of measurement tools to assess the patient's level of pain, function, and quality of life may be helpful in documenting therapeutic outcomes.

Toxicology Testing

When prescribing opioids for subacute or chronic pain, clinicians should consider the benefits and risks of toxicology testing to assess for prescribed medications as well as other prescribed and nonprescribed controlled substances.

Test results that suggest opioid misuse should be discussed with the patient. It is helpful to approach such a discussion in a positive, supportive fashion, in order to strengthen the physician-patient relationship and encourage healthy behaviors (as well as behavioral change where that is needed). It is recommended that both the test results and subsequent discussion with the patient be documented in the medical record.[48]

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[46] *See Recommendation 9*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[47] Isaacson JH, Hopper JA, Alford DP et. al., *Prescription drug use and abuse: Risk factors, red flags, and prevention strategies* Postgraduate Medicine Vol. 118 Issue 1, 19-26 (2005); *See also Recommendation 5*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[48] Gourlay D, Heit HA & Caplan YH, *Urine Drug Testing in Clinical Practice; The Art & Science of Patient Care*, John Hopkins University School of Medicine; 5th Edition (Aug. 2015).

Toxicology testing should not be used in a punitive manner but should be used in the context of other clinical information to inform and improve patient care. Clinicians should not dismiss patients from care based solely on a toxicology report. Dismissal could have adverse consequences for patient safety, such as the patient obtaining opioids or other drugs from alternative sources and the clinician missing opportunities to facilitate treatment for substance use disorder.[49]

Practitioners should obtain informed consent from pregnant, postpartum, or parenting individuals before toxicology testing. This consent should include the medical indication for the test, information regarding the right to refusal and the possibility of associated consequences for refusal, and discussion of the possible outcome of a positive test result, including any mandatory reporting requirement. The American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics (AAP) both support informed consent that includes how a positive test result will be used for both medical treatment and reporting to child welfare agencies.[50]

Adapting Treatment

As noted earlier, clinicians should consult the state's PDMP before initiating opioids for pain and during ongoing therapy. A PDMP plays a crucial role in monitoring compliance with the treatment agreement, as well as identifying individuals obtaining controlled substances from multiple prescribers and patients who may be at increased risk for overdose.

If the patient's progress is unsatisfactory, the clinician must decide whether to revise or augment the treatment plan, whether other treatment modalities should be added to (or substituted for) the opioid therapy, or whether a different approach—possibly involving referral to a pain specialist or other health professional—should be employed.[51] Such decisions should be made in consultation with the patient.

Evidence of misuse of prescribed opioids demands prompt evaluation by the clinician, including assessment for opioid use disorder or referral to a substance use disorder treatment specialist for such assessment, and providing or arranging for evidence-based treatment of opioid use disorder, in particular medications for opioid use disorder (MOUD), if present. Patient behaviors that require such evaluation may include early requests for refills, multiple reports of lost or stolen prescriptions, obtaining controlled medications from multiple sources without the

[49] *See Recommendation 10*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

[50] The American College of Obstetricians and Gynecologists, Statement of Policy; Opposition to Criminalization of Individuals During Pregnancy and the Postpartum Period, (Dec. 2020).

[51] Passik, S.D. and Kirsh, K.L., *Assessing aberrant drug-taking behaviors in the patient with chronic pain*, Current Science Inc. 8, 289–294 (2004). https://doi.org/10.1007/s11916-004-0010-3

clinician's knowledge, intoxication or impairment (either observed or reported), and pressuring or threatening behaviors.

When a toxicology test is inconsistent with currently prescribed therapy, discussion of the test results with the patient and action on the part of the clinician is required. Changes to the patient's treatment plan may be required depending on the discussion and further evaluation of the totality of the patient's medical history and treatment plan. In some cases, the physician may need to run a confirmatory test if the patient evaluation does not clarify the initial test results. Importantly, toxicology testing should not be used in a punitive manner, and clinicians should not dismiss patients from care based on a toxicology test result. Dismissal could have adverse consequences for patient safety and result in missed opportunities to facilitate treatment changes or treatment for substance use disorder.

Documented drug diversion or prescription forgery, and abusive or assaultive behaviors require a firm, immediate response,[52] which may include properly discharging a patient from the clinician's practice and/or referral to a treatment program or harm-reduction service. Indeed, failure to respond can place the patient and others at significant risk of adverse consequences, including accidental overdose, suicide attempts, arrests and incarceration, or even death.[53]

Consultation and Referral

It is important to consider, if available, referral to a comprehensive pain management program which includes modalities such as interventional pain management, physical and occupational therapy, acupuncture, or other non-pharmacologic therapies to avoid unnecessary reliance on opioids as the sole therapy for chronic or complex pain issues.

Specialty consultation may be considered if diagnosis and/or treatment for the condition manifesting as pain is outside the scope of the clinician's skills to manage the patient's medical condition(s). Opioid dose level, in and of itself, does not always warrant a referral. However, there is risk associated with higher doses and, therefore, that may be an indication for seeking consultation, depending on the clinician's training, resources and comfort level. The treating clinician, if possible, should seek consultation with, or refer the patient to, a pain, psychiatric, addiction or mental health specialist, as needed. While such a referral may not always be possible in every setting, clinicians should be knowledgeable about other options and resources that may be available and suggested in the community.

Clinicians should be knowledgeable about evidence-based treatment options for substance use disorder and opioid use disorder to make appropriate referrals when needed.

[52] *See* Douglas L. Gourlay, et. al., Universal Precautions in Pain Medicine: A Rational Approach to the Treatment of Chronic Pain, Pain Medicine Vol. 6, Issue 2 (Mar. 2005).

[53] *See* Turk DC, Swanson KS & Gatchel RJ. Predicting opioid misuse by chronic pain patients: A systematic review and literature synthesis. *Clinical Journal of Pain.* 2008 Jul-Aug;24(6):497-508.

Discontinuing Opioid Therapy

Throughout the course of opioid therapy, the clinician and patient should regularly weigh the potential benefits and risks of continued treatment and determine whether such treatment remains appropriate.

If opioid therapy is continued, the treatment plan may need to be adjusted to reflect the patient's changing physical status and needs, as well as to support safe and appropriate medication use.

Discontinuing or tapering of opioid therapy may be required for many reasons and clinicians should discuss with patients a strategy at the outset of treatment for approaching a taper and/or discontinuation of opioids, if clinically indicated. Reasons for discontinuing opioid therapy include resolution of the underlying painful condition, emergence of intolerable side effects, inadequate analgesic effect, failure to improve the patient's quality of life despite reasonable titration, failure to achieve expected pain relief or functional improvement, patient desire to discontinue treatment, significant failure to comply with the treatment agreement, or significant aberrant medication use. Additionally, clinicians should not continue opioid treatment unless the patient has received a benefit, including demonstrated functional improvement, improvement in quality of life, or at least a reduction in the patient's decline.

Tapering and discontinuation of opioid therapy carry significant risks. Unless there are indications of a life-threatening issue, such as warning signs of impending overdose (e.g., confusion, sedation or slurred speech), opioid therapy should not be discontinued abruptly.[54] In addition, if a tapering strategy is pursued, the goal should not necessarily be the discontinuation of opioid therapy, but to identify the appropriate level of therapy required to obtain an optimal level of benefit that outweighs risk. Clinicians should carefully weigh both the benefits and risks of continuing opioids and the benefits and risks of tapering opioids in collaboration with the patient. If opioid therapy is discontinued, the patient who has become physically dependent should be provided a safely structured tapering regimen. Clinicians should collaborate with the patient on the plan for tapering, including how quickly to taper and when pauses in tapering might occur. The termination of opioid therapy should not mark the end of treatment, which should continue with other modalities, either through direct care or referral to other health care specialists, as appropriate.

Discontinuing opioids is not an effortless process for some patients; therefore, a referral may be needed as clinicians have an obligation to provide transition therapy to minimize adverse outcomes.

Medical Records

[54] *See Recommendation 9*, Dowell D, Ragan KR, Jones CM, Baldwin GT, Chou R. *CDC Clinical Practice Guideline for Prescribing Opioids for Pain — United States*, 2022. MMWR Recomm Rep 2022;71(No. RR-3):1–95. DOI: http://dx.doi.org/10.15585/mmwr.rr7103a1.

Clinicians who treat patients for pain should maintain accurate and complete medical records.

Information that should appear in the medical record may include the following:

- Copies of the signed informed consent and treatment agreement
- The patient's medical history, including the underlying medical condition(s) leading to pain
- Results of the physical examination and all laboratory tests
- Results of the risk assessment, including results of any screening instruments used
- A description of the treatments provided, including all medications prescribed or administered (including the date, type, dose and quantity)
- Instructions to the patient, including discussions of risks and benefits with the patient and any significant others
- Results of ongoing monitoring of patient progress (or lack of progress) in terms of pain management, functional improvement, and addressing potentially reversible causes of pain
- Notes on evaluations by and consultations with specialists
- Results of queries to the state PDMP
- Any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors. These may include actual copies of, or references to, medical records of past hospitalizations or treatments by other providers.
- Authorization for release of information to other treatment providers as required by law

The medical record must include all prescription orders for opioids and other controlled substances, whether written, electronically prescribed or telephoned. In addition, written instructions for the use of all medications should be given to the patient and documented in the record.[55] The name, telephone number and address of the patient's primary pharmacy should also be recorded to facilitate contact as needed. Records should be up-to-date and maintained in an accessible manner to be readily available for review.[56]

Compliance with Controlled Substance Laws and Regulations

To prescribe, dispense or administer controlled substances, the clinician must be registered with the DEA, licensed by the state in which he or she practices, and comply with applicable federal and state regulations.[57]

Clinicians should be aware that while they are responsible for the proper prescribing and dispensing of controlled substances, pharmacists are legally bound by a corresponding

[55] Controlled Substances Act of 1970 (CSA). *Federal Register* (CFR). Public Law No. 91-513, 84 Stat. 1242.
[56] Controlled Substances Act of 1970 (CSA). *Federal Register* (CFR). Public Law No. 91-513, 84 Stat. 1242.
[57] Controlled Substances Act of 1970 (CSA). *Federal Register* (CFR). Public Law No. 91-513, 84 Stat. 1242.

responsibility when filling prescriptions for controlled substances. Questions that arise about a prescription should be discussed professionally between the physician and pharmacist.

Clinicians are referred to the *Practitioner's Manual of the U.S. Drug Enforcement Administration* and any relevant state-specific rules and regulations governing the use of controlled substances.[58]

Section 5 – CONCLUSION

The goal of this document is to provide state medical and osteopathic boards with updated recommendations for assessing a clinician's management of pain, to determine whether opioids are used in a manner that is both medically appropriate and in compliance with applicable state and federal laws and regulations. The appropriate management of pain, particularly as related to the prescribing of opioids and other controlled substances with potential for misuse may include the following:

- **Emphasis should be placed on individualized, patient-centered, equitable decision-making:** Patients with pain deserve the same care and compassion as any other patient with complex medical conditions.The decision to initiate, continue, taper or discontinue opioid therapy is one that must be made on an individualized basis. There is no specific numeric threshold or single indicator that applies equally to all patients.

- **Appropriate attention to the initial assessment to determine if opioids are clinically indicated and to determine risks associated with their use in a particular individual with pain:** There are significant risks associated with opioids and therefore benefits must outweigh the risks. Diagnosis and treatment of potentially reversable causes of pain should be a focus of care.

- **Avoid excessive reliance on opioids, particularly high dose opioids (including long-acting and extended-release formulations) for chronic pain management:** It is strongly recommended that clinicians be prepared for risk management with opioids in advance of prescribing. Clinicains should consider alternative treatments for chronic pain that are not generally associated with emergency care, cancer care, sickle cell-related care, palliative or end of life care, maintian opioid dosage as low as possible, and continue if clear and objective outcomes are being met.

- **Adequate attention to patient education and informed consent:** The decision to begin opioid therapy is a shared decision of the clinician and patient, following a discussion of the potential benefits and risks and a clear understanding that the clinical basis for the use of these medications for chronic pain is limited, that some pain may worsen with

[58] United States Department of Justice, Drug Enforcement Administration, *Practitioner's Manual, An Informational Outline of the Controlled Substances Act* (Revised 2023).

opioids, and that taking opioids with other substances (such as benzodiazepines, alcohol, cannabis or other central nervous system depressants) or certain conditions (e.g., sleep apnea, mental illness, pre-existing substance use disorder) may increase risk for adverse events and harms.

- **Adequate monitoring during the use of medications with misuse potential to assess for ongoing benefit and mitigation of potential harms:** Opioids are associated with increased risks, and some patients may benefit from opioid dose reductions or tapering or weaning off the opioid when done in an intentional manner based on a foundation of shared decision making. However, tapering or discontinuation carry signfiicant risks and should be approached through shared decision-making with the patient. Clinicians should not be penalized for accepting new patients who are using prescribed opioids for chronic pain, including high dosages of opioids.

- **Justify dose escalation with adequate attention to risks or alternative treatments:** Risks associated with opioids increase with escalating doses as well as in the setting of other comorbidities (i.e. mental illness, respiratory disorders, pre-existing substance use disorder and sleep apnea) and with concurrent use with respiratory depressants such as benzodiazepines or alcohol.

- **Utilization of available tools for risk mitigations:** The state prescription drug monitoring program should be checked in advance of prescribing opioids and can be a valuable tool for ongoing monitoring.

EXHIBIT F

STATE *of* ALABAMA

MEDICAL LICENSURE COMMISSION

MEMORANDUM

To: Medical Licensure Commission

From: Rebecca Robbins

Subject: FSMB Call for Nominations for Elected Positions to FSMB Board of Directors and Nomination Committee
FSMB Call for Nominations for Staff Fellows to the FSMB Board of Directors
FSMB Call for Applications for Committee and Workgroup Appointments

Date: October 23, 2023

The FSMB is seeking the following nominations and applications.

1. <u>Nominations for elected positions to the FSMB Board of Directors</u> (Requires Commission nomination):

- **Chair-elect - 1 Board Member Fellow, to be elected for 3 years: one year as Chair-elect; one year as Chair; and one year as Immediate Past Chair**
- **Treasurer – 1 Board Member Fellow, to be elected to a single three-year term**
- **Directors-at-Large - 3 Board Member Fellows, each to be elected for a three-year term*/**; if eligible, Directors-at-Large may be reelected to serve one additional term**
- **Nominating Committee - 3 Board Member Fellows, each to be elected to a single two year term***/****

*In accordance with the FSMB Bylaws, *"At least three members of the Board, who are not Staff Fellows, shall be non- physicians, at least two of whom shall be a Member Medical Board public member."* Currently, there are <u>two</u> non- physicians on the FSMB Board, who are Member Medical Board public members, who will continue serving through April 2025. Accordingly, **it is *required* that one non-physician be elected in 2024; additional non-physicians also may be elected.**

**Should a current Board member whose term does not expire in April 2024 be elected Chair-elect, then a 4th candidate will need to be elected to fill the remainder of that Board member's term

***In accordance with the FSMB Bylaws, *"At least one elected member of the Nominating Committee shall be a public member."* Currently, there is one public member on the Nominating Committee and that member's term will end in April 2024. Accordingly, **it is *required* that one public member be elected in 2024; additional public members also may be elected.**

****No two Nominating Committee members shall be from the same Member Medical Board. Continuing members of the Committee are from **Hawaii, Illinois, and the Virgin Islands; therefore, no Nominating Committee candidates shall be from those Member Medical Boards.**

2. <u>Nominations for appointment of Staff Fellows to the FSMB Board of Directors</u> (Requires Commission nomination):

- **Staff Fellow – Appointed to two-year term with eligibility to be reappointed to one additional term**

3. <u>Applications for FSMB Committees and Workgroups</u> (Does not require Commission nomination; Appointments will be made by the incoming FSMB Chair Katie Templeton, J.D.):

Standing Committees:

- Audit
- Bylaws
- Education
- Ethics and Professionalism
- Finance
- Journal Oversight Regulation
- FSMB special committee(s) and/or workgroup(s)

Committee and Workgroup Appointee Eligibility:

- **Board Member Fellow**: A Board Member Fellow is an individual member who as a result of appointment or confirmation is designated to be a member of a Member Medical Board. A Board Member Fellow shall be a Fellow of the FSMB during the member's

- period of service on a Member Medical Board, and for a period of thirty-six months thereafter.

- **Staff Fellow**: A Staff Fellow is an individual hired or appointed and who is responsible for the day-to-day supervision and performance of the administrative duties and functions for which a medical board is responsible. Each member board may denote only one individual to serve as a Staff Fellow of the FSMB. No individual shall continue as a Staff Fellow upon termination of employment by or service to the Member Medical Board.

4. **<u>Appointment to the 2024 Reference and Rules Committees</u>** FSMB current Chair, Dr. Jeffrey Carter, will appoint individuals to serve on these committees that will address business pertinent to the meeting of the 2024 House of Delegates on April 20, 2023.

Any nominations for elected/appointed positions and applications for standing committees and potential special workgroups must be submitted by December 15, 2023.

If the Commission does not wish to submit a nominee for an elected position, this item should be received as information.

EXHIBIT G

STATE *of* ALABAMA

MEDICAL LICENSURE COMMISSION

MEMORANDUM

To: Medical Licensure Commission

From: Rebecca Robbins

Subject: FSMB Call for Award Nominations

Date: October 24, 2023

The FSMB is seeking nominations for its annual awards presentation in which individuals and organizations are recognized for their service and leadership in the medical regulatory community.

Categories of awards include Award of Merit, Leadership Award, Distinguished Service Award, and Lifetime Achievement Award. The awards will be presented at the FSMB's 2024 Annual Meeting.

Past recipients representing Alabama include:

- Gerald L. Summer, M.D. – Award of Merit (1998)
- Kenneth C. Yohn, M.D. – Distinguished Service Award (1998)
- James E. West, M.D. – Distinguished Service Award (2001)
- Leon C. Hamrick, Sr., M.D. – Distinguished Service Award (2009)
- Regina M. Benjamin, M.D., MBA – Lifetime Achievement Award (2012)
- Larry D. Dixon – Award of Merit (2009); Lifetime Achievement Award (2014)
- George C. Smith, Sr., M.D. – Leadership Award (2016)
- J. Daniel Gifford, M.D. – Lifetime Achievement Award (2023)

Submissions are due by December 15, 2023. If the Commission does not wish to submit a nominee(s), this item should be received as information.

NOMINATIONS FOR FSMB AWARDS
2023-2024

Each year, the Federation of State Medical Boards (FSMB) is honored to recognize and encourage outstanding service and remarkable leadership among individuals and organizations involved in medical licensure and discipline.

FSMB Member Medical Boards and other organizations and individuals within the medical regulatory community are invited to nominate individuals for the FSMB's prestigious awards, scheduled to **be presented during the FSMB's Annual Meeting on April 18-20, 2024.**

BACKGROUND

The awards were established in 1986 when Frederick T. Merchant, MD, longtime secretary of the FLEX Board, was presented the Distinguished Service Award, and George E. Sullivan, MD, the perennial secretary of the Maine Board of Registration in Medicine and a former member of the FSMB Board of Directors, was given the Leadership Award.

NOMINATION DEADLINE

Member Medical Boards or individuals wishing to submit nominations should do so no later than **December 15, 2023**. Prior to submitting a nomination, **please refer to the list of past award recipients on pages 4-8** to ensure the individual has not previously been presented with the same award.

AWARD DESCRIPTIONS AND QUALIFICATIONS

AWARD OF MERIT

The Award of Merit is presented to an individual(s) in recognition of **an activity or contribution** that has positively impacted and strengthened the profession of medical licensure and discipline and helped enhance public protection. **Any individual**, whether a physician, non-physician, Fellow, or Honorary Fellow may be nominated. Individuals who are not members of the FSMB may also **be considered**.

LEADERSHIP AWARD

The Leadership Award is presented to an individual in recognition of outstanding and exemplary leadership, commitment, and contribution in advancing the public good **at the medical board level**. The Leadership Award may be presented to **any Fellow or Honorary Fellow of the FSMB** whose contributions to his or her board are believed by the Awards Committee to be in keeping with these guidelines. **No Chair or former Chair of the FSMB is eligible. Additionally, anyone who has served as an FSMB officer, member of the Board of Directors, or full-time FSMB staff member within two years of the presentation is ineligible for consideration**.

DISTINGUISHED SERVICE AWARD

The Distinguished Service Award is presented to an individual in recognition of the highest level of service, commitment, and contribution **to the FSMB**; the advancement of the profession of medical licensure and

discipline; and the strengthening and enhancement of public protection. **Any individual**, whether a physician, non-physician, Fellow, or Honorary Fellow may be nominated. Individuals who are not members of the FSMB may also **be considered**. However, **anyone who has served as an FSMB officer, member of the Board of Directors, or full-time FSMB staff member within two years of the presentation is ineligible for consideration. This award may be presented posthumously.**

LIFETIME ACHIEVEMENT AWARD

The Lifetime Achievement Award, on rare occasions, may be presented to an individual who has **demonstrated extraordinary and sustained service and commitment to the field of medical licensure and discipline**. **Any individual**, whether a physician, non-physician, Fellow, Honorary Fellow, or individuals not directly associated with FSMB **may be considered**. **This unique award is bestowed infrequently as the Awards Committee may deem appropriate and is not intended to be given on an annual basis**.

ADDITIONAL CRITERIA

- Individuals serving on the FSMB Board of Directors are ineligible to receive an award concurrent to service on the Board of Directors.
- Individuals nominated for FSMB elected office are ineligible to receive an award at the Annual Meeting.
- Individuals serving on the Awards Committee are ineligible to receive an award.

NOMINATION REQUIREMENTS

Member Medical Boards or individuals interested in nominating someone for an award should submit:

1. A Letter of Nomination *(see sample on page 9)*. The letter should specify:
    - The name of the nominee to be considered;
    - The award for which the nominee is being nominated;
    - Why the Member Medical Board or individual supports the nominee, including information on how the nominee meets the criteria of the award for which he/she is being nominated: and
    - The nominee's contact information, including mailing address, daytime phone number and email address.

    If nominating an individual for more than one award, please submit separate nomination letters for each award.

2. The nominee's *current* CV Summary **(maximum of 5 pages)**.

3. Please address your letter to:
    Sarvam P. TerKonda, MD, Chair
    FSMB Awards Committee

NOMINATION SUBMISSION

Your nomination letter and the nominee's CV/bio should be submitted to pmccarty@fsmb.org **no later December 15, 2023. Please submit all documents in one email.**

A confirmation email acknowledging receipt of the nomination will be sent within two business days. **If you do not receive confirmation, please contact Pat McCarty at the above email or at 817-868-4067.**

*****NOTIFICATION*****

Award recipients will be contacted **after the FSMB Board of Directors has considered the Awards Committee's recommendations and made its final determination in February 2024**. *It is advisable that nominees not be informed of their nominations prior to official notification of being a recipient in the event they are not selected this year.*

Award of Merit

(formerly the Special Recognition Award, then Meritorious Service Award)

1994	Andrew Watry, MPA, *North Carolina*
1996	Carole A. Smith, *Oklahoma Medical*
1998	Gerald L. Summer, MD, *Alabama*
	John J. Ulwelling, *Oregon*
1999	George M. Brown Jr., MD, *Oklahoma Medical*
	Salvatore N. Riggio, MD, *Missouri*
2001	Bryant D. Paris, *North Carolina*
2003	Dale G Breaden, *North Carolina*
2004	Janet D. Carson, JD, *(individual nonmember)*
	I. Kathryn Hill, MEd, *(individual nonmember)*
2005	Mark R. Yessian, PhD, *Massachusetts*
	Deanna Zychowski, *Wisconsin*
2007	Jordan H. Cohen, MD, *District of Columbia*
	John R. Gimpel, DO, MEd, *(individual nonmember)*
	Peter V. Scoles, MD, *(individual nonmember)*
	Gerald P. Whelan, MD, *(individual nonmember)*
2008	Guy T. Selander, MD, *(individual nonmember)*
	Gerold L. Schiebler, MD, *(individual nonmember)*
2009	Larry D. Dixon, *Alabama*
2010	Trent P. Pierce, MD, *Arkansas*
2012	Jaime B. Garanflo, *Texas*
	Barbara Neuman, JD, *Massachusetts*
2013	Carl F. Ameringer, PhD, JD *(individual nonmember)*
2014	H. Westley Clark, MD, JD *(individual nonmember)*
	Edward S. Salsberg, MPA *(individual nonmember)*
2015	Hedy L. Chang, MS, *California Medical*
	Bruce F. Cullen, MD, *Washington Medical*
	Kenneth B. Simons, MD, *Wisconsin*
2016	Kathy L. Apple, RN, MS *(individual nonmember)*
	Kevin D. Bohnenblust, JD, Wyoming
	Carmen A. Catizone, DPh, MS *(individual nonmember)*
	Ruth Horowitz, PhD, *New York PMC*
	Michael J. Kramer, *Washington Medical*
	Robert Lubran, MS, MPA *(individual nonmember)*
2017	Gerard F. Dillon, PhD *(individual nonmember)*
	Carole V. Erickson, *Montana*
	William E. Gotthold, MD, *Washington Medical*
2018	Alejandro Aparicio, MD, FACP *(individual nonmember)*
	Laura E. Forester, JD, *Illinois*
	Norman B. Kahn Jr., MD *(individual nonmember)*
2019	Michael L. Farrell, JD, *Washington Medical*
	Vladimir Lozovskiy, JD, RN, *Illinois*
	Amelia Boyd, *Washington Medical*

Award of Merit (cont.)

2020	Scott G. Kirby, MD, *North Carolina*
	Timothy E. Terranova, *Maine Medical*
2021	Anne K. Lawler, JD, RN, *Idaho*
	Ernest E. Miller, Jr., DO, *West Virginia Osteopathic*
2022	Melanie B. Blake, MD, MBA, *Tennessee Medical*
	Jimi Bush, MPA, *Washington Medical*
	Maureen S. Lathrop, *Maine Medical*
	Kristina D. Lawson, JD, *California Medical*
2023	Brian L. Blankenship, JD, *North Carolina*
	Marisa Courtney, *Washington Medical*
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2023 J. Daniel Gifford, MD, FACP, *Alabama*
R. David Henderson, JD, *North Carolina*

Award of Merit

(formerly the Special Recognition Award, then Meritorious Service Award)

1994	Andrew Watry, MPA, *North Carolina*
1996	Carole A. Smith, *Oklahoma Medical*
1998	Gerald L. Summer, MD, *Alabama*
	John J. Ulwelling, *Oregon*
1999	George M. Brown Jr., MD, *Oklahoma Medical*
	Salvatore N. Riggio, MD, *Missouri*
2001	Bryant D. Paris, *North Carolina*
2003	Dale G Breaden, *North Carolina*
2004	Janet D. Carson, JD, *(individual nonmember)*
	I. Kathryn Hill, MEd, *(individual nonmember)*
2005	Mark R. Yessian, PhD, *Massachusetts*
	Deanna Zychowski, *Wisconsin*
2007	Jordan H. Cohen, MD, *District of Columbia*
	John R. Gimpel, DO, MEd, *(individual nonmember)*
	Peter V. Scoles, MD, *(individual nonmember)*
	Gerald P. Whelan, MD, *(individual nonmember)*
2008	Guy T. Selander, MD, *(individual nonmember)*
	Gerold L. Schiebler, MD, *(individual nonmember)*
2009	Larry D. Dixon, *Alabama*
2010	Trent P. Pierce, MD, *Arkansas*
2012	Jaime B. Garanflo, *Texas*
	Barbara Neuman, JD, *Massachusetts*
2013	Carl F. Ameringer, PhD, JD *(individual nonmember)*
2014	H. Westley Clark, MD, JD *(individual nonmember)*
	Edward S. Salsberg, MPA *(individual nonmember)*
2015	Hedy L. Chang, MS, *California Medical*
	Bruce F. Cullen, MD, *Washington Medical*
	Kenneth B. Simons, MD, *Wisconsin*
2016	Kathy L. Apple, RN, MS *(individual nonmember)*
	Kevin D. Bohnenblust, JD, Wyoming
	Carmen A. Catizone, DPh, MS *(individual nonmember)*
	Ruth Horowitz, PhD, *New York PMC*
	Michael J. Kramer, *Washington Medical*
	Robert Lubran, MS, MPA *(individual nonmember)*
2017	Gerard F. Dillon, PhD *(individual nonmember)*
	Carole V. Erickson, *Montana*
	William E. Gotthold, MD, *Washington Medical*
2018	Alejandro Aparicio, MD, FACP *(individual nonmember)*
	Laura E. Forester, JD, *Illinois*
	Norman B. Kahn Jr., MD *(individual nonmember)*
2019	Michael L. Farrell, JD, *Washington Medical*
	Vladimir Lozovskiy, JD, RN, *Illinois*
	Amelia Boyd, *Washington Medical*

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	R. David Henderson, JD, *North Carolina*

SAMPLE NOMINATION LETTER
(The following letter is fictitious and is meant for guidance only; content should be adjusted according to the qualifications for the specific award for which the person is being nominated)

Sarvam P. TerKonda, MD, Chair
FSMB Awards Committee
c/o Pat McCarty, Director of Leadership Services

RE: Nomination of [NOMINEE'S NAME] for the [NAME OF AWARD]

Dear Dr. TerKonda:

[SAMPLE TEXT – please describe nominee's qualifications in your own words – include examples where appropriate – and adjust according to the award descriptions and qualifications provided in the Call for Award Nominations.]

It is with great pleasure that I [or the NAME OF STATE MEDICAL BOARD] nominate [Nominee's name] for the FSMB's 2024 [NAME OF AWARD].

[Nominee's Name] has served the medical community and her patients with extraordinary care and respect since entering into solo practice in April 1975. Since that time, she has not only distinguished herself as a physician and healer, but also as a public servant for the advancement of medicine and the medical regulatory process. Throughout her career, [Nominee's Name] has worked selflessly to ensure the safety, protection, and welfare of all patients.

[Nominee's Name] has held multiple positions of authority at the local, state, and national levels, including, but not limited to [EXAMPLES such as current position on the state medical board, positions on the county/state medical societies, hospitals, medical schools, etc.]. She has also been highly involved with the FSMB [EXAMPLES OF FSMB SERVICE]. Her involvement has led to [EXAMPLES OF IMPACT]. But it is also [Nominee's Name's] quiet strength, courage, and dedication in other areas of her life that have earned her the utmost respect and admiration of her patients and colleagues alike [EXAMPLES].

I am therefore honored and privileged to nominate [Nominee's Name] for one of the FSMB's highest honors of 2024.

Sincerely,

[NOMINATOR's NAME AND TITLE]

cc: [NAMES]

Enclosure – Curriculum CV with contact information

EXHIBIT H

STATE *of* ALABAMA

MEDICAL LICENSURE COMMISSION

MEMORANDUM

To: Medical Licensure Commission

From: Rebecca Robbins

Subject: Steven Wayne Powell, M.D. – Administrative Suspension

Date: October 19, 2023

Dr. Steven Wayne Powell was licensed in Alabama through the Interstate Medical Licensure Compact on January 1, 2020. On August 28, 2023, Dr. Powell voluntarily surrendered his license to practice medicine to the Louisiana State Board of Medical Examiners following a felony conviction relating to health care fraud in violation of 18 U.S.C. § 1347, in the United States District Court for the District of New Hampshire.

Pursuant to the provisions of Section 10(d) of the Interstate Medical Licensure Compact, codified in Ala. Code §34-24-529(d), Dr. Powell's Alabama medical license was administratively suspended for a period of 90 days. The suspension is retroactively effective from the surrender of the Louisiana medical license on August 28, 2023. Dr. Powell's license will automatically return to active status on November 26, 2023.

Attachments:

- Administrative Suspension Letter
- Louisiana State Board of Medical Examiners Action

EXHIBIT I

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, Complainant, vs. JOHN BUTLER BLALOCK, JR., M.D., Respondent.	)	CASE NO.: 2023-288

NOTICE OF INTENT TO CONTEST REINSTATEMENT

Comes now the Alabama State Board of Medical Examiners ("the Board"), under ALA. CODE § 34-24-337 (2007), and gives notice of the Board's intent to contest the reinstatement of the license to practice medicine in Alabama of Respondent John Butler Blalock, Jr., M.D., ("Respondent"), license number MD.9169. The Board has probable cause to believe that grounds exist for the denial of the application for reinstatement and will exhibit the same in its forthcoming Administrative Complaint.

The Board requests that a hearing be scheduled before the Medical Licensure Commission prior to a decision regarding the reinstatement of Respondent's license to practice medicine in Alabama.

EXECUTED this 28th day of September, 2023.

William M. Perkins
Executive Director
ALABAMA STATE BOARD OF MEDICAL EXAMINERS

Alicia Harrison, Associate General Counsel
ALABAMA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 946
Montgomery, Alabama 36101-0946
Telephone: 334-833-0167
Email: aharrison@albme.gov

EXHIBIT J

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, Complainant, vs. JOHN BUTLER BLALOCK, JR., M.D., Respondent.	)	CASE NO.: 2023-288

MOTION TO WITHDRAW NOTICE OF INTENT TO CONTEST REINSTATEMENT

Comes now the Alabama State Board of Medical Examiners ("the Board"), by and through its counsel, and moves to withdraw its Notice of Intent to Contest Reinstatement previously filed in this matter on September 28, 2023. As grounds for this motion, the Board states that Respondent John Butler Blalock, Jr., M.D. has agreed to enter into a voluntary agreement with the Board in lieu of proceeding further with this matter.

Respectfully submitted on this the 24th day of October, 2023.

s/ Alicia Harrison

Alicia Harrison, Associate General Counsel
ALABAMA STATE BOARD OF MEDICAL EXAMINERS
Post Office Box 946
Montgomery, Alabama 36101-0946
Telephone: 334-833-0167
Email: aharrison@albme.gov

CERTIFICATE OF SERVICE

I certify that on this 24th day of October, 2023, I served a true and correct copy of the foregoing on the following individuals by sending the same *via* U.S. Mail or electronic mail:

John Butler Blalock, Jr., M.D.
901 Crestview Drive
Mountain Brook, AL 35213
locks50@aol.com

Honorable William R. Gordon
wrgordon@charter.net

Aaron Dettling, Esq.
adettling@almlc.gov

Rebecca Robbins
rrobbins@almlc.gov

s/ Alicia Harrison
OF COUNSEL

EXHIBIT K

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **CARL EDWARD ALBERTSON, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-248**

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 September 27, 2023. The Board and the Respondent, Carl Edward Albertson, 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 Administrative Complaint, the Settlement Agreement, and this Consent Decree shall constitute public records under the laws of the State of Alabama. The Administrative Complaint, 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 June 25, 1997, having been issued license no. MD.20915. Respondent was so licensed at all relevant times.

2. On or about December 20, 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 AMA PRA Category 1™ credits had been met or would be met by December 31, 2022. Respondent further represented that, if audited, he would have supporting documents.

3. Respondent earned only 21.75 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 one thousand dollars ($1,000.00). 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]

[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 Respondent is ordered to obtain 25 ***additional*** credits of AMA PRA Category 1™ or equivalent continuing medical education, in addition to the 25 credits already required for calendar year 2023, for a combined total of 50 credits, during calendar year 2023.

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

DONE on this the 8th day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-08 14:00:12 CST

Craig H. Christopher, M.D.
its Chairman

EXHIBIT L

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **KEITH M. HARRIGILL, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-259**

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 October 17, 2023. The Board and the Respondent, Keith M. Harrigill, 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 Administrative Complaint, the Settlement Agreement, and this Consent Decree shall constitute public records under the laws of the State of Alabama. The Administrative Complaint, 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 September 17, 2009, having been issued license no. MD.29783. Respondent was so licensed at all relevant times.

2. On or about October 28, 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 AMA PRA Category 1™ credits had been met or would be met by December 31, 2022. Respondent further represented that, if audited, he would have supporting documents.

3. Respondent earned only 22.0 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 one thousand dollars ($1,000.00). 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]

[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 Respondent is ordered to obtain 25 ***additional*** credits of AMA PRA Category 1™ or equivalent continuing medical education, in addition to the 25 credits already required for calendar year 2023, for a combined total of 50 credits, during calendar year 2023.

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

DONE on this the 8th day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-08 13:59:16 CST

Craig H. Christopher, M.D.
its Chairman

EXHIBIT M

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **BRIAN J. TIERNEY, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-268**

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 October 10, 2023. The Board and the Respondent, Brian J. Tierney, 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 Administrative Complaint, the Settlement Agreement, and this Consent Decree shall constitute public records under the laws of the State of Alabama. The Administrative Complaint, 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 January 28, 2004, having been issued license no. MD.25827. Respondent was so licensed at all relevant times.

2. On or about December 1, 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 AMA PRA Category 1™ credits had been met or would be met by December 31, 2022. Respondent further represented that, if audited, he would have supporting documents.

3. Respondent earned only 0.75 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]

[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 Respondent is ordered to obtain 25 ***additional*** credits of AMA PRA Category 1™ or equivalent continuing medical education, in addition to the 25 credits already required for calendar year 2023, for a combined total of 50 credits, during calendar year 2023.

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

DONE on this the 8th day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-08 13:57:50 CST

Craig H. Christopher, M.D.
its Chairman

EXHIBIT N

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,	)	
Complainant,	)	
v.	)	
	)	**CASE NO.: 2023-087**
NEFERTITI HARMON DURANT, M.D.,	)	
Respondent.	)	

MOTION TO CONTINUE

COME NOW, the Alabama State Board of Medical Examiners ("the Board") and Nefertiti Harmon Durant, M.D. ("Respondent") (hereinafter collectively referred to as "the Parties"), and request that the hearing set before the Medical Licensure Commission ("the Commission") on October 31, 2023, in the above-styled case be continued. As grounds for this motion, the Parties state Respondent has recently experienced health issues that has caused delay in preparing for the hearing. Neither party will be prejudiced by a continuance.

WHEREFORE, premises considered, the Parties respectfully request that the Commission continue the hearing for at least three months from its current setting.

Respectfully submitted on this the 17th day of October, 2023.

s/ E. Wilson Hunter
E. Wilson Hunter, General Counsel
Alabama State Board of Medical Examiners
Post Office Box 946
Montgomery, Alabama 36101-0946
Email: whunter@albme.gov

CERTIFICATE OF SERVICE

I certify that on this 17th day of October, 2023, I served a true and correct copy of the foregoing on the following individuals, *via* U.S. Mail or electronic mail:

Robert P. MacKenzie, III
Starnes Davis Florie LLP
100 Brookwood Place, 7th Floor
Birmingham, AL 35209
bmackenzie@starneslaw.com

Honorable William R. Gordon
wrgordon@charter.net

Aaron Dettling, Esq.
adettling@almlc.gov

Rebecca Robbins
rrobbins@almlc.gov

s/ E. Wilson Hunter
OF COUNSEL

EXHIBIT O

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,	)	
Complainant,	)	
v.	)	**Case No. 2022-318**
RICHARD EDWIN JONES, III, M.D.,	)	
Respondent.	)	

ANSWER OF RICHARD EDWIN JONES, III, M.D.
TO ADMINISTRATIVE COMPLAINT

COMES NOW the Respondent, Richard Edwin Jones, III, M.D., ("Respondent" or "Dr. Jones") and, in response to the Administrative Complaint filed against him by the Alabama State Board of Medical Examiners ("ABME"), states as follows:

DEFENSES AND GENERAL DENIAL

FIRST DEFENSE

Respondent asserts that the Complaint fails to state a claim upon which to take negative action against Respondent's license to practice medicine in this state or impose any type of fine or penalty.

SECOND DEFENSE

Respondent denies that he violated any applicable rule or regulation of the ABME, the Medical Licensure Commission, or the state of Alabama so as to support any negative action against Respondent's license to practice medicine in the state of Alabama or impose any type of fine or penalty.

THIRD DEFENSE

Respondent denies that any act or omission on his part constitutes sufficient conduct so as to support the taking of any negative action against his license to practice medicine in this state or impose any type of fine or penalty.

FOURTH DEFENSE

Respondent specifically denies that he has violated Ala. Code § 34-24-360, Ala. Admin. Code 545-X-3-.08, or 545-X-1-.11.

FIFTH DEFENSE

Respondent denies that he is unable to practice medicine with reasonable skill and safety to his patients.

SIXTH DEFENSE

Respondent denies that he aided or abetted the unauthorized practice of medicine.

SEVENTH DEFENSE

Respondent denies that he committed gross malpractice, repeated malpractice or negligence.

EIGHTH DEFENSE

Respondent denies that he committed unprofessional conduct.

NINTH DEFENSE

The rules and regulations upon which the Board's Complaint is based violate Respondent's right to due process because they are unconstitutionally vague.

TENTH DEFENSE

The Board's actions are arbitrary and capricious.

ELEVENTH DEFENSE

Respondent complied with the Board's published Practice Issues & Opinions dated March 23, 1999 related to unlicensed assistive personnel in physicians' offices or clinics administering medications, including administering medications by injection. A copy of which is attached hereto as Exhibit A.

TWELFTH DEFENSE

The rules and regulations upon which the Board's Complaint is based violate Respondent's right to due process because they fail to give a person of ordinary intelligence a reasonable opportunity to know what is prohibited and fail to provide explicit standards to those who apply the laws.

ANSWER TO ALLEGATIONS

In response to the specific enumerated allegations against him, the Respondent states as follows:

1. Respondent admits the allegations contained in Paragraph 1.

2. Respondent admits the allegations contained in Paragraph 2. Jorge Rodriguez graduated from the School of Medicine, University of Havana and received his Doctor of Medicine degree in 1984 and was licensed to practice medicine in Cuba beginning in 1984, licensed to practice medicine in Mexico in 1994, and licensed to practice medicine in Nicaragua in 1984. Jorge Rodriquez practiced medicine at the Sports Medicine Institute in Hermanos Ameijeiras Hospital where he was a practicing physician and professor of medicine and performed imaging studies including MRI and ultrasound of the musculoskeletal systems including those for the Cuban Olympic Team members. He was a sonologist and sports medicine specialist and primary physician for the professional baseball team in Sinaloa, Mexico. Jorge Rodriguez was an ultrasound instructor and sonologist for Discovery Diagnostics in Los

Angeles, California and Diagnostic Medical Ultrasound Instructor and Continuing Education Instructor of Musculoskeletal Ultrasound in Miami, Florida. Jorge Rodriguez holds the Pioneer Certification of MSKUS from the American Registry for Diagnostic Medical Sonography (ARDMS) as a physician beginning in 2012 and a Physician Certification in RMSK from the Alliance for Physician Certification and Advancement (APCA) since 2016.

3. Patient 1 is not Respondent's patient, nor did Respondent care for Patient 1 on the day in question. Accordingly, Respondent lacks sufficient personal knowledge and information to either admit or deny the allegations in Paragraph 3, therefore Respondent denies the allegations.

4. Patient 1 is not Respondent's patient, nor did Respondent care for Patient 1 on the day in question. Accordingly, Respondent lacks sufficient personal knowledge and information to either admit or deny the allegations in Paragraph 4, therefore Respondent denies the allegations.

5. Patient 1 is not Respondent's patient, nor did Respondent care for Patient 1 on the day in question. Accordingly, Respondent lacks sufficient personal knowledge and information to either admit or deny the allegations in Paragraph 5, therefore Respondent denies the allegations.

6. Patient 1 is not Respondent's patient, nor did Respondent care for Patient 1 on the day in question. Accordingly, Respondent lacks sufficient personal knowledge and information to either admit or deny the allegations in Paragraph 6, therefore Respondent denies the allegations.

7. Patient 1 is not Respondent's patient, nor did Respondent care for Patient 1 on the day in question. Accordingly, Respondent lacks sufficient personal knowledge and information

to either admit or deny the allegations in Paragraph 7, therefore Respondent denies the allegations.

8. Respondent lacks sufficient personal knowledge and information to either admit or deny the allegations in Paragraph 8, therefore Respondent denies the allegations.

9. Respondent lacks sufficient personal knowledge and information to either admit or deny the allegations in Paragraph 9, therefore Respondent denies the allegations.

10. Respondent lacks sufficient personal knowledge and information to either admit or deny the allegations in Paragraph 10, therefore Respondent denies the allegations.

11. Respondent lacks sufficient personal knowledge and information to either admit or deny the allegations in Paragraph 11, therefore Respondent denies the allegations.

12. Respondent lacks sufficient personal knowledge and information to either admit or deny the allegations in Paragraph 12, therefore Respondent denies the allegations.

13. Respondent admits writing a letter to the Board in or around October 22, 2010. The terms of the letter speak for themselves. To the extent the allegations of Paragraph 13 are inconsistent with any of the terms or are taken out of context, they are denied.

14. Respondent denies the allegations in Paragraph 14.

CHARGES

15. Respondent denies the allegations in Paragraph 15.

COUNT ONE – AIDING OR ABETTING THE UNAUTHORIZED PRACTICE OF MEDICINE

16. Respondent denies the allegations in Paragraph 16.

COUNT TWO – GROSS AND REPEATED MALPRACTICE

17. Respondent denies the allegations contained in Paragraph 17.

COUNT THREE – UNPROFESSIONAL CONDUCT

18. Respondent denies the allegations contained in Paragraph 18.

To the extent that the remaining paragraphs require a response, Respondent denies the allegations set forth therein and respectfully requests that the Medical Licensure Commission of Alabama take no negative action against Respondent's license to practice medicine in this state or impose any type of fine or penalty.

Respondent reserves the right to add additional defenses and denials upon receipt of more definitive information or amendment to the Administrative Complaint.

Respectfully Submitted,

/s/ James A. Hoover
James A. Hoover (HOO022)

Attorney for Respondent

OF COUNSEL:

BURR & FORMAN LLP
420 North 20th Street
Birmingham, AL 35203
Telephone: (205) 251-3000
Facsimile: (205) 244-5762
jhoover@burr.com

CERTIFICATE OF SERVICE

I hereby certify that I have served the pleading via facsimile or electronic mail on this the 24th day of October 2023, on the following:

E. Wilson Hunter
General Counsel
Alabama State Board of Medical Examiners
P.O. Box 946
Montgomery, AL 36101-0946
Telephone: (334) 242-4116
Email: whunter@albme.gov

Alicia Harrison
Associate General Counsel
Alabama State Board of Medical Examiners
P.O. Box 946
Montgomery, AL 36101-0946
Telephone: (334) 242-4116
Email: aharrison@albme.org

Rebecca Robbins
Director, MLC Operations
Medical Licensure Commission of Alabama
P.O. Box 887
Montgomery, AL 36101-0887
Email: rrobbins@almlc.gov

William Gordon, Hearing Officer
Email: wrgordon@charter.net

Aaron L. Dettling
General Counsel, Medical Licensure Commission of Alabama
Fortif Law Partners, LLC
o 205.832.9105
c 205.515.4624
Post Office Box 530564, Birmingham, Alabama 35253
Email: adettling@almlc.gov

/s/James A. Hoover
OF COUNSEL

EXHIBIT A

ALABAMA STATE BOARD OF MEDICAL EXAMINERS
Larry D. Dixon, Executive Director

March 23, 1999

Dear :

The Alabama State Board of Medical Examiners has received and reviewed your January 14, 199, letter concerning unlicensed assistive personnel giving injections. You have asked for an Alabama State Board of Medical Examiners opinion on "physicians delegating medication administration, especially administration by injection, to unlicensed assistive personnel."

In your letter, you state that unlicensed assistive personnel in physicians' offices or clinics may be administering medications, including administering medications by injection. According to your information, the administering of medications by unlicensed personnel is occurring without the involvement of a licensed nurse. A practice consultant at the Alabama Board of Nursing has told you that the Alabama Board of Nursing has no jurisdiction over unlicensed personnel, and, therefore, could not comment on unlicensed assistive personnel giving injections when a licensed nurse is not involved. We understand that you have also requested an opinion from the Board of Nursing on the issue of whether the act of administering a mediation by injection is considered the practice of nursing and, therefore, an act which requires a license to practice as a nurse

After reviewing applicable law, including state and Federal statutes and Alabama State Board of Medical Examiners' Rules, it is clear, concerning physicians and unlicensed personnel, that only the physician has the authority to make the decision to provide medication, by injection or otherwise, to a patient. This decision-making authority should never be delegated to unlicensed assistive personnel.

There exists no Alabama State Board of Medical Examiners' Rule which addresses the act or task of injecting patients with medication by unlicensed assistive personnel. Consequently, if unlicensed assistive personnel in a physician's office or clinic administer medication by injection to a patient pursuant to delegation by the physician and under the direct supervision of the physician, it is the Board's opinion that no violation of any Board of Medical Examiners Rule has occurred; however, the physician remains responsible for the actions of the employee.

This opinion by the Board is limited to the facts and circumstances set forth in your letter dated January 14, 1999, and is issued on reliance of the correctness of those facts.

I hope that the foregoing information has been responsive to your requests.

Sincerely,
Alabama Board of Medical Examiners

/s/ William M. Lightfoot, M. D.

William M. Lightfoot, M. D
Chairman

WML:cjh

EXHIBIT P

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **NEFERTITI HARMON DURANT, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-087**

CONSENT DECREE

This matter comes before the Medical Licensure Commission of Alabama (the "Commission") on the Administrative Complaint filed by the Alabama State Board of Medical Examiners (the "Board"). The Board and the Respondent, Nefertiti Harmon Durant, M.D. ("Respondent"), have asked the Commission to approve and enter this Consent Decree.

General Provisions

1. **Protection of the Public.** The Board has stipulated and agreed that the terms and conditions of the Settlement Agreement and of this Consent Decree constitute a reasonable disposition of the matters asserted in the Administrative Complaint, and that such disposition adequately protects the public's health and safety. After review, the Commission also finds that this Consent Decree is a reasonable and appropriate disposition of the matters asserted in the Administrative

Complaint, and that the provisions of this Consent Decree will adequately protect the public safety. 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. The duration of the probation and/or restrictions imposed by this Consent Decree are mutually negotiated and bargained-for terms, and Respondent has validly waived any right to apply to the Commission for modification of those terms and any right to a hearing on such a request under Ala. Code § 34-24-361(h)(9).

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 will be reported by the Board and/or the Commission to the Federal National Practitioner Data Bank ("NPDB") and the

Federation of State Medical Boards' ("FSMB") disciplinary data bank. The Settlement Agreement and this Consent Decree may otherwise 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 23, 2006, having been issued license no. MD.27640. Respondent was so licensed at all relevant times.

2. On or about August 16, 2020, Respondent received an Alabama Uniform Traffic Ticket and Complaint for driving under the influence of alcohol in Jefferson County, Alabama in violation of Ala. Code § 32-5A-191(a)(2). On or about November 19, 2020, Respondent disclosed the DUI arrest during the process of renewing her medical license for calendar year 2021. The Board interviewed Respondent on or about July 21, 2021, and thereafter closed the matter.

3. On December 27, 2022, Respondent signed an Agreement Not to Practice Medicine until completion of a professional evaluation and approval by the Alabama Professionals Health Program's ("APHP") Director, Medical Director and the Wellness Committee.

4. On or about January 3, 2023, Respondent received an Alabama Uniform Traffic Ticket and Complaint for driving under the influence of alcohol in St. Clair County, Alabama in violation of Ala. Code § 32-5A-191(a)(2).

5. On or about March 16, 2023, APHP notified the Board that Respondent was directed to complete a professional evaluation as a result of behavior displayed at UAB and for possible substance abuse issues.

6. APHP further informed the Board that Respondent entered the Florida Recovery Center ("FRC") on or about January 17, 2023, for evaluation and treatment. While in treatment, Respondent was reportedly disruptive and difficult to work with. Respondent was discharged from FRC on February 27, 2023, without completing her treatment program. On or about March 10, 2023, Dr. Scott Teitelbaum, the Medical Director at FRC, notified APHP that Respondent left the program against medical advice.

7. In late April 2023, Respondent entered treatment at Bradford Health Services in Warrior, Alabama. On July 19, 2023, Respondent was discharged after twelve (12) weeks of residential addiction treatment.

8. Respondent was next evaluated at Acumen Assessments during the week of July 31 through August 3, 2023. In a report dated August 18, 2023, Dr. Peter Graham stated that Respondent was diagnosed with alcohol use disorder, severe; social anxiety disorder, performance type; dysthymia with intermittent major depressive episodes, and obsessive-compulsive, histrionic, narcissistic, and dependent personality traits consistent with her professional cohort but disruptive to her functioning. Dr. Graham's report concluded that, at the time of writing, Respondent had successfully engaged in treatment to the point that she is considered fit for duty and able to practice medicine with reasonable skill and safety to her

patients with appropriate monitoring and follow-up outpatient care. APHP advocates for Respondent's continued licensure and for the entry of this Consent Decree.

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 concludes, as a matter of law, that the determined facts constitute violations of Ala. Code § 34-24-360(19)a. as charged in Count One of the Administrative Complaint, and of Ala. Code § 34-24-360(2) and (23) as charged in Count Two of the Administrative Complaint.

Order/Discipline

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

1. That Respondent is adjudged GUILTY of the charges alleged in Counts One and Two of the Administrative Complaint;

2. That the suspension of Respondent's license to practice medicine in Alabama imposed by our Order of March 27, 2023 is VACATED;

3. That Respondent's license to practice medicine in the State of Alabama is REVOKED; that pursuant to Ala. Code § 34-24-361(h)(4) such revocation is

SUSPENDED, and that Respondent's license to practice medicine in Alabama is placed on PROBATION for a period of sixty (60) months, conditioned as follows:

a. Respondent shall not commence the practice of medicine until she submits a detailed practice plan to the Commission, including the location, employer, scope of practice, and other pertinent information, and the practice plan is approved by the Commission;

b. Respondent's initial practice plan shall include the provision that she shall not practice medicine more than 30 hours per week for a minimum period of six months and unless and until she is approved to return to full time work by her treatment professionals and the Commission;

c. Respondent shall not practice medicine outside the scope of her approved practice plan, including "moonlighting," during the term of probation without prior written authorization from the Commission;

d. Respondent shall maintain a lifetime monitoring contract with APHP;

e. Respondent shall implement and abide by all past, present, and future treatment recommendations made to her by the evaluating

professionals at APHP, Acumen Assessments, Bradford Health Services, or any other treatment individual as directed by APHP; and

f. Respondent shall abide by all state and federal laws and regulations related to the practice of medicine.

4. That the Board shall monitor Respondent's compliance with the requirements of this Consent Decree. As part of such monitoring, Respondent shall have an affirmative obligation to inform the Board's Physician Monitor of any updated assessments or recommendations by the evaluating professionals at APHP, Acumen Assessments, Bradford Health Services, or any other treatment individual as directed by APHP, and Respondent shall execute any necessary consents or waivers allowing such assessments or recommendations to be provided to the Board and the Commission. The Board's Physician Monitor shall obtain and provide the Commission copies of any updated assessments or recommendations.

5. That no administrative fine nor costs of this proceeding are assessed against Respondent at this time.

DONE on this the _____ day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-13 17:13:27 CST

Craig H. Christopher, M.D.
its Chairman

EXHIBIT Q

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

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 October 25, 2023, attached hereto as Exhibit "A". Upon review and consideration by the full Commission, the recommended Findings of Fact and Conclusions of Law of the three-member panel are **RATIFIED** and **ADOPTED** as the findings of the Commission. *See* Ala. Code § 34-24-366; Ala. Admin. Code r. 545-X-3-.14(3).

Based on those Findings of Fact and Conclusions of Law, it is **ORDERED, ADJUDGED**, and **DECREED** as follows:

1. That the Respondent is adjudged **GUILTY** of violations of rules of the Board of Medical Examiners as charged in Counts Three, Four, Five, and Seven of the Administrative Complaint.

2. That Counts One, Two, Six, and Eight are **DISMISSED WITH PREJUDICE.**

3. That the Respondent's license to practice medicine in the State of Alabama is **RESTRICTED** such that Respondent shall not be permitted to engage in a collaborative practice agreement for a period of three years from the date of this Order.

4. That Respondent is **ASSESSED** an administrative fine of five thousand dollars ($5,000.00) as to each of Counts Three, Four, Five, and Seven of the Administrative Complaint, for a total administrative fine of twenty thousand dollars ($20,000.00). In accordance with Ala. Admin. Code r. 545-X-3-.08(8)(d)(i), Respondent shall pay the administrative fine within 30 days of this Order.[1]

5. That upon expiration of the restriction on collaborative practice agreements provided for above, Respondent is **ORDERED** to comply with the following requirements in connection to any future collaborative practice agreement:

a. Respondent will maintain a daily log which memorializes the facility at which he works for every working day, and Respondent

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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).

will maintain this log in a manner readily accessible to his staff and immediately producible to the Board upon request;

b. Respondent will maintain all CRNP quarterly Quality Assurance Review and certification and training paperwork in a manner readily accessible to his staff, available at each practice site, and immediately producible to the Board upon request;

c. Any collaborating CRNP shall not prescribe any controlled substance unless and until he or she obtains an Alabama DEA and QACSC from the Board. Respondent will provide training, and document such training, to the CRNP concerning the rules and regulations governing the prescribing of controlled substances in Alabama;

d. Respondent shall prohibit any CRNP working at a practice site with which he is affiliated from administering TriMix injections and reverse priapism injections to patients unless and until said CRNP is authorized in writing by the Board to perform said functions; and

e. Before applying for any new collaborative practice agreement, Respondent shall complete a collaborative practice educational course approved by the Board.

6. The Board shall file its bill of costs pursuant to Ala. Admin. Code r. 545-X-3-.08(9), (10), within 30 days of this Order.

DONE on this the 8th day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-08 14:04:20 CST

Craig H. Christopher, M.D.
its Chairman

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

THREE-MEMBER PANEL'S RECOMMENDED FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter came before a three-member panel of the Medical Licensure Commission of Alabama for a contested case hearing on October 11, 2023. After receiving and considering all of the relevant evidence and argument, the Panel recommends that the full Commission find the Respondent, Thomas Paul Alderson, M.D., guilty of the disciplinary charges, and impose professional discipline as set out below.

I. Introduction and Statement of the Case

The respondent in this case is Thomas Paul Alderson, M.D. ("Respondent"). Respondent was first licensed by the Commission on August 24, 1983, having been issued license no. MD.11121. The disciplinary charges in this case arise out of Respondent's alleged deficiencies in professional supervision,

oversight, and direction of various Certified Registered Nurse Practitioners ("CRNPs") with whom Respondent had collaborative practice agreements.

II. Procedural History

On May 15, 2023, the Alabama Board of Medical Examiners filed an Administrative Complaint ("the Administrative Complaint"), alleging certain deficiencies in the medical supervision and oversight of his CRNPs. The Administrative Complaint, as originally filed, contained eight counts. At the commencement of the evidentiary hearing in this matter, however, the Board voluntarily dismissed Counts One, Two, Six, and Eight, and proceeded only on Counts Three, Four, Five, and Seven.

Counts Three, Four, and Five all rest on Ala. Code § 34-24-360(23), which provides that professional discipline can be taken on the basis of a physician's "[f]ailure to comply with any rule of the Board of Medical Examiners or Medical Licensure Commission." Count Seven alleges that Respondent is guilty of "[a]iding or abetting the practice of medicine by any person not licensed by the commission" in violation of Ala. Code § 34-24-360(13).

Counts Three and Four share a common factual nucleus: the alleged failure of Respondent to maintain and produce documentation required by Board rules. In Count Three, the Board alleges that Respondent failed to maintain

documentation of quarterly quality assurance reviews and patient charts as required by Rules 540-X-8-.08(5)(f) and 540-X-8-.15(1)(f), and in Count Four, the Board alleges that Respondent failed to maintain documentation proving training of his CRNPs and the certifications for procedures being performed, in violation of Rule 540-X-8-.15(1)(f).

Count Five alleges that Respondent knowingly allowed one of his CRNP's to administer treatments not included within her Board-approved protocol, including TriMix injections and reverse priapism injections, in violation of Ala. Admin. Code r. 540-X-8-.15(1)(b).

In Count Seven, the Board accuses Respondent of "[a]iding or abetting the practice of medicine by any person not licensed by the commission," in that he "co-signed" one or more prescriptions for testosterone pellets—a Schedule III controlled substance—written by one of his CRNPs who did not, at the time, hold the Qualified Alabama Controlled Substances Certificate ("QACSC") required by law, in violation of Ala. Code § 34-24-360(13).

On or about August 22, 2023, the Board and Respondent submitted a proposed Consent Decree to the Commission for consideration. After considering the proposed Consent Decree at its August 23 monthly business meeting, the Commission declined to accept the proposed Consent Decree, and re-set this matter for an evidentiary hearing.

On October 11, 2023, the Panel conducted an evidentiary hearing as prescribed in Ala. Admin. Code r. 545-X-3-.14. The case for disciplinary action was presented by the Board through its attorneys E. Wilson Hunter and Alicia Harrison. Respondent appeared and testified before the Panel in person, represented by attorneys Thomas McKnight and Wes Winborn. 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. The Panel recommends that the full Commission adopt the following findings.

III. Findings of Fact

The relevant facts of this matter are free from substantial dispute.

1. A "collaborative practice agreement" is an agreement between a licensed physician, an advanced practice provider (in this case, a CRNP), and the Board, which allows the advanced practice provider to perform certain procedures that would otherwise constitute the practice of medicine, under the close supervision and oversight of the physician. Under a collaborative practice agreement, the physician's activities remain regulated by the Board and

Commission, while the collaborating CRNP in this case is regulated by the Board of Nursing.

2. A collaborative practice agreement is initiated by the physician filing a "Commencement for Collaborative Practice" form with the Board. The collaborative practice agreement is not valid unless and until it is approved by the Board.

3. In October 2022, Respondent filed a "Commencement for Collaborative Practice" form with the Board, seeking to commence a collaboration with Hannah Whitney ("Whitney"). (ABME Ex. 3.) Because Whitney's specialty certification was in the area of family practice, she was authorized to perform the tasks outlined in the "standard protocol" for family practice. The "standard protocol" for family practice includes:

A. Arrange inpatient admissions, transfers and discharges in accordance with established guidelines/standards developed within the collaborative practice; perform rounds and record appropriate patient progress notes; compile detailed narrative and case summaries; complete forms pertinent to patients' medical records.

B. Perform complete, detailed, and accurate health histories, review patient records, develop comprehensive medical and nursing status reports, and order laboratory, radiological, and diagnostic studies appropriate for complaint, age, race, sex, and physical condition of the patient.

C. Perform comprehensive physical examinations and assessments.

D. Formulate medical and nursing diagnoses and institute therapy or referrals of patients to the appropriate health care facilities and/or agencies; and other resources of the community or physician.

E. Plan and initiate a therapeutic regimen which includes ordering legend drugs, medical devices, nutrition, and supportive services in accordance with established protocols and institutional policies.

F. Institute emergency measures and emergency treatment or appropriate stabilization measures in situations such as cardiac arrest, shock, hemorrhage, convulsions, poisoning, and allergic reactions. In emergencies, initiate mechanical ventilatory support and breathing, if indicated.

G. Interpret and analyze patient data and results of laboratory and diagnostic tests.

H. Provide instructions and guidance regarding health care and health care promotion to patients, family and significant others.

(ABME Ex. 5.)

4. If a physician wants a collaborating CRNP to be able to perform duties outside the standard protocol, the physician must specifically seek and obtain the Board's approval for those additional duties. Respondent requested and received approval for only one additional skill for Whitney: "administering local anesthetic agents." (ABME Ex. 5 at p. 3.)

5. Respondent was first licensed to practice medicine in the State of Alabama since 1983, having been issued license no. MD.11121. Respondent was so licensed at all relevant times.

6. Respondent is a urologist who lives in Tennessee and currently serves as the Medical Director of the Huntsville Men's Clinic in Huntsville, Alabama. He also serves as the Medical Director at two remote practice sites: Montgomery Men's Health Clinic in Montgomery, Alabama, and Wave Men's Health in Mobile, Alabama.

7. On or about July 22, 2021, Respondent entered into a collaborative practice agreement ("CPA") with Jennifer Hughes, CRNP ("Hughes"), identified by number CP.26425. Respondent collaborates with Hughes at Huntsville Men's Clinic located at 250 Chateau Drive SW, Suite 150, Huntsville, Alabama 35801.

8. On September 15, 2022, Respondent entered into a collaborative practice agreement with Susan Logan, CRNP ("Logan"), identified by number CP.29751. Respondent collaborates with Logan at Wave Men's Health located at 1110 Montlimar Drive, Suite 560, Mobile, Alabama 36609.

9. On or about November 17, 2022, Respondent entered into a collaborative practice agreement with Hannah Whitney, CRNP ("Whitney"), identified by number CP.30428. Respondent collaborates with Whitney at Montgomery Men's Health located at 4780 Woodmere Blvd., Montgomery, Alabama 36106.

10. On or about November 17, 2022, Respondent entered into a collaborative practice agreement with Connesuala Powers, CRNP ("Powers"),

identified by number CP.30427. Respondent collaborates with Powers at Huntsville Men's Clinic located at 250 Chateau Drive SW, Suite 150, Huntsville, Alabama 35801.

11. On January 31, 2023, February 8, 2023, and February 9, 2023, the Board investigated Respondent's collaborative practice with Hughes, Logan, Whitney, and Powers.

12. The Board's investigation also revealed that routine quality assurance reviews, training of the CRNPs, and certifications for procedures being performed by each CRNP were not readily available at each practice site.

13. The Board's investigation also revealed that Whitney administered TriMix injections and reverse priapism procedures without Board approval, outside the scope of her collaborative practice agreement.

14. The Board's investigation also revealed that Powers prescribed testosterone to patients of the Huntsville clinic, and such prescriptions appeared to be "co-signed" by Respondent and Powers, even though Powers did not hold or maintain an Alabama DEA license or a Qualified Alabama Controlled Substance Certificate in Alabama.

15. When Powers wrote the prescriptions at issue, she signed the line "Dispense as Written," and Respondent countersigned the line "Product Selection Permitted." (Respondent's Ex. 17.)

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)(1), and Ala. Admin. Code r. 545-X-3-.03(3), (4). At all relevant times, Respondent was a licensee of the 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. Specifically, the Commission may discipline a license to practice medicine if the holder of that license "[f]ail[s] to comply with any rule of the Board of Medical Examiners or Medical Licensure Commission." Ala. Code § 34-24-360(23). The Commission may also impose discipline upon a physician who "[a]id[s] or abet[s] the practice of medicine by any person not licensed by the commission" Ala. Code § 34-24-360(13).

4. The rules of collaborative practice require a collaborating physician to: "[c]omplete quarterly quality assurance with each CRNP. Documentation of any quality assurance review required by this chapter **shall be maintained by the**

collaborating physician for the duration of the collaborative practice and for three years following the termination of the collaborative practice agreement." Ala. Admin. Code r. 540-X-8-.08(5)(f) (emphasis added). Further, a collaborating physician is required "to maintain [and] **produce for inspection upon request by the Board of Medical Examiners** any documentation required to be maintained by the collaborative physician." Ala. Admin. Code r. 540-X-8-.15(1)(f) (emphasis added).

5. The facts are undisputed that Respondent was not able to produce for inspection, upon demand of the Board, documentation of the quarterly quality assurance reviews, and documentation proving training and certification for his collaborating CRNPs.

6. Board Rule 540-X-8-.15(1)(b) provides that a physician may not "require or ... knowingly permit or condone a certified registered nurse practitioner to engage in any act or render any services not authorized in his or her protocol." Ala. Admin. Code r. 540-X-8-.15(1)(b).

7. The evidence is undisputed that Respondent did knowingly permit and condone CRNP Whitney administering diagnostic TriMix injections and priapism reversal injections, and that those procedures were not within Whitney's authorized scope of practice. Respondent attempts to justify this transgression by arguing, basically, that the injections are extremely benign, and (critically, *after*

the in-office diagnostic injections) can even be done at home by the patient. Based on our own medical experience and judgment,[1] we reject this argument. It is not the administration of the injection *per se* that concerns us—it is the content of the injection. A TriMix injection is a combination of three powerful medicines that can cause serious adverse reactions. As Respondent himself admitted, TriMix injections involve a complication rate of between 5 and 10 percent. This is not to say, of course, that CRNPs cannot administer TriMix or priapism injections. Of course they can, *if those procedures are included in their approved collaboration agreements which have been approved in advance by the Board.*

8. Count Seven alleges that Respondent is guilty of aiding and abetting the unlicensed practice of medicine, in that he enabled CRNP Powers to prescribe controlled substances, namely testosterone, a Schedule III controlled substance, when she did not hold a QACSC authorizing her to do so. The undisputed facts substantiate the Board's charge. We are distressed by the apparent lack of institutional control exhibited by the facts. The law requires that a prescription for a controlled substance have two separate lines, one labeled "dispense as written," and the other labeled "Product selection permitted." *See* Ala. Admin. Code r. 540-

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[1] In contested cases, "[t]he experience, technical competence, and specialized knowledge of the agency may be utilized in the evaluation of the evidence." Ala. Code § 41-22-13(5).

X-4-.06(6). As found above, Powers signed one line, while Respondent signed the other, making it impossible to tell which instruction was intended. The dual signatures of Powers and Respondent have also made it impossible to tell if the prescription was actually "dated as of, *and signed on, the date when issued*" as required by federal law. *See* 21 C.F.R. Part 1306.05(a).

V. Recommended Decision

The Panel recommends that the Commission adopt the following disposition:

1. That the Respondent be adjudged guilty of violations of rules of the Board of Medical Examiners as charged in Counts Three, Four, Five, and Seven of the Administrative Complaint, and that Counts One, Two, Six, and Eight be dismissed.

2. That the Respondent's license to practice medicine in the State of Alabama be restricted such that Respondent shall not be permitted to engage in a collaborative practice agreement for a period of three years from the date of the Commission's final order.

3. That Respondent be assessed an administrative fine of five thousand dollars ($5,000.00) as to each of Counts Three, Four, Five, and Seven of the Administrative Complaint, for a total administrative fine of twenty thousand

dollars ($20,000.00). In accordance with Ala. Admin. Code r. 545-X-3-.08(8)(d)(i), Respondent should be ordered to pay the administrative fine within 30 days of the Commission's Order adopting these proposed findings.

4. That upon expiration of the restriction on collaborative practice agreements provided for above, Respondent be ordered to comply with the following requirements in connection to any future collaborative practice agreement:

a. Respondent will maintain a daily log which memorializes the facility at which he works for every working day, and Respondent will maintain this log in a manner readily accessible to his staff and immediately producible to the Board upon request;

b. Respondent will maintain all CRNP quarterly Quality Assurance Review and certification and training paperwork in a manner readily accessible to his staff, available at each practice site, and immediately producible to the Board upon request;

c. Any collaborating CRNP shall not prescribe any controlled substance unless and until he or she obtains an Alabama DEA and QACSC from the Board. Respondent will provide training, and document such training, to the CRNP concerning the rules and

regulations governing the prescribing of controlled substances in Alabama;

d. Respondent shall prohibit any CRNP working at a practice site with which he is affiliated from administering TriMix injections and reverse priapism injections to patients unless and until said CRNP is authorized in writing by the Board to perform said functions; and

e. Before applying for any new collaborative practice agreement, Respondent shall complete a collaborative practice educational course approved by the Board.

5. That the Board should be directed to file its bill of costs pursuant to Ala. Admin. Code r. 545-X-3-.08(9), (10), within 30 days of the Commission's Order adopting these proposed findings.

DONE on this the 25th day of October, 2023.

COMMISSIONERS CHRISTOPHER, NAGRODZKI, AND ALDRIDGE

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-10-25 09:16:25 CDT

Craig H. Christopher, M.D.
Panel Chairman

EXHIBIT R

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

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 October 25, 2023, attached hereto as Exhibit "A". Upon review and consideration by the full Commission, the recommended Findings of Fact and Conclusions of Law of the three-member panel are **RATIFIED** and **ADOPTED** as the findings of the Commission. *See* Ala. Code § 34-24-366; Ala. Admin. Code r. 545-X-3-.14(3).

Based on those Findings of Fact and Conclusions of Law, it is **ORDERED, ADJUDGED**, and **DECREED** as follows:

1. That the Respondent is adjudged **GUILTY** of violations of rules of the Board of Medical Examiners as charged in Counts One through Five of the Administrative Complaint.

2. That the Respondent's license to practice medicine in the State of Alabama is **RESTRICTED** such that Respondent shall not be permitted to engage in a collaborative practice agreement for a period of one year from the date of this Order.

3. That Respondent is **ASSESSED** an administrative fine of two thousand dollars ($2,000.00) as to each of Counts One through Five of the Administrative Complaint, 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 shall pay the administrative fine within 30 days of this Order.[1]

4. That upon expiration of the restriction on collaborative practice agreements provided for above, Respondent is **ORDERED** to comply with the following requirements in connection to any future collaborative practice agreement:

a. Respondent will maintain a daily log which memorializes the facility at which he works for every working day, and Respondent will maintain this log in a manner readily accessible to his staff and immediately producible to the Board upon request;

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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).

b. Respondent will maintain all CRNP quarterly Quality Assurance Review and certification and training paperwork in a manner readily accessible to his staff, available at each practice site, and immediately producible to the Board upon request;

c. Respondent will provide training, and document such training, to the advanced practice provider concerning the rules and regulations governing the prescribing of controlled substances in Alabama;

d. Respondent shall immediately comply with Board regulations governing the prescribing of controlled substances and shall ensure compliance by implementing a prescription protocol (using his electronic medical records system or other similar solution) which ensures that no patient receives more than two consecutive testosterone prescriptions from a collaborating CRNP;

e. Respondent and his collaborating CRNPs, or his or her delegate, shall access and check the Prescription Drug Monitoring Program ("PDMP") database prior to administering or prescribing testosterone to any patient;

f. Respondent shall prohibit any CRNP working at a practice site with which he is affiliated from administering TriMix injections or

reverse priapism injections unless and until said CRNP is authorized in writing by the Board to perform said functions; and

g. Before applying for any new collaborative practice agreement, Respondent shall complete a collaborative practice educational course approved by the Board.

5. The Board shall file its bill of costs pursuant to Ala. Admin. Code r. 545-X-3-.08(9), (10), within 30 days of this Order.

DONE on this the 8th day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-08 14:03:06 CST

Craig H. Christopher, M.D.
its Chairman

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

THREE-MEMBER PANEL'S RECOMMENDED FINDINGS OF FACT AND CONCLUSIONS OF LAW

This matter came before a three-member panel of the Medical Licensure Commission of Alabama for a contested case hearing on October 11, 2023. After receiving and considering all of the relevant evidence and argument, the Panel recommends that the full Commission find the Respondent, Rodney Lowell Dennis, M.D., guilty of the disciplinary charges, and impose professional discipline as set out below.

I. Introduction and Statement of the Case

The respondent in this case is Rodney Lowell Dennis, M.D. ("Respondent"). Respondent was first licensed by the Commission on May 27, 1987, having been issued license no. MD.13319. The disciplinary charges in this case arise out of Respondent's alleged deficiencies in professional supervision,

oversight, and direction of Laura Alyson Dean ("Dean"), a Certified Registered Nurse Practitioner ("CRNP") with whom Respondent had a collaborative practice agreement.

II. Procedural History

On May 15, 2023, the Alabama Board of Medical Examiners filed an Administrative Complaint ("the Administrative Complaint"), alleging certain deficiencies in the medical supervision and oversight of Dean. The Administrative Complaint contains five counts, all of which rest on Ala. Code § 34-24-360(23), which provides that professional discipline can be taken on the basis of a physician's "[f]ailure to comply with any rule of the Board of Medical Examiners or Medical Licensure Commission."

Count One alleges that Respondent knowingly allowed Dean to administer treatments not included within her Board-approved protocol, including administering TriMix injections, performing extracorporeal shock wave therapy, and reverse priapism injections, all in violation of Ala. Admin. Code r. 540-X-8-.15(1)(b).

Counts Two and Three share a common factual nucleus: the prescribing of testosterone, a Schedule III controlled substance, without first checking the Prescription Drug Monitoring Program ("PDMP") database for signs of abuse or

diversion. In Count Two, the Board alleges that Respondent's actions violated Rule 540-X-4-.09, and in Count Three, the Board alleges that Respondent permitted or condoned Dean prescribing testosterone without first checking PDMP in violation of Rule 540-X-18-.15(3)(c) and (5).

Counts Four and Five similarly share a common fact pattern: the alleged failure to rotate prescriptions for testosterone. In Count Four, the Board alleges that Respondent violated the QACSC Prescribing Protocol by failing to rotate testosterone prescriptions, and in Count Five, the Board alleges that Respondent permitted or condoned his CRNP to commit the same transgression.

On or about August 22, 2023, the Board and Respondent submitted a proposed Consent Decree to the Commission for consideration. After considering the proposed Consent Decree at its August 23 monthly business meeting, the Commission declined to accept the proposed Consent Decree, and re-set this matter for an evidentiary hearing.

On October 11, 2023, the Panel conducted an evidentiary hearing as prescribed in Ala. Admin. Code r. 545-X-3-.14. The case for disciplinary action was presented by the Board through its attorneys E. Wilson Hunter and Alicia Harrison. Respondent appeared and testified before the Panel in person, represented by attorneys Thomas McKnight and Wes Winborn. 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. The Panel recommends that the full Commission adopt the following findings.

III. Findings of Fact

The relevant facts of this matter are free from substantial dispute.

1. A "collaborative practice agreement" is an agreement between a licensed physician, an advanced practice provider (in this case, a CRNP), and the Board, which allows the advanced practice provider to perform certain procedures that would otherwise constitute the practice of medicine, under the close supervision and oversight of the physician. Under a collaborative practice agreement, the physician's activities remain regulated by the Board and Commission, while the collaborating CRNP in this case is regulated by the Board of Nursing.

2. A collaborative practice agreement is initiated by the physician filing a "Commencement for Collaborative Practice" form with the Board. The collaborative practice agreement is not valid unless and until it is approved by the Board.

3. In April 2019, Respondent filed a "Commencement for Collaborative Practice" form with the Board, seeking to commence a collaboration with Dean. (ABME Ex. 3.) Because Dean's specialty certification was in the area of family practice, she was authorized to perform the tasks outlined in the "standard protocol" for family practice. The "standard protocol" for family practice includes:

A. Arrange inpatient admissions, transfers and discharges in accordance with established guidelines/standards developed within the collaborative practice; perform rounds and record appropriate patient progress notes; compile detailed narrative and case summaries; complete forms pertinent to patients' medical records.

B. Perform complete, detailed, and accurate health histories, review patient records, develop comprehensive medical and nursing status reports, and order laboratory, radiological, and diagnostic studies appropriate for complaint, age, race, sex, and physical condition of the patient.

C. Perform comprehensive physical examinations and assessments.

D. Formulate medical and nursing diagnoses and institute therapy or referrals of patients to the appropriate health care facilities and/or agencies; and other resources of the community or physician.

E. Plan and initiate a therapeutic regimen which includes ordering legend drugs, medical devices, nutrition, and supportive services in accordance with established protocols and institutional policies.

F. Institute emergency measures and emergency treatment or appropriate stabilization measures in situations such as cardiac

arrest, shock, hemorrhage, convulsions, poisoning, and allergic reactions. In emergencies, initiate mechanical ventilatory support and breathing, if indicated.

G. Interpret and analyze patient data and results of laboratory and diagnostic tests.

H. Provide instructions and guidance regarding health care and health care promotion to patients, family and significant others.

(ABME Ex. 4.)

4. If a physician wants a collaborating CRNP to be able to perform duties outside the standard protocol, the physician must specifically seek and obtain the Board's approval for those additional duties. Respondent requested and received approval for only one additional skill for Dean: "administering local anesthetic agents." (ABME Ex. 4 at 2.)

5. Dean also possesses a Qualified Alabama Controlled Substances Certificate ("QACSC") authorizing her to administer, dispense, and prescribe Schedules III, IV, and V controlled substances within the confines of a collaborative practice. Board rules require the holder of a QACSC to comply with the Board's Qualified Alabama Controlled Substances Certificate (QACSC) (Schedules III-V) Prescribing Protocol ("QACSC Protocol").[1]

[1] *See* https://www.albme.gov/uploads/pdfs/QACSC-LPSPprotocol.pdf.

6. The QACSC Protocol generally restricts a CRNP to prescribing a 30-day supply of a Schedule III, IV, or V controlled substance, after which the collaborating physician must generally reauthorize the prescription. This is known colloquially as "rotation" of controlled substance prescribing, and it ensures regularly recurring physician oversight over an advanced practice provider's prescribing of controlled substances. Testosterone is a Schedule III controlled substance.

7. In January 2023, the Board's Collaborative Practice Nurse Consultant, Sandi Kirkland, performed an audit of the collaboration between Respondent and Dean. (ALBME Ex. 14.) Kirkland's audit identified deficiencies in the collaboration. Specifically, Respondent and Dean were not reviewing the Prescription Drug Monitoring Program ("PDMP") database before prescribing testosterone, and were not properly "rotating" testosterone prescriptions between the CRNP and physician. The audit also disclosed that Dean was performing diagnostic TriMix and priapism reversal injections in the office, although those tasks were not part of her approved protocol.

8. Respondent admits that, before the audit, he and Dean were not checking the PDMP database before each testosterone prescription. Respondent also agrees that prescription rotation as required by QACSC Protocol was not occurring in every case. Respondent admits that Dean was performing diagnostic

TriMix injections and priapism reversal injections in the office, even though these specific tasks were not listed in and approved in Dean's collaborative agreement.

9. Respondent insists that he has changed his standard procedures to cure all of the deficiencies noted above. Respondent has requested an amendment to Dean's collaborative practice agreement to permit the administration of TriMix injections and priapism reversal agents, but the Board has not yet approved the amendment.

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)(1), and Ala. Admin. Code r. 545-X-3-.03(3), (4). At all relevant times, Respondent was a licensee of the 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. Specifically, the Commission may discipline a license to practice

medicine if the holder of that license "[f]ail[s] to comply with any rule of the Board of Medical Examiners or Medical Licensure Commission." Ala. Code § 34-24-360(23).

4. Board Rule 540-X-8-.15(1)(b) provides that a physician may not "require or ... knowingly permit or condone a certified registered nurse practitioner to engage in any act or render any services not authorized in his or her protocol." Ala. Admin. Code r. 540-X-8-.15(1)(b).

5. The evidence is undisputed that Respondent did knowingly permit and condone Dean administering diagnostic TriMix injections and priapism reversal injections, and that those procedures were not within Dean's authorized scope of practice. Respondent attempts to justify this transgression by arguing, basically, that the injections are extremely benign, and (critically, *after* the in-office diagnostic injections) can even be done at home by the patient. Based on our own medical experience and judgment,[2] we reject this argument. It is not the administration of the injection *per se* that concerns us—it is the content of the injection. A TriMix injection is a combination of three powerful medicines that can cause serious adverse reactions. It simply is not, as Respondent argues, "way

[2] In contested cases, "[t]he experience, technical competence, and specialized knowledge of the agency may be utilized in the evaluation of the evidence." Ala. Code § 41-22-13(5).

more benign than a flu shot." This is not to say, of course, that CRNPs cannot administer TriMix or priapism injections. Of course they can, *if those procedures are included in their approved collaboration agreements which have been approved in advance by the Board.*

6. Counts Two and Three fault Respondent and Dean for not checking the PDMP database before prescribing testosterone. Board Rule 540-x-4-.09 provides, in relevant part:

> (3) **Every practitioner shall utilize medically appropriate risk and abuse mitigation strategies when prescribing controlled substances.** Examples of risk and abuse mitigation strategies include, but are not limited to:
>
> (a) Pill counts;
>
> (b) Urine drug screening;
>
> (c) **PDMP checks**;
>
> (d) Consideration of abuse-deterrent medications;
>
> (e) Monitoring the patient for aberrant behavior;
>
> (f) Using validated risk-assessment tools, examples of which shall be maintained by the Board; and
>
> (g) Co-prescribing naloxone to patients receiving opioid prescriptions when determined to be appropriate in the clinical judgment of the treating practitioner.

Ala. Admin. Code r. 540-X-4-.09(3) (emphasis added). Rule 540-X-18-.15 makes the very same requirements applicable to holders of QACSC's.

7. The evidence is undisputed that Respondent and Dean did not routinely check the PDMP system before prescribing testosterone. Respondent argues that PDMP checks are not *always* required for *all* controlled substance prescriptions, and that is correct as far as it goes. Under the circumstances presented here, however, we believe that the practice of checking the PDMP database before prescribing testosterone is required by Ala. Admin. Code r. 540-X-4-.09(3) and 540-X-18-.15 as an indispensable component of a "medically appropriate risk and abuse mitigation strategy."

8. Counts Four and Five both rest on violations of the QACSC Protocol. The QACSC protocol is promulgated pursuant to Board Rule 540-X-18-.07, which provides:

> "A CRNP ... shall prescribe, administer, or authorize for administration controlled substances in accordance with the requirements of Code of Ala. 1975, §§ 20-2-250 through 20-2-259; any other applicable sections of the Alabama Uniform Controlled Substances Act (Code of Ala. 1975, §§ 20-2-1, et. seq.); Board rules; **protocols, formularies, and medical regimens established by the Board for regulation of a QACSC**; and any requirements or limitations established in an approved formulary by the collaborating physician."

Ala. Admin. Code r. 540-X-18-.07(3) (emphasis added).

9. The QACSC Protocol governing CRNPs' controlled substance prescribing clearly requires "rotation" of controlled substance prescriptions:

> The quantity of a controlled substance in Schedule III, IIIN (non-narcotic), IV, or V initially prescribed by a Physician Assistant (PA), Certified Registered Nurse Practitioner (CRNP) or Certified Nurse Midwife (CNM) who holds a QACSC shall be limited to a thirty (30) day supply, and a reissue must be prescribed by the approved supervising, collaborating or covering physician.

10. The undisputed evidence presented at the hearing establishes that Respondent and Dean sometimes did, but sometimes did not, "rotate" testosterone prescriptions as required by the QACSC Protocol.

V. Recommended Decision

The Panel recommends that the Commission adopt the following disposition:

1. That the Respondent be adjudged guilty of violations of rules of the Board of Medical Examiners as charged in Counts One through Five of the Administrative Complaint.

2. That the Respondent's license to practice medicine in the State of Alabama be restricted such that Respondent shall not be permitted to engage in a collaborative practice agreement for a period of one year from the date of the Commission's final order.

3. That Respondent be assessed an administrative fine of two thousand dollars ($2,000.00) as to each of Counts One through Five of the Administrative Complaint, 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 should be ordered to pay the administrative fine within 30 days of the Commission's Order adopting these proposed findings.

4. That upon expiration of the restriction on collaborative practice agreements provided for above, Respondent be ordered to comply with the following requirements in connection to any future collaborative practice agreement:

a. Respondent will maintain a daily log which memorializes the facility at which he works for every working day, and Respondent will maintain this log in a manner readily accessible to his staff and immediately producible to the Board upon request;

b. Respondent will maintain all CRNP quarterly Quality Assurance Review and certification and training paperwork in a manner readily accessible to his staff, available at each practice site, and immediately producible to the Board upon request;

c. Respondent will provide training, and document such training, to the advanced practice provider concerning the rules and regulations governing the prescribing of controlled substances in Alabama;

d. Respondent shall immediately comply with Board regulations governing the prescribing of controlled substances and shall ensure compliance by implementing a prescription protocol (using his electronic medical records system or other similar solution) which ensures that no patient receives more than two consecutive testosterone prescriptions from a collaborating CRNP;

e. Respondent and his collaborating CRNPs, or his or her delegate, shall access and check the Prescription Drug Monitoring Program ("PDMP") database prior to administering or prescribing testosterone to any patient;

f. Respondent shall prohibit any CRNP working at a practice site with which he is affiliated from administering TriMix injections, reverse priapism injections, and testosterone pellets to patients unless and until said CRNP is authorized in writing by the Board to perform said functions; and

g. Before applying for any new collaborative practice agreement, Respondent shall complete a collaborative practice educational course approved by the Board.

5. That the Board should be directed to file its bill of costs pursuant to Ala. Admin. Code r. 545-X-3-.08(9), (10), within 30 days of the Commission's Order adopting these proposed findings.

DONE on this the 25th day of October, 2023.

COMMISSIONERS CHRISTOPHER, NAGRODZKI, AND ALDRIDGE

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-10-25 09:15:28 CDT

Craig H. Christopher, M.D.
Panel Chairman

EXHIBIT S

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **TARIK YAHIA FARRAG, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-023**

ORDER

This matter is before the Commission on the October 21, 2023 correspondence from the Commission's General Counsel to the Respondent and to the Board's General Counsel regarding various shortcomings and errors noted in the initial draft of the hearing transcript in this matter. The General Counsel's correspondence noted, among other things:

- The draft transcript is incomplete, in that it ends at the lunch break, and omits all of the proceedings that occurred after lunch (including all of Dr. Farrag's testimony, and the testimony of Edmond F. Ritter, M.D., who was called by Dr. Farrag);
- The draft transcript incorrectly lists the Commission's General Counsel as counsel for the Board of Medical Examiners;
- The draft transcript incorrectly identifies Commission Member Dr. Pam Varner as "Dr. Pam Garner"; and
- The draft transcript indicates that the direct examination of Dr. John Drew Prosser was conducted by Commission Member Varner, which

is incorrect; that direct examination was conducted by Alicia Harrison, counsel for the Board of Medical Examiners.

The General Counsel's correspondence also included a schedule of suggested corrections.

On October 26, 2023—notwithstanding the fact that the draft transcript altogether omitted Respondent's testimony and that of another witness called by Respondent—Respondent sent an e-mail message opposing any corrections to the transcript. Respondent wrote, "No. I disagree with any changes. The transcript needs to be presented as is. Thank you."

The Commission concludes that it is imperative that a complete and accurate transcript of the proceedings be prepared for transmission to the Court of Civil Appeals. Accordingly, it is ORDERED that General Counsel's correspondence be forwarded to the Court Reporter, along with a copy of this Order, and that the Court Reporter is hereby DIRECTED to complete and correct the transcript.

DONE on this the 8th day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-08 14:02:12 CST

Craig H. Christopher, M.D.
its Chairman

FORTIF
LAW PARTNERS

2021 Morris Avenue, Suite 300
Birmingham, Alabama 35203

Post Office Box 530564
Birmingham, Alabama 35253

Aaron L. Dettling
o 205.832.9105
c 205.515.4624
aaron@fortif.com

October 21, 2023

Via E-mail Only: tfarrag1@gmail.com; whunter@albme.gov

Dr. Tarik Y. Farrag
14541 Sanctuary Drive
Orland Park, Illinois 60467

E. Wilson Hunter
General Counsel
Alabama Board of Medical Examiners
848 Washington Avenue
Montgomery, AL 36104

RE: ***Alabama State Board of Medical Examiners v. Tarik Yahia Farrag, M.D.*, Case No. 2023-023 Before the Medical Licensure Commission of Alabama; Case No. CL-2023-0745 Before the Alabama Court of Civil Appeals**

Preparation of Reporter's Transcript

Dear Dr. Farrag and Mr. Hunter:

This office has the privilege of representing the Medical Licensure Commission of Alabama. The Commission has received a draft of the reporter's transcript of the hearing held on August 23, 2023. For your review, a .pdf of the draft transcript is transmitted along with this letter.

Based on preliminary review, the Commission has identified several obvious errors in the draft transcript, including the following:

- The draft transcript is incomplete, in that it ends at the lunch break, and omits all of the proceedings that occurred after lunch (including all of Dr. Farrag's testimony, and the testimony of Edmond F. Ritter, M.D., who was called by Dr. Farrag);

- The draft transcript lists me as counsel for the Board of Medical Examiners, which is incorrect; I am General Counsel for the Medical Licensure Commission;

FORTIF
LAW PARTNERS

- The draft transcript incorrectly identifies Commission Member Dr. Pam Varner as "Dr. Pam Garner"; and

- The draft transcript indicates that the direct examination of Dr. John Drew Prosser was conducted by Commission Member Varner, which is incorrect; that direct examination was conducted by Alicia Harrison, counsel for the Board of Medical Examiners.

The Recording Secretary of the Commission has also reviewed the current draft transcript, and has identified a longer list of potential errors and corrections. That list of potential errors and corrections is listed on the attached Schedule.

The Commission intends to request that the court reporter correct all of these errors, and submit a complete and correct transcript of the proceedings of August 23, 2023. Will you please review the draft transcript and these changes, and kindly let me know if you agree that these changes should be made?

Because of the limited time available for the Commission to prepare and file the administrative record with the Court of Civil Appeals, a reply via e-mail is respectfully requested no later than Tuesday, October 24.

Thank you in advance for your anticipated cooperation.

Yours very truly,

Aaron L. Dettling

Enclosures
ec: Honorable William R. Gordon, Hearing Officer
Rebecca Robbins, MLC Recording Secretary

		Case No. 2023-023 Transcript Corrections	
Page No.	Line No.	Content	Correction
2	10-15	Aaron Dettling, Esq.	Should be identified as MLC General Counsel.
3	5	"Dr. Pam Garner"	"Dr. Pam Varner"
4	15	"Dr. Pam Garner"	"Dr. Pam Varner"
5	4	"Dr. Pam Garner"	"Ms. Harrison"
5	10	"Dr. Pam Garner"	"Ms. Harrison"
7	15	"Dr. Pam Garner"	"Dr. Pam Varner"
8	11	"collated"	"allege"
8	23	"reviewing"	"renewing"
9	3	"(inaudible) fellow plaintiff's"	"call upon Wilson"
9	7	"rotation"	"revocation"
9	18	"for"	"foreign"
9	25	"for your"	"a four year"
14	19	"to go?"	"to make opening remarks"
14	25	"Kenneth"	"Tarik"
15	1	"and he"	"in Egypt. He"
17	5	"the - -"	"of order"
17	23	"Mr. Hunter"	"Mr. Hart" [Mr. Chris Hart, BME Technology]
18	7	"exhibit?"	"exhibits?"
21	7	"surgeon."	"physician."
22	4	"pummel"	"problem"
28	8	"discreet"	"suspicious"
34	2	"I'm Jorge…"	"I'm Jorge Alsip…"
37	7	"Dr. Garner?"	"Dr. Varner?"
37	9	"DR. GARNER:"	"DR. VARNER:"
37	10	"…Dr. Garner…"	"…Dr. Varner…"
38	23	"DR. GARNER:"	"DR. VARNER:"
39	2	"residence"	"residency"
39	22	"Russell"	"Wilson"
39	23	"RUSSELL:"	"MR. HUNTER:"
40	2	"RUSSELL:"	"MR. HUNTER:"
40	4	"RUSSELL:"	"MR. HUNTER:"
40	7	"DR. GARNER:"	"DR. VARNER:"
40	10	"RUSSELL:"	"MR. HART:"
40	12	"RUSSELL:"	"MR. HART:"
41	1	"Rachel"	"Bridgett"
41	10	"Rachel"	"Bridgett"
44	10	"company"	"somebody"
45	1	"...feels and cares…"	"...bigot and hater…"
45	2	"feedback"	"...did that..."
45	11	"...bad mistake, be fired."	"...bad mistake to be fired."
45	20	"...with feedback that…"	"...has impacted…"
49	18	"...told me this from (inaudible)."	"...problem with his program director."
55	8	(inaudible)	"if one encounter with police"
57	8	"Facebook"	(inaudible)
57	12	"wide."	"...,why?"
58	4	"and"	"Kent,…"
59	5	"...that goes (inaudible)…"	"...which routinley goes…"
59	10	"I'm going to stop this…"	"Doctor - - Doctor, this is the…"
60	3	"Commisioner (indiscernible) has…"	"Commision members have…"
60	4	"UNIDENTIFIED SPEAKER:"	"DR. CHRISTOPHER:"
60	4	"If I had…"	"Anybody have…"
60	24	(indiscernible)	"...worked with…"
64	8	"UNIDENTIFIED SPEAKER:"	"DR. CHRISTOPHER:"
66	6	"DR. GARNER:"	"MS. HARRISON:"
66	9	"DR. GARNER:"	"MS. HARRISON:"
66	14	"DR. GARNER:"	"MS. HARRISON:"
66	17	"DR. GARNER:"	"MS. HARRISON:"
66	19	"DR. GARNER:"	"MS. HARRISON:"
68	11	(indiscernible)	"outside"
82	8	"forgettable?"	"...unforgettable?"
82	16	"reports"	"purports"
84	22	(indiscernible)	"trainee"
89	2	"DR. GARNER:"	"MS. HARRISON:"
89	7	"Counsel"	"Kent"
98	16	"… inspected six weeks…"	"… expected sixty…"
99	9	"reporting"	"purporting"
104	7	"DR. GARNER:"	"MS. HARRISON:"
104	17	"DR. GARNER:"	"MS. HARRISON:"

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,
Complainant,
CASE NO. 2023-023

vs.

TARIK YAHIA FARRAG, M.D.,
Respondent.

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

ALABAMA MEDICAL LICENSURE COMMISSION HEARING

DATE TAKEN: Wednesday, August 23, 2023
PLACE: Montgomery, Alabama 36104
BEFORE: HONORABLE WILLIAM GORDON
~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

APPEARANCES OF COUNSEL

On behalf of the Complainant, ALABAMA STATE BOARD OF MEDICAL EXAMINERS:

ALICIA HARRISON, ESQ.
EFFIE HAWTHORNE, ESQ.
E. WILSON HUNTER, ESQ.
ALABAMA BOARD OF MEDICAL EXAMINERS
848 Washington Avenue
Montgomery, Alabama 36104
334-242-4153
aharrison@albme.gov
ehawthorne@albme.gov
whunter@albme.gov
APPEARED VIA IN-PERSON

AND

AARON DETTLING, ESQ.
FORTIF LAW PARTNERS
2021 Morris Avenue
Suite 300
Birmingham, Alabama 35203
205-832-9100
aaron@fortif.com
APPEARED VIA IN-PERSON

On behalf of the Respondent, TARIK YAHIA FARRAG, M.D.:

KENT GARRETT, ESQ.
KENT GARRETT, ATTORNEY AT LAW, LLC
200 South Lawrence Street
Montgomery, Alabama 36104
334-318-4213
APPEARED VIA IN-PERSON

AND

WILLIAM RAYBORN, JR., ESQ.
RAYBORN LAW FIRM, LLC
9385 North Main Street
Brantley, Alabama 36009
334-527-1700
raybornlaw@gmail.com
APPEARED VIA IN-PERSON

Also present:

Dr. Craig H. Christopher, Chairman
Ms. Rebecca Robbins, Operations Director
Dr. Jorge Alsip, Member of the Commission
Dr. Ken Aldridge, Member of the Commission
Dr. Joey Falgout, Member of the Commission
Dr. Paul Nagrodzki, Member of the Commission
Mr. Dan Morris, Member of the Commission
Dr. Pam Garner, Member of the Commission
Dr. Tarik Yahia Farrag, Respondent

INDEX OF PROCEEDING

INDEX OF PROCEEDING (CONT.)

INDEX TO EXHIBITS

INDEX TO EXHIBITS (CONT.)

(Beginning of audio recording.)

DR. CHRISTOPHER: I would like to call the hearing to order. I'm Craig Christopher, Chairman of the Medical Licensure Commission. This case is the Board of Medical Examiners v. Dr. Tarik Farrag.

For the record, I would like to introduce the participants, the main participants in -- in the hearing. To my right is Judge William Gordon, who is our Hearing Officer. To my left is Aaron Dettling, the counsel for the MLC, legal counsel. Rebecca Robbins, the operations director.

The physicians, or the members of the Commission, are Dr. Jorge Alsip, Dr. Ken Aldridge, Dr. Joey Falgout, Dr. Paul Nagrodzki, Mr. Dan Morris, and Dr. Pam Garner.

Dr. Farrag is present, and he is represented by Mr. Kent Garrett, his attorney, and William Rayborn, I think, is the other attorneys, correct?

MR. GARRETT: That's correct.

DR. CHRISTOPHER: And the Board of Medical Examiners is represented by Wilson Hunter, Alicia Harrison, and Effie Hawthorne is here, too.

I would just like to ask for the recording secretary that anybody that's talking to make sure your green light is on. And we only -- we don't talk over

each other.

And we're going to have a lot of audio video stuff today, so let's -- let's try to be as -- as loud as we can into the -- into the right microphones, okay.

So with that, I'll turn the hearing over to -- to Judge Gordon.

THE HEARING OFFICER: Thank you, Dr. Christopher.

Briefly, ladies and gentlemen, this case involves six counts Administrative Complaint. Four counts of that complaint collated that Dr. Farrag committed fraud when he applied for his COQ and medical license in Alabama in 2013.

One count alleges unprofessional conduct when he applied to obtain or renew privileges at a healthcare facility in Sarasota, Florida. And that time period involves November the 28th, 2022, through December 31 of 2022.

And the last count of that is unprofessional conduct by impersonating the residency program director at Augusta University Medical College of Georgia. And this was done in connection with applying of -- or reviewing those privileges at the healthcare facility in Sarasota.

And it involves the same time period of

November through December of 2022.

Dr. Farrag denies all of these allegations. So with that summary, I'll allow fellow Plaintiff's to present the opening statements.

MR. HUNTER: Thank you, Judge.

May it please the Commission, the Board is here asking for the rotation (sic) of Dr. Farrag's medical license and the imposition of the maximum fine, $10,000 per count.

The facts of the case are -- are pretty simple. I think that it -- it may sound a little more complicated at times. I think some of the evidence and testimony may try to steer you away from the main focus. But it really is a basic simple case.

At the time Dr. Farrag applied for a medical license in January of 2013, he was not eligible. Because he had not completed his three years of residency, which was required for -- for medical graduates at the time, to obtain a COQ and a medical license.

Documentation that you'll see in the record from his residency program, at the time he was there at Medical College of Georgia, now the Georgia Health Science University, that showed that he was terminated.

Prior to finishing for your residency

program, you'll have, maybe, disparate data on how long -- how much credit you got. The State of Maryland found that he only got 11 months. You might see some documents that, maybe, Georgia was a little bit lenient on him and gave him credit for 19 months.

In any event, the facts will be, he did not have 36 months of residency at the time he applied for a license with the State of Alabama. Thus, he was not eligible. However, the verification process appeared to show that he had the three years.

There's a document in our COQ application that purports to be from the medical direct -- from the residency program director saying that Dr. Farrag completed three plus years. The plus, we're not sure what that means, of residency.

And again, no academic or -- or disciplinary problems on that document. The board charges Dr. Farrag with fraudulent -- with fraud in a couple of different layers.

First, he himself concurs, and swore under oath -- penalty, that he completed three years of residency. The facts will show that this is false.

Second, the document that purports to be from Dr. Stil Kountakis from Georgia Health Sciences University cannot be authentic, because of the numerous

-- because of the misrepresentations within it, and with an odd letter that will be -- that's appended to it apologizing for the lack of a seal.

And the evidence will show that the -- the letter itself can't be credited because what it says is -- is -- is bogus.

It'll say that -- the letter itself says, sorry, we can't have the seal. We're going through a transition from our name of Medical College of Georgia to Georgia Health Sciences University.

Unfortunately for Dr. Farrag, that transition happened two years before that letter was sent. And data -- data in your exhibits will show that Georgia Health Science University was already using new stationary at the time that Dr. Farrag applied for his license.

So we contend that that was a fraudulent document that Dr. Farrag submitted on his own behalf to accomplish the -- you know, the fooling, the hoodwinking of the Board and the Commission that he had completed three years of residency.

Dr. Farrag also misrepresented and committed fraud by answering no to questions 22 and 23, which asked whether or not you've been on academic or -- or disciplinary probation in a medical school or a

post-grad program, and then whether or not you've been disciplined.

Dr. Farrag not only had -- gone over remediation plans, not once but twice, during his short-term residency at -- at Medical College of Georgia.

He was also terminated twice. Now that didn't only -- after the first termination, they let him back in. But eventually he was terminated again with finality and dismissed from the program.

So those two statements were false and fraudulent, but they are supported by the false and fraudulent certification from the medical school that says he had -- didn't have any academic probation.

You'll see there's a thousand-page record, Exhibit 16, that's complete with an extensive effort to put him on probation, remediate, and then his violations. How somebody at that -- and with the person who purportedly signed the -- the document says he didn't have any issues.

How that person could have been so misled to authentically sign the document, I think you'll find -- that you see the evidence to be beyond belief.

How this case came about though, is because in 2013, he was issued a license. Last year he

attempted to apply for privileges at Sarasota Memorial Hospital in Florida.

The evidence will show that Dr. Farrag's application hit a snag when a credentialing person, doing her -- doing her due diligence, went for the primary source verification at Georgia Health Sciences University.

When that credentialor showed the purported verification that they received from that actual Resident Training Director, who you'll hear from today, he said, that's not my signature, those aren't my documents. Somebody has, basically, impersonated me.

The Board charges Dr. Farrag as that person impersonating Dr. Drew Prosser, the then, I think still, Residency Program Director at Georgia Health Sciences University.

Any event, he either obtained it, did it himself, or sub-caused it to be submitted. And that's why we charged the way we did it, falsified the documents in connection with his effort to get privileges at the Sarasota Memorial Hospital.

Now this is an exceptional case. I don't know how many times we've seen a physician go to such lengths to -- to try to commit a fraud. But coming back to the core point, the Board is asking you to

revoke his license because 2013, he was ineligible. He's never been eligible.

And to date, and he may try to argue that he's obtained other training since then, that's neither here nor there.

The only question before you is, one, did he commit fraud in trying to get privileges at Sarasota.

Two, on the date that he applied for a COQ with this state, was he eligible for a license and did he misrepresent, in a meaningful sense, whether or not he had academic and disciplinary probation and -- and -- and discipline during his residency program.

The -- I'm confident when you see the facts, you'll agree that he did, and thus, his license was voided this year. He never should have gotten it, but due to his deceit he obtained it. Now is the time to fix the remedy -- fix that error or revoke his license.

THE HEARING OFFICER: Kent, would you like to go?

MR. GARRETT: Okay.

Good morning. Thank you-all for being here. I appreciate you-all giving me your time. On behalf of Dr. Farrag, I appreciate you listening to us.

I'm going to try to be expeditious on this -- on this case. Kenneth Farrag came from Egypt. He

received his initial medical education and he -- he went to the Medical College Board.

I have three physicians who will explain the problems, to be brutally frank about it, and they're very qualified and good physicians they had at the Medical College of Georgia. What caused that, they would testify.

Upon one of them, in fact, Dr. Ritter. Mr. Technology, just told me that he had to go to surgery and will be available in an hour. Okay, I don't know if that's the first one you had or not.

But at any rate, I've got three, Paul Fischer, former Professor of Medical College of Georgia. He is a medical -- he was a professor, there knows Tarik. I've got Edmond Ritter, former Chief of Plastic Surgery at the Medical College of Georgia. He knows about the situation and will testify.

Mirsad, I can't pronounce his last name, Associate Professor of Plastic Surgery, Medical College of Georgia, and he will testify. They will all talk about Tarik's experiences at the Medical College of Georgia, and how all of this unusual story unwound and why it occurred. That -- that's really it.

Tarik will explain what he was attempting to do, and how he did it, and what he did. As a threshold

matter, when you look at this, I think, under your statute that you operate under, it looks like the requirement is that Tarik had three years of post-medical school training.

He will talk about the -- a lot of training that he had, and a lot of training at the University of Georgia -- I mean, at the -- at the Georgia Medical College, and also at Johns Hopkins, all of that. And the surgeries he's done.

And I -- it is, as I read it, it's an -- it's -- it -- it -- it is within this Board's discretion to interpret what he did as satisfactory of that requirement. And I encourage you to ask Dr. Farrag the questions about that, about what he did and what his training was.

I won't belabor the points, but I think he will be able to explain to you all of the representations that were made in the application. What he said, to whom, and why he said it. And what he told people about what was going on.

I will allow him to give the testimony and let you ask him any questions that you -- you might have. And I appreciate you giving up your service and your time here. Thank you very much.

THE HEARING OFFICER: Wilson?

MR. HUNTER: Doctor, yeah. So we -- just for you-all's information, we've got active practicing physicians on the witness list. I'm proposing, now, Kent has a couple lined up, ready, and we're going to take his witnesses out the --

MR. GARRETT: We have one --

MR. HUNTER: We also have Dr. Prosser, who just got out of surgery, and then has patient rotation at 1:30 Eastern Time. He's ready to go.

If you-all could bear with us, I think it is probably best for all our witnesses to take those doctors now. We'll go through his and Dr. Prosser, and then since Dr. Farrag's here, he can, you know, Taylor and Charlie.

I expect that our case will be Dr. Prosser -- I expect we that will be able to do everything I need to do with Dr. Farrag, and -- and then that'll be sort of the case. I don't -- I think we can finish with Dr. Farrag if everybody's agreeable to that.

THE HEARING OFFICER: Okay. You have your witness.

MR. GARRETT: Do I? Is he queued up?

MR. HUNTER: Yes, sir. He's the one named in 4145.

Judge, I offer Board's Exhibits 1 through 16

into evidence at this time.

And Kent, I think he has maybe something -- some exhibits later -- exhibits he's going to introduce through his client, which we've previously discussed and then used everything.

THE HEARING OFFICER: Any objections to the exhibit?

MR. GARRETT: No, Your Honor.

(EXHIBIT 1 RECEIVED INTO EVIDENCE)

(EXHIBIT 2 RECEIVED INTO EVIDENCE)

(EXHIBIT 3 RECEIVED INTO EVIDENCE)

(EXHIBIT 4 RECEIVED INTO EVIDENCE)

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MR. HUNTER: I just want to make sure

they're available for the witnesses. I just want to make sure the exhibits were available from the witnesses, Your Honor.

THE HEARING OFFICER: If you could.

MR. GARRETT: Go ahead and queue up Dr. Fischer, I think so, you got.

MR. HUNTER: You can speak to him.

MR. GARRETT: Okay.

Dr. Fischer?

DR. FISCHER: Yes.

MR. GARRETT: Okay. Can you hear me?

DR. FISCHER: Yes, I can hear.

MR. GARRETT: I'm having a little --

May I sit down?

THE HEARING OFFICER: Sure.

MR. GARRETT: I'm having a little bit of trouble.

THE HEARING OFFICER: Not to worry. Well, you got a microphone --

MR. GARRETT: Got one.

THE HEARING OFFICER: If you want to pull that microphone real close.

MR. GARRETT: Yeah.

THE HEARING OFFICER: Is the green light on?

MR. GARRETT: It is.

THE HEARING OFFICER: Go ahead.
MR. GARRETT: Can you hear me, Doc?
DR. FISCHER: Yes, I can.
MR. GARRETT: All right. There's a little bit of a delay. You are in front of the Medical Licensure Commission right now, giving testimony in the case.
And I wanted to ask you some questions about Tarik Farrag, okay?
MR. HUNTER: Judge, we --
DR. FISCHER: Yep. Yes, go ahead.
MR. HUNTER: -- swear him in.
MR. GARRETT: Yes. I think they're going to swear you in, Doctor.
THE HEARING OFFICER: Madam, would you please swear our witness in?

DR. PAUL FISCHER,

having first been duly sworn, testified as follows:

THE HEARING OFFICER: And would you have the witness state his name again please?
MR. GARRETT: Yes.
THE HEARING OFFICER: You know, I'm not --

EXAMINATION

BY MR. GARRETT:

Q. Please state your name for the record

please.

A. Dr. Paul Fischer. Fischer is F-I-S-C-H-E-R.

THE HEARING OFFICER: Thank you.

BY MR. GARRETT:

Q. Doctor, tell us who you are and what you do, and what your career has been premised upon?

A. I'm a family surgeon. I was recruited to the Medical College in Georgia about 30 years ago and became a tenure full professor at the Medical College.

And then about 20 years ago, I left from the school and went into private practice, and started the Center for Primary Care, which is now the largest primary care group in Augusta with 40 physicians in nine locations.

I retired about a year and a half ago.

Q. Doctor, how long were you at the Medical College of Georgia?

A. About 15 years.

Q. And what did you teach there?

A. I was the Professor of Family -- Family Medicine and Director of Research in the -- Family Medicine.

Q. Do you know Dr. Tarik Farrag?

A. Yes, I do.

Q. How do you know him? Tell us -- tell the

panel how you know him, the Commission.

A. I met him at the church during the second year of his residency. And then the third-year residency, when he developed a pummel with the faculty, he -- I tell -- my contacts on my phone, and he felt that he was being unjustly treated by the medical school, considered bringing a lawsuit against the school.

And at that time, my advice to him was not to do that. As I told him, usually the universities win in those situations. And then for his career, it'd be better to think about his family and, you know, try to proceed professionally without spending a lot of time and money on a lawsuit.

Q. Let me just cut straight to it.

What was the nature of his grievance with the medical college, and what was your opinion about the validity of that grievance?

A. Well my input on this comes from two sources. One is the phone call that I had with him during several months that he was in conflict with the -- with the faculty.

And then also a professional friend of mine was Dr. David Terris, who's head of the department. And I did make a phone call, or two, to him to just try

to understand what was going on and what -- that could be done -- could helpful to the problem.

Q. What was the problem?

A. And -- well, it was never a problem of his clinical skills or the amount of his work, both were exemplary. But it seemed to me that there was a personality conflict between he and Kountakis, who was, at the time, the program director and is currently the chairman.

And the two of them got into a pissing contest. And since Dr. Kountakis had all the power, it appeared to me that they were trying to get rid of him over things that were really not pertinent to his work.

And that in the end, it was almost like they were trying to see, like, Dr. Kountakis was trying to get him -- achievement (inaudible) prime fact -- and it got very contentious.

And again, there were never any specific -- there's no specific, again, never been -- not, well as a resident -- part personality clash between the two of these. And this was in my -- my discussions with Dr. Terris, who was the chairman at the time.

And he sort of deferred to his program chairman and said, well, the two of them, you know, are not seeing eye to eye, and I have to support my

chairman. So it looks to me like there was more of a personality clash than any specific behavioral things.

And that Dr. Kountakis has, to this day, appears to me, is looking for vengeance against him for confronting his authority as the program director.

Q. Well, he's done a good job of it. Dr. Kountakis is actually the supervisor for Dr. Prosser, isn't he?

A. Yeah. He -- Dr. Prosser, is currently in the position of -- the head of the residency program at ENT, and so Dr. Kountakis is his chairperson.

Q. So I think what you're trying to say, and you tell me if this is accurate, that there were grievances that somebody had with Tarik that did not have to do with his work ethic, his skills, or anything like that.

But somebody wanted him to be removed from the residency program. And that somebody was -- pronounce his name again?

A. Kountakis.

Q. And Kountakis is the supervisor for Dr. Prosser, who will testify in this case. Who was, after the fact, years later, they revisited this situation with the Medical College of Georgia. And the same people that got him kicked out of the program responded

to the accusation.

MR. HUNTER: Objection. Counsel testifying for the witness.

MR. GARRETT: He is right. He is right. I withdraw it, Your Honor. I withdraw it.

BY MR. GARRETT:

Q. If somebody inquired of the Medical College of Georgia about the credentials of Tarik Farrag, would it be correct that the people at the Medical College of Georgia, that answered questions about whether Tarik was truthful in his application --

Would it be truthful that those people are the same -- that's the same group of people that orchestrated his expulsion from the residency program?

Is it the same group of people?

A. Yes. It -- it's the identical people. I'm sure Dr. Prosser has had conversations, and been advised by his chairman, on how to proceed with this hearing.

Q. I'm -- I'm 70 years. I'm 70 years old. And why would somebody be that small?

Do you have an opinion about that?

THE HEARING OFFICER: Oh, I -- I'm sorry. Kent, but the cause is just -- just not an issue.

MR. GARRETT: I -- I'll withdraw it. I

withdraw it.

BY MR. GARRETT:

Q. Do you know why this happened?

A. As I said, I -- I think Dr. Kountakis was behaving like a bully and wanted to prove that he's in control of this outspoken resident. And Tarik is not an easygoing kind of guy, he did not just want to be subservient to the program director. So I'm sure that that's where the conflict came from.

As I said, I tried to find some evidence of misbehavior or malpractice that would be applicable to this situation, and even in discussions with the chairman, was unable to. So I felt like it was a personality problem and these things happen.

What's unusual, as for a person in Dr. Kountakis' position, for so long to be carrying on a vendetta against this person and trying to ruin his life.

MR. GARRETT: Thank you. I don't think I have any further questions. I will ask the panel, please question the doctor.

THE HEARING OFFICER: Well, cross examination please.

EXAMINATION

BY MR. HUNTER:

Q. And Dr. Fischer, this is Wilson Hunter. I'm General Counsel for the State Board of Medical Examiners.

Can you hear me okay?

A. Yes, I can.

Q. Great. I want to ask you, when did you leave Medical College of Georgia?

A. It was about 20 years ago.

Q. About 20 years ago? Do you have a firm date, or at least a year?

A. Not off the top of my head, no. I was not at the medical school when this was going on at the -- at the school.

Q. That -- that's really what I'm getting at.

And maybe I should have asked it a bit more simply, but you didn't overlap with Dr. Farrag's residency?

A. No. I -- I didn't know him professionally, as I said. I did know Dr. Terris, who was the chairman at the -- at the time, but it -- this was -- I was in private practice by the time this was all going on.

Q. Okay. And you made references to Dr. Farrag being in his third-year residency.

Are you aware that he was terminated from the residency, in or about, May of 2011?

A. To my understanding, he was in his third year when he was terminated, and so he would have been close to the end of his third year, but missing it by a -- a month or two.

Q. If -- would it surprise you then, that official correspondence from Georgia Health Sciences University only credits him with completing PGY1?

A. You know, I -- I would be very discreet about things coming in about this case from MCG since Dr. Kountakis clearly had a -- a personal issue and is, you know, is trying to keep him from practicing.

So whatever you get officially, I'd go back and look at, when was the last night that he served as a resident on call? My understanding is that that was close to the end of the third year of his residency.

When was the last paycheck that he received? When was the last time he was on the schedule? Those will be very clear indicators of how he was being treated, and he was being treated as a third-year resident.

So if they sent you a letter saying something different than that, I think the evidence would be clear from looking at some of these scheduling things from the department.

Q. What evidence, for your own opinion, do you

have of --

A. I would like especially --

Q. What other -- what evidence, other than your own opinion -- for your own opinion, do you have other than representations made to you by Dr. Farrag?

A. Well, I -- I spoke to the Chairman of the department, and this was in his third year. And at that time, his residency had not been terminated. So you know, that's pretty good evidence. The third year, I acknowledge that he was here when all this went on.

Q. So yeah. And you've garbled a little bit, so I'm just going to restate what you said, just if you can confirm it.

Your understanding is, irrespective of whether or not he completed one or two years, your understanding is he did not complete three years?

A. He did complete two years, and was working as a third-year resident. Was taking call like a third-year resident. You know, all of the things -- curriculum that with her -- your residence.

Have you completed the third year? That's -- that is correct, because of this conflict that arose during the end of his third year.

MR. HUNTER: That's all the questions I have, Your Honor.

THE HEARING OFFICER: Any other commissioners have -- Dr. Nagrodzki?

EXAMINATION

BY MR. NAGRODZKI:

Q. Dr. Fischer, this is Paul Nagrodzki, I'm --

A. Yes.

Q. -- with the Commission.

This goes along with what Mr. Hunter was asking, but did you physically participate in any of the meetings associated with Dr. Farrag's disciplinary action?

A. No.

Q. Okay. So you don't know exactly what happened in those meetings, do you?

A. No, I do not.

Q. Okay. And -- and you used the word feelings and appearances a good bit, but those are -- those are reflections that you've come to based on the personnel that you've spoken to; is that correct?

A. Yes. As I said, my knowledge of business is limited to contact with Tarik and with Dr. David Terris. I -- I don't have any other input.

MR. NAGRODZKI: Okay. Thank you.

THE HEARING OFFICER: Any other questions from members?

Dr. Aldridge?

EXAMINATION

BY DR. ALDRIDGE:

Q. Dr. Fischer, this is Ken Aldridge. Thank you for helping us today. I -- explain to me again, and I want to be clear.

Dr. David, did you say Terris?

A. Terris, our (inaudible) chairman of the department.

Q. So this was -- this doctor was the chairman at the time that there were disagreements between the department and Dr. Farrag?

A. Yes.

Q. So I -- I'm sorry, just bear with me.

Where does Dr. Kountakis fit in here if Dr. Terris was the chairman?

A. So he was under Dr. Terris. The chairman of the department had a number of people below him, and one of those people would be the program director, and Kountakis was the program director.

Q. At the time that Dr. Farrag was relieved from his residency?

A. Yes.

Q. Dr. Terris was the chairman?

A. Yes.

Q. Would you spell his name for me, please?

A. T-E-R-R-I-S.

DR. ALDRIDGE: Thank you. And that's all I have.

THE HEARING OFFICER: Any other questions by Commissioners?

EXAMINATION

BY DR. CHRISTOPHER:

Q. Doctor, this is Craig Christopher. I -- briefly, you said that this was a personality problem, and that, basically, Dr. Kountakis wanted him to be fired.

And where did you get that information? Didn't all this information basically come from Dr. Farrag?

You said that you weren't present in any of the meetings where he was terminated. We have evidence that he was terminated halfway through his second year, was allowed to do research.

But he did not -- we have hard evidence on what's in -- in the documents that we have before us, that he did not get past his second year.

So is it not true that your -- your views are coming basically from what Dr. Farrag told you.

Is that not correct? Your opinion that --

A. A lot of them are, but as I said, I always -- I always -- also spoke with the Chairman of the department. I would say, go look when the last night was that he took call. If he was doing research, he wasn't going to be taking any call for the department.

On the other hand, if he was functioning as a third-year resident in May of that final year, then I would say that the information that you have from the school, at this point in time, is maliciously wrong.

And that this continues a vendetta that they started a -- a long -- long time ago. And I -- you know, I'm sorry to be brought into this at this point in time, but -- and you -- and he -- the group need to decide, you know, where are the -- the laws, and were they broken or not.

But I can tell you that the thing that you will not see in any of the documents is this piece that I have personally observed, which is that there was a personality problem between the two of these.

And that's then -- that Dr. Kountakis has behaved like a bully, rather than as a mentor, in this person's training.

THE HEARING OFFICER: Okay.

Dr. Alsip?

EXAMINATION

BY DR. ALSIP:

Q. Okay, Doctor. I'm Jorge, also one of the commissioners. And we've had a little bit of challenge with your -- your phone breaking up, so not all the answers have been clear.

Have you previously been involved, at some point in your career, with -- with the residency program in teaching family medicine residents? Or teaching residence, period.

A. Yes.

Q. All right. Did --

A. Yes. I was on the faculty in family -- family medicine.

Q. All right. During your years being on the faculty, did you ever have residents who, for whatever reason, whether it was clinical deficiencies or professionalism or timeliness, or whatever, performed so poorly on a -- on a monthly rotation they did not get credit for that unless they repeated it?

A. Occasionally. And you know, I -- and I've dealt with -- with residents who had to be terminated because their (inaudible) was not good.

Q. All right.

A. So the --

Q. Right. And when you --

A. (Inaudible).

Q. All right.

And so when you -- when you terminated in those -- in those situations, where you terminated residency, did you -- were -- did the program give them credit for having completed that year successfully?

A. If they were in their third year, and they were terminated in mid-year, then they would not get credit for the third year.

Q. All right. Were -- were they -- were they -- so the -- so they weren't given credit for all the work they'd done up to that point, because they had not done well on some of their rotations?

A. Right.

Q. Did they get paid the whole time they were doing those rotations?

A. Yes.

Q. So looking at the last time they took call or got paid probably isn't a -- necessarily a good -- a good indicator for when they were -- for the time that they successfully did their rotation.

Because -- just because you're getting paid for it doesn't mean you got -- got to perform to the -- the degree to get credit for that rotation.

Would you agree with that?

A. I would agree that a check isn't as good as the record of their night calls.

If somebody is on a -- a night-call rotation and is responsible, as the third-year resident, for all the clinical work happening at the hospital, that's pretty good evidence that they're actively involved as a -- a resident at that point in time.

Q. Okay. So the scenario you mentioned --

A. So I think, go back and find out when he -- go back and find out when the -- he stopped taking call, and you'll have a good idea about when the faculty felt that he was no longer actively involved in the residency.

Q. All right. So when you were teaching, you never had a -- a situation where a -- a third-year resident performed poorly and had to be let go before the end of -- before they completed that third year?

A. I -- I don't remember specifically, but generally, by the third year you know if somebody's going work out okay or not.

DR. ALSIP: That's all.

THE HEARING OFFICER: Other questions?

EXAMINATION

BY MR. NAGRODZKI:

Q. Okay. Doctor, when did -- when did Dr.

Farrag leave Georgia Medical School? Do you have the exact date?

A. No. It was, I think, you know, in the middle of the year. June or -- May or June, something like that.

Q. Okay.

THE HEARING OFFICER: Dr. Garner?

EXAMINATION

BY DR. GARNER:

Q. Yes. I'm Dr. Garner, a commissioner also. I wanted to ask you, when you talk about the fact that he left and should -- you thought he would get credit.

Is -- when someone is asked to leave a residency, is that a process or an action that's taken by one individual, or is there a process and multiple people involved in committees?

How is that usually accomplished?

A. Well, there are evaluations that come in after every rotation, and the Program Director collates these. And if there's a decision to terminate somebody, the program decision, and then of course it would get checked off on -- on people up the -- (inaudible) up to the Program Director.

Q. All right. No one person has the authority to, so to speak, fire him or remove him from the

residency without review by others; is that correct?

A. Well, you know, this is a the great issue, I would say. The program -- they want somebody to be fired, it'll -- but to make that happen.

Q. So to make that happen, though, they have to go through a process; is that correct?

A. Yes. But they have -- put sufficient control over that process so that if a program director wanted somebody to go, they would be able to make that happen.

Q. And -- and how is that that they would make it happen?

A. Well, they would talk to the other people who had to sign off and make -- create paperwork that made it -- look to get rid of somebody. So it -- it would be -- it would be one person would make the decision, though there would be a number of people who sign off on it. I think it's pretty typical scenario.

Q. Okay. But then there would be other people involved with it also, is what you're saying, correct?

A. Oh, it -- it -- involved in, you know, that's a term with a lot of flexibility.

DR. GARNER: All right. Thank you.

THE HEARING OFFICER: Doctor, this is Bill Gordon. I'm the hearing officer and I -- I'm just not

clear on one thing, and that is whether you were still at the medical school when Dr. Farrag's residence was -- was terminated?

THE WITNESS: No, I was not.

THE HEARING OFFICER: Okay. Thank you, sir.

THE WITNESS: I was -- I was previously involved as a, you know, as a person at the medical school in any of this. So this is not in my official capacity.

THE HEARING OFFICER: Thank you, sir.

Kenneth, do you have any questions?

DR. ALDRIDGE: I don't.

THE HEARING OFFICER: Jorge, do you have any --

DR. ALSIP: No, sir.

THE HEARING OFFICER: Dr. Fischer, thank you for being with us this morning.

THE WITNESS: Thank you for your fair and balanced decision-making.

THE HEARING OFFICER: All right. May the 4th.

Russell, you ready for the next witness?

RUSSELL: Yeah. I think Kenneth -- do you have?

MR. GARRETT: Yes. I think you got it

queued up, don't you?

RUSSELL: Yes.

MR. GARRETT: Please put it on.

RUSSELL: Who are you -- who are you calling?

MR. GARRETT: Dr. Nishant Agrawal.

DR. GARNER: Agrawal?

MR. GARRETT: Agrawal. Get him to spell his name out.

RUSSELL: Is there a -- that's him.

MR. GARRETT: Okay. You ready?

RUSSELL: There's some noise on his end.

MR. GARRETT: On his end? Okay.

Are you there?

DR. MUJADZIC: Hello?

MR. GARRETT: Yes, hello. My name is Kent Garrett. You're in front of the Medical Licensure Commission. Judge Gordon and the members of the Licensure Commission are here to hear your testimony relative to Tarik Farrag, and I think they want to swear you in first.

DR. MUJADZIC: Okay.

THE HEARING OFFICER: This is Dr. Agrawal; is that correct?

MR. GARRETT: That -- that's right.

THE HEARING OFFICER: Rachel (phonetic), would you please swear him in?
MR. GARRETT: I -- I -- I'm sorry.
THE WITNESS: Yes.
MR. GARRETT: Give me your name.
THE WITNESS: I'm not Dr. Agrawal, I'm Dr. Mujadzic. M-U-J-A-D-Z-I-C.
MR. GARRETT: I got you. Not Agrawal.
THE HEARING OFFICER: Would you swear the witness, please, Rachel?
THE COURT REPORTER: Please raise your right hand. Do you swear or affirm the testimony --
THE WITNESS: Hello? Are you talking to me now?
THE COURT REPORTER: Yes, sir. Please raise your right hand.
THE WITNESS: Okay. I -- I am raising my hand.

DR. MIRSAD MUJADZIC,

having first been duly sworn, testified as follows:

THE HEARING OFFICER: Doctor, would you please state your full name and spell your surname for the commission, please, sir?
THE WITNESS: My full name is M-I-R-S-A-D, Mirsad, M-U-J-A-D-Z-I-C, Mujadzic, pronounced properly,

but Mujadzic is okay, too.

EXAMINATION

BY MR. GARRETT:

Q. Doctor, I'm going to try to be expeditious in -- in what we're doing here.

You know Tarik Farrag, I -- I take it?

A. Yes.

Q. Where do you --

A. Yes, I do.

Q. Where do you work, sir? What is your general background?

A. I'm a physician. I'm a plastic surgeon. I used to work at Augusta University.

In 2017, I left Augusta University and joined Prisma Health in Columbia, South Carolina, in (indiscernible), South Carolina. I'm a plastic surgeon, Chief of (inaudible) Services here in -- in Prisma Health. And I'm a full clinical professor.

Q. And you're a professor at this time?

A. Yes, sir. I'm a full professor at this time.

Q. What do you teach?

A. I'm -- I'm a plastic surgeon, and I operate on people, but I -- we have residency, and we have medical students.

Q. Let me cut to the chase here. We're here before the Licensure Commission with Dr. Farrag's license on the line, to be frank about it.

How do you know Dr. Farrag, and what is your -- I --

A. At the time, I was --

Q. I'm sorry?

A. That -- at the time I was attending, employed at Augusta University. So Tarik Farrag was a resident over there, and I remember him being resident. And -- and he also did some presentations, did some research.

He showed a lot of interest in this procedure I personally performed in patients (inaudible). We worked together. He's talked with me multiple times in cases and given some presentations, some plastic surgery papers.

He was very -- I would say a hardworking, good resident, and good human being.

Q. Well, what in the world happened then?

A. It happened that we got, unfortunately, some people who have high intolerance. They're simply bigots. I believe that Dr. Kountakis is a bigot. He's not a nice and pleasant person to anybody, but he was extremely harsh towards Farrag. Not only at that

particular day.

I mean, to all account, I am -- I was in residency in Augusta, and I'm in residency now. By no means was Tarik did deserve to be -- him to be fired. By no means. Tarik was -- I -- at that time, I -- I advised him.

I said, listen, you need to chill it. And you're going to get easily that -- that case, because he has no right to fire with this kind of small thing.

Who the heck has fired company for some small thing to happen, something with he was trying to get a -- get to the hospital, and police stopped him, and he said he's going to the hospital.

And it was -- it was a -- it was a some -- some nonsense thing which practically doesn't even have -- have anything to do with residency, with his performance as the resident, with his behavior, with his knowledge, anything to do with anything. It's something totally unrelated.

But we knew all that Dr. Kountakis was really harsh on him from very beginning. I'm not going to judge and say reason why was he that harsh. I have my personal opinion about that, but I'm not going to share the -- because I don't really have some proof that that's behind.

I believe that he simply feels and cares -- and unjustifiably and unfairly feedback to Tarik, even at that time, practically finishing -- finish his third year.

Who the heck in the world, for minor things, fired somebody when he was practically finishing his residency and year -- he had the one more year to finish his residency.

Who could fire somebody that way? That -- that -- he has to really do something bad, some big, bad mistake, be fired.

I mean, I -- I'm in residency my whole career. I mean, I've been teaching residents, and we had problems and people who did much worse, and much bigger things, than Tarik did. But, you know, you got to be human being, you got to treat people properly, you know.

God teaches us to be forgiving, right? And for my opinion, to fire somebody like he was fired, with feedback that his career and his whole life was messed up. He was cut from his -- practically, he almost, like, finished that -- that residency, and then do that to somebody.

You got to be really -- that -- that's pure evil. On my -- my team, that's pure evil. But -- but

Dr. Kountakis, this is pure evil. He's just a bigot and hater. That's all I can say for you.

I know him personally, we have to professionally cooperate with the colleagues. And I can't -- I can't tell you anything favorable about him. I can't. I -- I don't believe I have anything personal against him. We always had fair, professional relationship.

But is he a nice person? No, he's definitely not. He's definitely did not. And he unjustifiably, really, punished Tarik harshly, and he definitely didn't deserve what happened to him.

Q. Did you develop an opinion as to Tarik's abilities as a doctor?

A. He -- I would say, as a resident, decided what happened. As a resident, he was a great resident. He had good surgical -- technical skills, he had a -- a great knowledge, medical knowledge.

And as a resident, he would definitely fall in the category of five to -- five to 10 percent of best residents I actually dealt with. So there -- there's no doubt in my mind that he'd be (crosstalk) --

Q. It's -- it's a strange case. It's a strange case because if you look at the documents, you'll see some documents that are critical of him, based on

personal things. But other documents, where he was written up, very high caliber in terms of his ability as a doctor.

You know what I'm talking about? How can I reconcile those things?

A. Such as giving (indiscernible)?

THE HEARING OFFICER: And I don't know that the witness can help you reconcile (crosstalk) --

MR. GARRETT: Right, that. Yeah.

BY MR. GARRETT:

Q. Do you believe that Tarik deserves to be a physician?

A. Absolutely.

Q. Why?

A. Absolutely.

Q. Why?

A. Why? Because he's a -- he's a good human being. He's got good technical knowledge. He's empathetic and empathetic to his patient, and he can take care, probably, more than many others who have licenses in this country.

He can take better -- he can take better care of patients than many others who do have licenses. He is -- in my mind, he's 10 times better physician than Kountakis. He needs help. You need to have --

you to be empathetic to be a really caring about your patients, and Tarik has a good soul.

He's a good human being. He's got good knowledge of medicine, good technical skills as a surgeon. And I don't see, in my view, a single reason for him not to be allowed to practice medicine in this country.

MR. GARRETT: I don't think I have anything further.

THE HEARING OFFICER: Cross?

EXAMINATION

BY MR. HUNTER:

Q. Doctor, this is -- my name is Wilson Hunter. I am General Counsel for the State Medical Board.

Can you hear me okay?

A. Yes, sir. I do.

Q. I want to clear up and make sure I understood correctly.

Were you employed at the Medical College of Georgia during the time period in which Dr. Farrag was a resident?

A. Yes, sir.

Q. And did you have an opportunity to observe him during that time?

A. I -- he worked with me. He did research

with me. And I know him well, because ENT and plastic cooperate as a services because we cover same consult.

At that time, they work -- ENT would cover 10 days, plastic would cover 10 days. And all my physicians there, we would practice 10 days in a month or (inaudible) consult.

So -- and there was a lot of cases incorporated in the services together, and have joint cases where they do surgical inspections, and he would (crosstalk) --

Q. Let me cut you off there --

A. Yes. I have --

Q. -- and then redirection to the -- the questions I need get answered.

Are you aware that Dr. Farrag was on a remediation plan during his residency?

A. Remediation plan? Yes. I know that he had told me this from (inaudible).

Q. Doctor, when you've done medical licensing, have you applied for a license or credentials at a hospital before?

A. Many times, sir.

Q. Okay. And don't those normally ask you --

When they ask you whether or not you were on academic or disciplinary probation during your medical

school or residency program, if you were on a remediation plan, should you answer yes to that question?

A. The question -- I usually -- from my credentials, don't get questions about my residency. They really -- my -- I never had that question, when did I have -- (crosstalk)

Q. Okay. Let me -- let me rephrase.

A. This isn't my case.

Q. In -- in our case, Dr. Farrag applied for a medical license with the state of Alabama in 2013, and answered no to the question asking whether or not he was on any type of probation during his postgrad training.

Do you think that was true or a false statement?

A. There's a difference between probation and remediation, because they are two different things.

Remediation -- remediation can be behavioral or educational remediation. That means that the resident needs some improvement, but resident, possibly, doesn't have to do anything wrong whatsoever.

Q. Well, how about, I guess -- Doctor, let me -- (crosstalk)

A. We can't -- we can't -- but you do -- when

you have -- I'm sorry, if I may just say this?

Q. No, sir. No, sir. I'm asking the questions, sir --

A. Okay. Okay, fine.

Q. -- and I -- I -- need to limit you to what I'm -- you -- your answer needs to reflect my question.

So the next question I'm going to ask you is, whether or not you consider a termination from a residency to be discipline?

A. If it is justified.

Q. No, sir. That's not the question.

Is termination from residency a form of discipline?

A. No.

Q. It's not. Okay.

A. No.

Q. Well, I don't --

A. No.

Q. I think -- okay. My next question to you, sir, is, you state that Dr. Farrag was terminated or fired based upon the bigotry of Dr. Kountakis.

Were you a member of the Residency Program Evaluation Committee?

A. I was president of -- Residence Evaluation Committee.

Q. Were you member of the Residency Program Evaluation Committee in 2011?

A. Which committee? ENT or plastic?

Q. The -- okay, well, I -- this -- I'm going to read you a letter on -- that memorializes a meeting on May 25th, 2011, regarding the Residency Program Evaluation Committee meeting regarding Dr. Tarik Farrag. And --

THE HEARING OFFICER: Which exhibit?

MR. HUNTER: Sorry. Yes, sir. This is Exhibit 16, Page 995.

BY MR. HUNTER:

Q. I'm going to pull up a couple names, pull that up, but let me read to you the -- the letter, since you don't have that available.

THE HEARING OFFICER: Okay. (inaudible).

MR. HUNTER: Yes, please.

BY MR. HUNTER:

Q. "A faculty meeting was called by Dr. Terris today to notify faculty members of the situation that happened with Dr. Farrag earlier this morning.

"Dr. Farrag was pulled over by a law enforce -- law official for running a red light. He falsely told the officer that he ran the red light because he had a patient emergency in the ICU.

"During the course of gathering information about the situation throughout the day, it had been found that Dr. Farrag had been dishonest with the officer, faculty members, residents and the program director.

"He provided a statement, via e-mail, that proved to be extremely fabricated. Dr. Farrag also admitted to asking a resident in an outside department to provide false information on his behalf.

"All the meetings that took place today between those involved have been documented and statements received from both chief residents."

Now, my question to you, Doctor, is, you made a statement, I think, that -- about a police encounter and that didn't justify his termination.

Is that the encounter you're referring to?

A. Yes, sir. I do.

Q. And this is -- all right. So I'm going to read you the next paragraph in the letter.

"The committee determined that Dr. Farrag violated the terms of his remediation plan by not demonstrating professionalism and adhering to ethical principles. It was then proposed by Dr. McKinnon that Dr. Farrag be terminated. This notion was seconded by Dr. Postma.

"The Otolaryngology Residency Program Evaluation Committee all unanimously voted that Dr. Tarik Farrag should be terminated as a resident physician in the Department of Otolaryngology."

My question to you, Doctor, is, is Dr. McKinnon a bigot?

A. I am not sure, sir.

Q. All right. My next question, is Doctor --

A. Maybe. Maybe.

Q. -- is Doctor --

A. Maybe.

Q. -- is Dr. Postma a bigot?

A. Maybe. There are bigots in this country, sir.

Q. Is Dr. Terris --

A. There is a lot of bigots in this --

Q. Hold on, but my question -- these are going to be yes or no.

Is Dr. Terris a bigot?

A. I (inaudible) him personally. I think he probably is not bigot.

Q. Is Dr. Lana Jackson a bigot?

A. I cannot -- I don't know that.

Q. Is Dr. Jack Borders a bigot?

A. I don't know that.

Q. Is Dr. Melanie Seybt a bigot?

A. I don't know that, sir.

Q. Is Dr. Jimmy Brown a bigot?

A. Objection. So Doctor, we can go over forever. I don't know for all these session.

Q. Okay.

A. I don't know. But the questions should be asked (inaudible) does not have to do anything with the residency and his performance as a resident.

Q. Do you believe in that position (crosstalk) --

A. It doesn't have anything (crossstalk) in his performance as a resident.

THE HEARING OFFICER: Doctor, this -- this is the hearing officer, and I'm going to ask you to confine your answers to Mr. Hunter's questions, please. And -- and then Dr. Farrag's lawyer can come back and talk to you about this.

BY MR. HUNTER:

Q. Based upon your own testimony, sir, more than half of the committee that voted to terminate Dr. Farrag is not known to be bigots.

How can you maintain that his dismissal is 100 percent attributable to bigotry and not his own behavior?

A. Yes. I maintain that no resident, American, and I'm going to state this clearly -- no resident has ever been terminated for something that has nothing to do with residency and his performance as resident.

We have his evaluation and resident may be terminated only based on evaluation. I've been a resident a long time. I was program -- committee president a long time. And this practically -- what happened, what this committee did is totally inappropriate, illegal, and not justified.

I can tell you that for sure, and he can get this case -- I -- I advised him to sue the committee. Because based on all residency rules and regulations, he cannot be terminated based on this part.

Has nothing to do with his performance as a physician. It has nothing to do with just anything. This event is not to terminate somebody really.

If you -- do you support -- can I ask you question? Do you support --

Q. No, sir.

A. Would you terminate based on that?

Q. No. Do -- are you still employed by this university?

A. No, sir.

Q. Why did you leave employment?

A. I left employment because the plastic surgery fell apart, because the whole difference was, I would say, after they changed director.

After they changed dean, who was of -- of British origin -- and after they changed director -- the whole director, CEO, who was origin -- Argentina origin and brought the guy -- brought some guy from Facebook, the whole policy and culture at MCG changed.

Whole policy and culture has changed. From one place, which was really widely open place, only became highly intolerant and highly bigotist.

Plastic surgery got dismantled wide. So the chief of plastic surgery was Jack Yu, Chinese. I'm Bosnian. The next plastic -- next plastic person was from Peru. Somebody has ultimately said and I can testify -- I can testify this as well.

Charlie Howell (phonetic) has said, plastic surgery has too many (indiscernible) foreigners. Got that -- got that (indiscernible). That's what happened, sir.

So if you're not aware that there's a lot of bigotry in certain places, I can -- I can tell you they get all these people who left -- because he said they get one guy. He said, did you keep this guy -- and he left upset because (crosstalk) --

MR. HUNTER: I -- I'm finished, Doctor. I have no further questions. You can --

THE WITNESS: Okay. Thank you.

THE HEARING OFFICER: And do you have any questions?

EXAMINATION

BY MR. GARRETT:

Q. I do have one more if I may. I believe that the committee report was signed by this gentleman -- I mispronounced his name, Kountakis.

Do you know who that is? Hello?

A. Yeah. I know who that doctor is.

Q. Well, that's the guy that signed the committee report, -- had all those names on it. He was in charge of -- as I understand it, at that time, was in charge of Farrag's residency.

A. Yes, sir. He was.

Q. And he's the guy -- let's be frank about it.

Whether it's true or not, you feel like he was being unfair to Farrag and singling him out?

A. He has singled him out many times. He made his life really difficult.

And the previous -- whoever asked the question, I'm sorry. I don't -- I apologize. I don't know the name. Asked me about remediation and

remediation. It can be educational, and it has -- has nothing to do -- is not -- is not the form action of the punishment.

And to go for fire -- from the remediation to firing is also not a process that goes (inaudible) cases. And this is not a -- if -- if he goes to -- if he goes to CME, he can get the case. I can guarantee you, because I have a lot of experience. And I would recommend he --

THE HEARING OFFICER: I'm going to stop this -- hearing officer. I believe you answered the question. I -- I would like to pose the question to you.

Did I understand you correctly to say that Dr. Farrag was in his second year of residency when he was terminated?

THE WITNESS: No, sir. He was -- no, sir. He was finishing -- he finished -- he was finishing -- had finished third year of residency.

THE HEARING OFFICER: All right. Thank you.

THE WITNESS: He had one more year to go.

THE HEARING OFFICER: He had a year to go?

THE WITNESS: Yes. A residency ENT is five years or, I believe, four years. And he finished three out of four.

THE HEARING OFFICER: All right. I don't have any further questions.

Commissioner (indiscernible) has questions?

UNIDENTIFIED SPEAKER: If I had any questions?

Dr. Alsip?

EXAMINATION

BY DR. ALSIP:

Q. Thank you, Doctor. Couple of questions.

So if I recall your testimony, you were at Georgia Health Sciences University when Dr. Farrag was -- was terminated.

But to your recollection, did Farrag leave Augusta then -- or leave Georgia Health Sciences, or did -- did he change programs, or did he do a research year or was that the -- was that it in May 2011?

A. He -- he did not -- I don't think he had opportunity to stay at MCG. He left -- he left MCG, because he did not have a chance to stay. They didn't give him any chance. They didn't give him any opportunity. So -- so he was just simply fired.

And we had a resident who -- who did 10 times worse things that Farrag did, and we didn't fire him. We (indiscernible) him.

Q. All right.

A. (Crosstalk).

Q. I'm sorry to cut you off. We're really just talking about Dr. Farrag today, and not other residents.

So it sounds like you were pretty involved with -- with teaching residents back at MCG back -- back then.

If -- if a resident was terminated from any program, did they have due process, as far as the right to appeal the decision?

A. They normally do -- and they normally do have due process, and that should be all performed. And I don't think that Farrag had that chance. I don't think that he was given that chance.

And I -- I don't think that he had any actual process involved in all this. He was just bluntly fired. There was a low tolerance.

I would say, in average, there's a much worse resident, all the times, who were not fired. In his case, the tolerance toward him was very low.

Q. As far as you know -- as far as you are aware, there was no -- there was no appeal of this decision?

A. I'm not aware of one. However, by -- when he left, he was, I believe, probably -- we communicated

quite frequently when he was in residency and we -- he even -- you know, we had a lot -- from research encounters, professional encounters.

And after that -- after this event happened, he really disappeared from my radar. We didn't communicate much, so.

Q. All right.

A. And he got hooked up with (indiscernible). I guess he got depressed with the whole situation. And I can't really tell much about what happened after that event.

Q. So as far as you know, though, there was no appeal? You were not aware of an appeal of this decision?

A. I'm not aware of it. Correct.

Q. And then last question that I -- I want to make sure you -- you know, we spent some time talking about the May 2011 termination letter.

And -- and I -- if I'm understanding correctly, we're on the same page that was when his -- his time as a resident at MCG ended; is that correct?

A. Correct.

Q. All right. Well, on his last application, he indicated that he started that program in July of '09, so it seems that he did not spend a full two years

there.

So are you -- are you certain that he was in his third year?

And when you say third year, are we counting -- was the first -- his first year actually -- his PG2 year, because he did a general -- he did a PG1 year, and something else first, before he went to Otolaryngology?

Is that what we're talking about? Because it --

A. Usually -- usually that's what happens. They do, like, PGY-1, an intern year, out there, some other places. And then they -- when they apply, they practically apply for first year of residency, but in reality, he got PGY-2 position.

So then practically when he applied the (indiscernible) residency, he started the PGY-2, meaning practically second year residency. So when he finished, he did finish third year residency.

Q. Okay. All right. Well -- well, I -- I -- I think we're -- I think we're just a little mixed up on the dates. We can -- we can take that up with Dr. Farrag to get that cleared up.

On his application, it looks like the first residency training he did was -- began in July of '09,

in which case a termination May of 2011 would have been in his second total year of residency training, which may have been the PGY-2 year.

But we're just missing -- we're missing something there. So -- so thank you for that.

A. You're welcome.

DR. ALSIP: No other questions.

UNIDENTIFIED SPEAKER: No other questions here.

THE HEARING OFFICER: All right. Thank you very much. Doctor, thank you for being with us today. We appreciate your testimony.

DR. MUJADZIC: Yes, sir. Thank you for accepting my testimony.

THE HEARING OFFICER: Next witness?

MR. HUNTER: Are you-all -- do you have --

MR. GARRETT: Well, Wilson, I've got one more, but we've got to line him up.

MR. HUNTER: Can we -- so --

MR. GARRETT: You can go ahead and --

MR. HUNTER: No, no. We're -- Dr. Prosser -- we're -- I wanted to give him a hard -- if we could do a hard stop on the next witness at noon our time so that he can get on, because he's got to go.

MR. GARRETT: Okay.

MR. HUNTER: So if you want to get your next guy in in the next 15 minutes.

MR. GARRETT: He went into surgery. He said, I'll be out in an hour, and I'm ready for the rest of the day. I don't know if that surgery is over.

MR. HUNTER: Okay.

MR. GARRETT: We might ask these gentlemen.

MR. HUNTER: That's all right. Get Dr. Prosser on out.

THE HEARING OFFICER: Do we have a witness? That's my question.

MR. GARRETT: I think Wilson --

MR. HUNTER: No, we don't. We --

MR. GARRETT: I'm sorry. I talked at the same time.

MR. HUNTER: No. Been trying to accommodate him, so.

MR. GARRETT: Do you have Dr. Prosser ready now?

MR. HUNTER: He's -- I been -- we've been texting, trying to get him an idea of when this would be over, so.

MR. GARRETT: Honestly, I mean, I -- just to move things along, I mean -- I know everybody --

Wilson, if you want to go ahead and start

with Dr. Farrag --

MR. HUNTER: He says he can go now.

MR. GARRETT: Okay.

MR. HUNTER: So we'll call Dr. Drew Prosser. Let me know when he gets on.

DR. GARNER: Hey, Dr. Prosser, how are you?

DR. PROSSER: Hey, good. How are you doing? Can you hear me?

DR. GARNER: Yes. Great. Thank you. We're going to let the court reporter swear you in.

DR. PROSSER: Okay.

DR. JOHN DREW PROSSER,

having first been duly sworn, testified as follows:

DR. GARNER: May it please the Commission -- do you want to introduce (inaudible)?

MR. HUNTER: Yeah. I'm sorry.

DR. GARNER: Okay.

EXAMINATION

BY DR. GARNER:

Q. All right. Dr. Prosser, please introduce yourself to the Commission.

A. Hello. My name's John Drew Prosser. I'm a pediatric ENT at Medical College of Georgia. Augusta University. I've been in practice here since 2015.

I completed my residency here in 2013, did

fellowship at Cincinnati Children's, then returned as faculty. Served as Associate Program Director of the residency program for five years.

And then served as the Residency Program Director for three years and just transitioned out of that role to focus more on clinical practice and Chief of the division.

Q. Thank you.

So just to be clear, when we talk about Medical College of Georgia and Augusta University, it's the same thing, right?

A. Correct. Yeah, the Medical College of Georgia was a essentially a -- a state medical school that was merged back several years ago with Augusta State University at the time.

And merging in undergrad and graduate institutions, the -- the parent institution formed was -- then named Augusta University, and the individual colleges retained their names.

So we're technically the Medical College of Georgia at Augusta University.

Q. Okay. Thank you for clearing that up. When were you a resident?

A. I was a resident from -- let's see, 2008 to 2013.

Q. All right. Dr. Farrag was an active resident at Medical College of Georgia at one point in time also, correct?

A. That's right. He was a year -- year behind me.

Q. All right. Did you ever cross paths with Dr. Farrag during your residency?

A. We did. Mostly at -- mostly at meetings.

Your intern year, you're -- you're not that much in -- in the ENT training. You're mostly on, you know, (indiscernible) rotations, ICU emergency medicine, anesthesia, general surgery rotations, that -- that sort of thing.

So we didn't have any rotations together but saw each other at -- at conference meetings occasionally.

Q. Okay. And then since he has left, you haven't had any communication or interaction with him, correct?

A. Correct. He sent me an -- an e-mail a couple months back, but no interaction other than that.

Q. All right. What was the nature and the content of that correspondence?

A. It was in January of -- of this year after Sarasota had reached out about residency verification.

You know, he had sent me an e-mail, you know, half -- half catching up, how's the family, half, you know -- you know what was done to me, all -- all these -- all these things.

It's a little bit rambling. I -- I forwarded it to our legal department and was advised not to respond, so.

Q. Fair to say that he was angry about how things happened and went down?

A. I think that's fair to say.

Q. During your residency -- you know, we know now that you're familiar with his medical suspensions.

Were you aware of any of that during your residency?

A. We -- we would be notified when he was placed on suspension. So typically, you know, the residents would get an e-mail saying, you know, Dr. Farrag's been placed on clinical suspension. Please do not contact him regarding clinical care.

Obviously, for -- I don't know how familiar you-all are with residency programs.

But it's not uncommon to say, hey, you know, I got this on Thursday night, but I'm scheduled to take a call. Can you take my call?

Or, you know, the -- the residents will

trade trade call days with each other or, you know, you might see a patient and follow up that one of your co-residents saw.

And send an e-mail to them or call them and say, hey, did this -- did this look like this when you saw this patient on -- you know, on -- on this date a week ago? Did this look like this?

And so department leadership would notify the -- the other residents, you know, when he was placed on suspension to not -- not contact him regarding clinical care.

But they, appropriately, were not telling us the issues. I mean, that's what we get. We get a statement that Dr. Farrag was placed on, you know, clinical suspension. Please do not contact regarding clinical care.

Q. Okay. And just so you know, because I did not explain this to you earlier, you are speaking to a room full of physicians,

A. Oh, okay, great.

Q. We are very familiar, yes, with residency programs.

What were your duties as residency program director?

A. Mainly, you -- you administer the -- the

program, do rotation schedules, you know, didactic schedules, these -- these kind of things.

You -- you -- and as far as graduating residents, and what brings us to this, is you're also responsible for verification of residency training for anyone who has completed the program.

Any time folks change hospitals, or apply for credentials at other hospitals, usually that hospital will reach out and ask for verification that they completed the training program. What dates they were there, were there any -- any suspensions, any -- any things like that.

And we have files kept on every -- every resident that -- that has those -- you know, that has completed the program, or that's ever been in the program. And we usually consult -- consult the file, put the dates in, check the appropriate boxes, and -- and mail it right back.

Q. All right. And during your tenure as a residency program director, how many -- how many inquiries would you say you got per year?

A. Well, we -- we always get the ones for the graduating chiefs, right, because they're -- they're always starting a -- a new job usually at -- usually either for fellowship, or sometimes they cover multiple

hospitals.

And so you know, that -- we alternate two -- two and three residents a year, so. And then the occasional, you know, person in -- in practice, who's -- who's moving jobs, so I'd estimate it at a minimum three per year, at a maximum seven per year. So some -- somewhere around five, a handful -- handful per year.

Q. Okay. During the time that you were residency program director, did you ever receive an inquiry on Dr. Farrag?

A. Yes.

Q. All right. Tell me, when did that happen and who made the request?

A. So I got an e-mail from the credentialing office at Sarasota Memorial Hospital. The initial e-mail was in December of last year. In fact, I looked up the date -- December 19th, 2022 -- an e-mail from them.

I responded with the -- the dates that Dr. Farrag was at our program, and they had reached -- they reached back out to me and requested a meeting, a virtual meeting, which was done by WebEx on January 4th.

And it -- it is at that meeting, they showed me the -- the documents, which -- which you-all have,

and asked me to verify whether these were filled out by me or not.

Q. Okay. You know, before we just jump into the documents, when you went to look at Farrag's file, Dr. Farrag's file, to determine, you know, what -- compare what they had seen to what was in the file, what was the first thing you noticed about his file?

A. That his file is quite large, particularly for the amount of -- amount of time he was here.

Many of our you know, residents that complete the program in the 80s and 90s, their -- their file will be one or -- one or two pages that will say they were here, will have their exit evaluation, the dates they were here, that they satisfactorily completed the program.

You know, newer residents will have their -- their evaluations in there, and some things.

But -- but Dr. Farrag's file was -- was quite large. It was two -- two full folders full of information.

Q. And before we start talking about the documents, I do want to establish just, kind of, the timeline of when he was there, which is in the Exhibit 4 that we sent you.

So it looks like he was an active resident

from July 1 of 2009 through November 23 of 2010; is that correct?

A. That's -- that sounds right. I'd have to -- I'd have to verify, but that sounds right.

Q. Do you have that exhibit just to make sure, because I don't want to --

A. Yeah. Let me get -- right. Let me -- let me pull that. Let me pull that up.

Q. Okay.

A. I do. Exhibit -- Exhibit 4 is the one you're referencing?

Q. Yes. If you could just walk us through just kind of his -- his time there, his suspension, and then the termination date?

A. Right. So activated as a resident from July 1, 2009 to November 23rd, 2010. Was placed on suspension from November 24th, 2010, to March 20th, 2011.

Reactivated as a resident from March 21st, 2011, to May 25th, 2011. Placed on clinical suspension May 26th, 2011, until June 8th, 2012, and was terminated on June 8th, 2012.

Q. And in looking through his file, can you tell us maybe some of the incidents that led to his suspensions and termination?

A. Right. The -- you know, the -- the file really describes mostly professionalism issues. Arguments, disagreements.

You know, incidences with campus police, incidents with ER attendings, incidents with patients discharged from the hospital. Told not to go file a complaint, told not to contact the patient, contacted the patient at home, you know, asking to withdraw the complaint.

It is -- again, nearly every descriptor of the events and the suspensions were for professionalism concerns, not -- not necessarily clinical concerns.

Q. And can you tell us about the one where he was pulled over by the campus police?

A. Right. That was -- it seemed to be the last event right before the termination as -- as the -- as his file reflects.

But just again, briefly paraphrasing, it seemed that they was pulled over, potentially, for speeding and claimed was paged for an airway emergency.

And the -- the police essentially went into the hospital to investigate whether he was paged for an airway emergency and -- and it was found that he was not paged and had -- had asked asked someone to -- to -- to cover for him and -- and say they -- they paged

him.

And -- and that led the -- led to the final termination.

Q. Okay. How long is the ENT residency program?

A. It's five years.

Q. All right. How much of the residency program did Dr. Farrag receive credit for?

A. He received credit for 19 months.

Q. Based on what you reviewed in his file, did he attempt to get credit for months When he was on clinical suspension, but possibly doing some research work? And can you tell us --

A. Right. There -- there is -- there is actually a lot of -- a lot of back and forth in this -- in his record regarding -- regarding this. When he was placed on clinical suspension, there were some requests.

Oh, well, can -- can this be -- can I be moved to a research -- research rotation?

And -- and so it was back and forth about well, can you get research credit for -- for some of these rotations?

And communication from the Program Director and the Chair at the time with the American Board of

Otolaryngology, who ultimately does, you know, the certification of the -- of the programs.

And it was determined that if he was doing research on some of these, you could potentially give partial credit for some of these areas, but that you would have to demonstrate that he had a mentor and was actively working on a project.

And there were some -- some issues, they said, that would have to be demonstrated to give research credit for these months. And when they went back through and pulled work hour logs, and -- and pulled all these things, the determination at the time was to award credit for 19 months of training.

Q. Okay. All right, I want to walk through the documents that we have as Exhibit 4. The first one, Page number is 8866, saw at the bottom. This one is called a Reference Verification Results.

First of all, just -- did you prepare this document?

A. No. I need to -- I need to pull up exactly the one you're -- you're referring to.

Q. Okay. It's on the second page of Exhibit 4.

A. I've got it as -- as Market SMHCS on the top left?

Q. Yes. That one.

A. Okay.

Q. Did you have anyone prepare this document on your behalf?

A. No.

Q. All right. Is this one of the documents when you sat down, you know --

First of all, tell us about that.

When you sat down with the credentialing people from Sarasota Memorial Hospital, are these the documents that are attached to this exhibit that they put in front of you?

A. Yes. Yes. So when I -- when I joined the meeting, I -- I didn't really know much what the -- what the meeting was about other than -- other than Dr. Farrag had requested privileges there. You know, I pulled back through my e-mails.

I had e-mailed, well, is he requesting privileges for otolaryngology or other, you know.

And they just said, well, let's -- let's -- can we have a meeting.

On that WebEx were two folks from the credential's office, and I believe the CMO, so it was -- hospital leadership was -- was there as well. And -- and they took me through similar. We received this document.

Is -- did you fill out this document?

No.

Did -- did -- have you ever seen this document, is this your signature, et cetera? You know, kind of went -- went through the documents, and from there -- and that was the first time I'd -- I'd seen any of these.

Q. And -- and just to -- to round up, you didn't -- you didn't complete any of these, correct?

A. Correct.

Q. All right. All right. Let's walk through the first one. The one with the Market SMHCS at the top.

A. Okay.

Q. One, I want go through on the first page to -- some of this document --

First of all, some of the information is untrue, correct?

A. Correct.

Q. All right. And so in the middle of the page, when it says, how long have you known this person, is that an incorrect representation?

A. That is -- that is incorrect.

Q. All right. And then at -- at the bottom of the page where it says, "To the best of your knowledge,

has he ever been subject to disciplinary action," and he wrote, "No."

Is that incorrect?

A. That's incorrect.

Q. Okay. And then below that, "To the best of your knowledge, has the applicant ever exhibited disruptive behavior," the answer is, "No."

Is that incorrect?

A. That is incorrect.

Q. And then on the next page, the second question about having, well, privileges suspended, and the answer is no.

Is that incorrect?

A. That is incorrect.

Q. All right. And then I also want to talk about just some of the wording and the language that's used in the document. When you read it, were you able -- well, you knew you didn't submit it.

But were you also able to say, I wouldn't have said things that way?

A. Correct. I mean, if -- even the -- the first -- if you look at the first comment on the page and -- and from the -- from the folks at Sarasota, this is what flagged them initially to -- to reach out to me through my e-mail address that was available online.

Yeah.

So you know, Dr. Tarik Farrag is extremely physician, surgeon, and person. He is on the top 1 percent in all above aspects for all providers I have ever known.

So you know, again, the -- the grammars incorrect. I -- you know, I would have said he is in the top 1 percent if I -- you know, would have written this.

Is extremely physician, surgeon, and person is -- is not a sentence. You know, and so it -- it -- the -- the wording is not wording --

Q. Okay.

A. -- which I would have used. Yeah.

Q. Okay. And then if you'll go to 68, on the third page of that document, which is ABME68, at the bottom.

A. Uh-huh.

Q. What about at the top under comments? Would you have ever said huge knowledge?

A. Right. Correct. No.

Q. Okay. And would you -- in the -- let's see. Six lines down that said that Dr. Farrag was known as the anatomy guy.

Did you ever known -- know him to be called

the anatomy guy?

A. I -- I never knew that as a -- as a -- as a nickname of -- of Dr. Farrag.

Q. Did you ever call him that?

A. No.

Q. All right. And then kind of middle of the page under comments, would you ever describe him as forgettable?

A. No.

Q. All right. All right. Let's go -- and then at the bottom it says, "Submitted by Drew Prosser."

But you do not submit this, correct?

A. No. I did not submit that. Correct.

Q. All right. And then on the next page, which is the all Exhibit 4, the ABME69. In the middle of the page, it has an e-mail address which reports to be yours, which is DProsser1@augustaunivsom.org.

Is that your e-mail address?

A. That's not my e-mail address. I -- I've never had that e-mail address. I don't have access to that e-mail address. Our -- our state-issued e-mail addresses are -- are public and they're -- all end in augusta.edu.

Q. Okay. So any documents that were submitted from this e-mail address did not come from you,

correct?

A. Correct.

Q. All right. We'll go to ABME70, which is called the Confidential Privilege Peer Review document.

Can you just kind of go through and tell us the errors that you see in this document?

A. All right. So as we scroll down, the -- the dates of attendance, the end date is -- is incorrect.

Voluntary non-renewal of contract due to -- due to family health, that's not reflected in his -- in his chart. I obviously hope it's not true, but I -- I do not know of any medical conditions with his -- with his wife. They're not reflected in his -- in his chart for number -- for Number 3.

Number 4 is -- is correct. Our -- our program is ACGME accredited. The -- the requested privileges, we're -- we're unable to certify from our training as he did not complete our training program, whether he is competent to perform these requested privileges.

And then the disciplinary action, Number 6, no. Obviously we have multiple, you know, kind of reports in his file about disciplinary action.

This is, again, signed, it looks like D. Prosser. You know, again, that -- that is not my

signature. And -- and in fact, I don't know how much you -- you may have caught that my -- my first name is John, and I go by Drew.

But just because of -- of the confusion, I sign all official documents John Drew Prosser. And so not -- not only is this not my signature, it's not even in the manner in which I sign verification documents.

Q. Okay. All right, let's go to the next page, which is ABME71. Oh, that's the second page of that same document. Sorry.

But under -- in the middle of page about -- that -- oh, the form was completed.

Nevermind. Let's skip over that. Let's go --

A. All right.

Q. -- to Page 72, the Verification of Graduate Medical Education and Training.

Again, can you kind of go over what's incorrect in this document?

A. So again, the -- the top training program is ACGME accredited.

The -- "did the above named (indiscernible) successfully complete the program?" No. "This is due to voluntary non-renewal." Again, it was -- you know, that's not reflected in the file. It's reflected that

he was terminated for professionalism issues.

Again, I don't have any knowledge or -- or record of -- of any of his wife's medical issues.

"In addition to completion of full specialty training, completion of training -- constitute for completion of the program." I'm not sure what that's in reference to.

As I stated above, "The extremely high level of five years of residency completion, as well as several (inaudible) fellowships placed Dr. Farrag above and beyond."

I did not -- did not write that, and don't have any verification of -- of, you know, prior -- prior training.

Q. Okay. And then as far as under the suspension being checked no, that should have been checked yes; correct?

A. Correct. Each of those would have been checked yes. There were conditions and restrictions beyond generally associated with the training program. Obviously, clinical suspension is not part of our program, so that would have been yes. Involuntary leave of absence would have been yes. Suspension would have been -- would have been yes.

Q. Okay. And then on the next page, 73, where

it has dismissal and then it's checked no, but that should have been checked yes; correct?

A. Correct.

Q. Or would have been if you had completed it?

A. Correct.

Q. And then next, on Page 74, again, is this your signature?

A. No. Again, that's not my signature. It's not even the manner in which I do sign documents.

Q. Okay. And not your e-mail either, correct?

A. Correct. That e-mail is -- is incorrect.

Q. Okay. And then next, I want to go to the diploma.

A. Okay.

Q. Or tell us what this document is.

A. Right. So this -- this document is a -- is a scanned copy of what we have in his file as the certificate he was given, you know, after -- after termination. There's some communication, again, back and forth in the -- in the record regarding credit for months -- for the months he was here.

And it was determined that he could be given a certificate for the months he was here and that it would be reported as completed a term of service.

So if you see on the -- on the one it has,

"Satisfactory. Completed a term of service as a resident," and then the dates -- the dates there. And then signed by -- by the Department Chair at the time, the Program Director at the time, the Dean, and the President of the -- of the institution at the time.

Q. All right. When you met with the individuals from Sarasota, did they provide you with a copy of a similar certificate that had been provided by Dr. Farrag when he applied for his privileges?

A. They did. They provided a -- a document that -- that the -- the dates and name did not -- did not match, but the remainder of the document did.

Q. All right. And what about the degree parts?

A. The -- the degree name had been changed from MBDCH to MD or -- or -- and then the -- the dates had been changed. I'd have to pull up the document, but --

Q. Okay. Also, can you pull up the document and share your screen?

A. Yes, I can. All right. Are -- are you-all able to see this -- see this document?

Q. It's -- it's pretty small, but if you'll just go through and kind of show us what the differences are.

A. Yeah. I'll zoom in. I apologize for the format. This is the format which they sent it to me.

Let me zoom here.

So this is the document that was submitted to Sarasota. Again, it's the Medical College of Georgia. It has Tarik Farrag, MD. And then the dates which they typed on the -- on the bottom document states dates are July 1, 2009, to June 30th, 2012.

And the remainder -- let's see if I can increase this. So you can clearly see the -- the MD there. And then the June date there, July 1 to June -- June 30th, 2012.

Q. Yeah. Thank you for showing us that. But in -- in conclusion, that -- after reviewing your file, there's no dispute you (sic) received 19 months of credit from the residency at Medical College of Georgia, correct?

A. Correct. Correct. After -- after much back and forth. But again, in consultation with the -- with the Board, he was awarded 19 months credit in the file.

Q. All right. Is Dr. Kountakis your supervisor today?

A. He is. He's chair of the department.

Q. All right. The fact that he is your supervisor, did that in any way impact your testimony here today?

A. No.

Q. No? Okay.

DR. GARNER: All right. Thank you. The Commission will probably have some questions for you.

THE WITNESS: Okay.

THE HEARING OFFICER: (Inaudible).

MR. GARRETT: Thank you.

THE HEARING OFFICER: Counsel, do you have some questions?

MR. GARRETT: I do have a couple questions. Thank you.

THE HEARING OFFICER: Doctor -- Dr. Farrag's counsel is going to ask you some questions first.

THE WITNESS: Okay.

EXAMINATION

BY MR. GARRETT:

Q. Doctor, as I understand it, you were notified by the people in Sarasota December 19th, 2022; is that right?

A. That's -- that's correct. I received an e-mail.

Q. And then if I understand what occurred, you-all had some type of a conference call with those people.

I guess it was January 4th you had a meeting?

A. January 4th, correct.

Q. Right. Did you have an opportunity to talk with Dr. Kountakis about this between those times?

A. Not between those times. I had an opportunity, but I -- I don't -- I don't recall contacting him in-between those times.

Q. You do not? Do you --

A. No.

Q. -- do you talk -- do you talk with him generally about what's going on?

He's your, for lack of a better term, in the chain of command, he's above you, isn't he?

A. Correct, correct. He -- he is -- he is above me and we talk, probably, monthly.

Q. Right.

A. Monthly, I'd say, is a good -- is a good thing. I'm -- I'm a -- I'm a pediatric otolaryngologist and we have a Children's Hospital, so I'm -- I'm mostly in the Children's Hospital.

For instance, my office is in a separate -- separate area than -- than the other -- the adult faculty offices. These folks have offices in -- in a -- in a different location. So we don't -- we don't interact on a daily basis, but -- but probably monthly.

Q. Have you reached out to any of the people

that practiced medicine with Tarik after he left, you know, the hospital -- the (crosstalk)?

A. Right. No. No, I haven't.

Q. So it's basically been, I don't know, more than a decade, really, right?

A. Correct.

Q. Okay. Have you talked to the people at Johns Hopkins --

A. No.

Q. -- of what, if anything, he's done there?

A. No.

Q. Have you checked out to see if he's done any research work since that time?

A. No.

Q. I mean, nor would it necessarily be something you would need to do (crosstalk)?

A. That would be a -- that would be atypical. We have 80 --

Q. Right.

A. -- 85 graduates of the program.

Q. The other thing that -- in the material that was sent to Sarasota, I will let Dr. Farrag explain this, but one of the documents he filled out had to do with -- it was entitled waiver.

Do you know what those are? It has to do

with whether or not you complied with medical requirements, as I understand it, to be -- to be there.

A. I'm not familiar with a waiver. No, sir.

Q. The reason I asked the question, and it puzzled me, because what has been suggested here, through your testimony, is that Dr. Farrag was being disingenuous. I don't know any other way to put it.

But if -- you -- you may not be able to shed any light on this, but it would seem to me that if somebody was trying to be disingenuous with a job applicant, they would not request a waiver, simultaneously, with that application for the fulfillment of some requirements.

To put it the way I can understand it, if you were not going to be truthful with parts of the application, you wouldn't ask for a waiver on other parts, I would not think.

Is that -- do I make sense to you?

A. Is -- potentially it's difficult -- difficult to follow. I'm not familiar with a waiver.

Q. And we don't know -- that's right. And we don't know what's in somebody's mind, right?

A. Right.

Q. Ever, really. The other thing that I -- I did wonder about was the -- your knowledge of his

actual clinical practice after he left, what he did as a doctor.

A. Right.

Q. Do you have any real knowledge of that?

A. I -- I don't. I don't. I don't really have any -- any direct knowledge of any -- of any of that.

Q. Just from a skill level standpoint, I have not heard you say anything adverse about his skill as a physician.

Are you coming here and telling us that you've got an opinion based on your professional expertise that he's not quite -- not able to be a good physician from a skill standpoint?

A. No. I don't -- I don't have any direct, you know -- no. I -- I have not observed him. I've not worked with him in a clinical capacity. I mean --

Q. Can I just ask --

A. -- (crosstalk) a decade ago. I'm left to -- to go by the record.

Q. I'm too commonsensical about this. I apologize.

A. Oh, that's okay.

Q. But do you know whether or not Dr. Kountakis just -- you know, they just didn't get along?

Did you have any impression about it, one

way or the other?

A. Right. No. I -- I -- I didn't have any impression of that. And as someone who's worked with -- with Dr. Kountakis for -- you know, since -- since returning as -- as faculty, I don't think that would ever -- ever be an issue.

Q. Strange. Thank you.

THE HEARING OFFICER: What other questions? (Inaudible).

Was that correct?

Dr. Alsip?

DR. ALSIP: I think I have cross here.

EXAMINATION

BY DR. ALSIP:

Q. Two questions. In the -- I guess the time it's called MCG and -- and the MCG Otolaryngology Program, did new resident start as -- as PG1s, or did they enter at the PG2 level after doing an internship and something else?

A. They -- they entered in -- in as PG1s. That was a recent change when otolaryngology went -- I'd have to -- I'd have to get the -- get the full date for you. It used to be a prelim year plus four --

Q. Right.

A. -- or -- or a general surgery intern year

plus four, but that was moved in -- I -- I can tell you it was before 2008, because I -- I was considered a "capital resident" as the -- as the PGY1. So --

Q. And do you recall back -- what date (crosstalk) --

A. But --

Q. Go ahead.

A. Yeah, sorry. I was just going to say, but they limit -- they limited the number of otolaryngology rotations you could do during the intern year, back at that time, to three.

So you could do a maximum of three with the -- with the department. The rest had to be off -- you know, other -- other service rotations. Now, they've increased that to six. So currently our residents are able to do six months otolaryngology in the intern year, but that's a relatively new change.

Q. Okay, thank you. And if I recall, you said you were a year ahead of Dr. Farrag?

A. Yes.

Q. Did -- did -- and you recall receiving a notification that Dr. Farrag was placed on clinical suspension?

A. Yes.

Q. At the time, if you can think back that far,

based on your own experience with Dr. Farrag, did that -- did that come as a surprise?

Like, I wouldn't have expected that or, you know, something --

A. No. You know -- again, we -- we -- I was in the otolaryngology portion of the training at that time, so I was in the PGY-2 year. And again, he was an intern doing mostly other -- other service rotations.

And so you know, obviously -- you know, I haven't gotten e-mails like that before or since, so -- so it was, I'm sure, shocking at the time, but -- but --

Q. But you didn't have -- you didn't have enough experience --

A. But I didn't -- right. I didn't have direct experience with -- with him in a clinical capacity, no.

Q. Fair enough. And -- and earlier you went through kind of your review of Dr. Farrag's file and --

A. Right.

Q. -- mentioned some incidents -- those incidents that you -- you mentioned, were they from multiple different specialties and different -- and different physicians, or were they all from a single physician or department?

A. No. They were -- they were multiple --

mostly -- mostly outside. There was an incident in a call room that involved a psychiatry resident.

The -- the incident regarding the patient complaint, I believe, was an otolaryngology patient, if I recall. I'd have to -- I'd have to double check that.

The incident with the attending in the ER was a -- was a pediatric ER attending that had filed that complaint. The -- and then obviously the issues with -- with campus police were -- were through the police department.

Q. So it sounds like the -- and I don't want to put words in your mouth, it sounds like your review of the file doesn't paint a pattern of one or two people having -- having it out for Dr. Farrag and -- and filling his -- his file with complaints?

A. Correct.

Q. Last question. If you were looking at -- at his -- you know, at his history objectively, you know, and -- and didn't already have a score, would you still give him 19 months credit for what he did at MCG?

Or would you hang that one way or the other, up or down?

A. Right. I mean, I think -- I think clinical credit for -- for 19 months is -- is appropriate. They

vetted everything through the -- the (indiscernible). They went back and looked, you know, meticulous (indiscernible) rotation of time logs, and all these things.

And I haven't -- haven't really seen any -- anything that I would do differently as program director now than they did back then. So 19 months is -- is appropriate for the amount of time there.

DR. ALSIP: Thanks, Dr. Prosser.

Thanks, Judge.

THE HEARING OFFICER: Dr. Aldrige?

EXAMINATION

BY DR. ALDRIDGE:

Q. Dr. Prosser, this is Ken Aldridge. I'm a member of the Commission.

That 19 months having inspected six weeks to complete the problem?

A. Five years. Yes, 19 months is a five-year program.

DR. ALDRIDGE: Thanks.

THE HEARING OFFICER: Further question?

MR. GARRETT: I have one other question, if I may.

THE HEARING OFFICER: Yes.

MR. GARRETT: I'm sorry. I'm sorry.

DR. CHRISTOPHER: I have one.

EXAMINATION

BY DR. CHRISTOPHER:

Q. This is Dr. Craig Christopher. Dr. Prosser, thanks you for being here.

Just -- just for the record, I just hope to be absolutely certain. There is no question in your mind that your -- your -- that all these documents were fraudulently filled out reporting to be you --

A. Correct.

Q. -- and they were not you?

A. Correct.

Q. And the only person you know that would -- it would benefit to do that fraudulently would be Dr. Farrag; is that correct?

A. That's the -- that's the best summary I've -- I've heard. I -- you know, I don't know who filled out these documents. I know they weren't me. I -- I know the person who filled them out that directly benefits the most is Dr. Farrag.

You know, again, they -- they -- I didn't fill them out. That's not my e-mail address. I've never had access to that e-mail address or know how that e-mail address even came to be.

But -- but it was -- it was not of -- of my

doing or at my direction at all.

DR. CHRISTOPHER: Thank you.

THE HEARING OFFICER: Kent?

MR. GARRETT: Just one other.

EXAMINATION

BY MR. GARRETT:

Q. If -- if a resident is taking call in year three of their residency, are they in year three of their residency, if they take a call?

A. Not necessarily. Promotion -- that's a -- that's a great question, because our -- our current residents get -- get tripped up -- up on -- on this as well. Your -- your PGY level and your years are -- are different -- are -- are different.

So we actually -- we have a resident in the program right now. One of our -- one of our chief residents is -- actually was a -- completed oral surgery residency program prior to going back to medical school, completing medical school requirements, and then matched into an ENT program.

So her -- you know, her -- her years employed in -- in residency are -- are now pushing 10, but she is on the advancement track in otolaryngology. She is listed as a PGY-5 resident, if that makes sense. So your --

Q. It does.

A. -- so your -- your years -- and we've had a -- a subsequent resident after Dr. Farrag who had an extended leave time who had to graduate all phase. So he actually graduated.

And so he completed the -- the five years -- actually five and a half years after his start date, he completed the fifth year. The PGY-5 year was completed five and a half years after his start date, if that makes sense.

So your -- so your PGY year and your -- and your years of employment are different from a training perspective. They -- they -- 90 percent -- 99 percent of the time, they match one-to-one, but -- but not always.

Q. Another thing that got confusing to me. I think you said that actually research stuff in some capacity, depending on what you did, and how you did it, and when you did it, can be part of your residency and (crosstalk)?

A. That's right. Yeah. We have a -- we have a required research rotation that's done in the -- in the third year. It's four -- four months of your -- of your training done in the third year. And the expectation is to complete a -- complete a major

project with a -- with a faculty mentor.

Q. And what I'm getting to is it's kind of -- it is an objective finding as to whether what -- how much residency you completed, but it's based on subjective criteria.

Is this research something that would qualify? What was that person doing during that period?

How long was that person on probation? All of those things are -- can -- are -- is an objective fact arrived at by subjective analysis. Would that be --

A. So -- correct. You have a -- you have a -- you have a guide of -- of things that our board allows us to -- to give credit for. But ultimately -- ultimately, you're right.

There is a -- there's a -- a committee which makes recommendations for credit and advancement to the program director, and the program director, for the most part, signs off.

Q. And this is straightforward common sense, but you were not required to nor should you -- nor did you after not -- having seen Farrag for, I guess, a decade.

You didn't call him up, or reach out to him,

and go, why did you -- why did you fill this thing out and (indiscernible) like that?

A. Correct. I -- I got to be honest with you. It was my -- it was my first instinct, was to what?

Was to give them a call and say, hey -- hey, what's going on? What -- you know, what's -- what's going on with this?

But after not having contact for -- for a decade plus, it's you know, almost -- how you -- how do you start that conversation?

Q. And you know, quite frankly, that's not your job. But what your job was, was to report what you were going to tell the people in Florida to Doctor -- I can't ever pronounce his name, Dr. Kountakis.

That was part of your job, wasn't it?

A. Correct. We -- well, we -- we -- after the meeting, I obviously reported to our -- our legal folks and -- and Dr. Kountakis, hey, I just was in this meeting. They had these documents that I had to fill out.

What -- what -- you know, what are -- what are the next steps?

Q. Let's face it, you probably said he's toast to Dr. Kountakis, didn't you? Or something like that?

A. No. No. I didn't. You know, I think -- I

think the -- the -- the mood of the conversation was more shock than anything.

Q. Okay. Thank you.

THE HEARING OFFICER: One -- one final question before we --

EXAMINATION

BY DR. GARNER:

Q. Dr. Prosser, I know you were just being asked questions about whether it was subjective about the research.

But what I hear you say in your testimony is that the Medical College of Georgia went back through his file and made an objective determination, putting all of his service together, and whatever research he did, and determined that there were 19 months, correct?

A. Correct.

DR. GARNER: Thank you.

THE HEARING OFFICER: There are no other questions.

Thank you for being with us today, Dr. Prosser.

DR. PROSSER: Okay. Thank you.

THE HEARING OFFICER: And we'll stand in recess for 1:15 for lunch.

DR. CHRISTOPHER: Yeah. 1:15. Can you-all

be back by 1:15? Is that -- works?

UNIDENTIFIED SPEAKER: Yes.

DR. CHRISTOPHER: Okay. 1:15.

(HEARING RECESSED)

I, Doug Yarborough, a transcriber, hereby declare under penalty of perjury that to the best of my ability the above 105 pages contain a full, true and correct transcription of the tape-recording that I received regarding the event listed on the caption on page 1.

I further declare that I have no interest in the event of the action.

September 8th, 2023

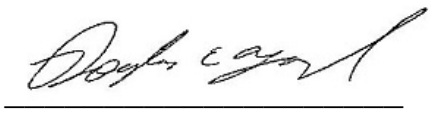

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EXHIBIT T

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **LAUREN ELIZABETH DUENSING, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2020-381**

CONSENT DECREE

This matter comes before the Medical Licensure Commission of Alabama (the "Commission") on the Administrative Complaint filed by the Alabama State Board of Medical Examiners (the "Board"). The Board and the Respondent, Lauren Elizabeth Duensing, M.D. ("Respondent"), have asked the Commission to approve and enter this Consent Decree.

General Provisions

1. **Protection of the Public.** The Board stipulates and agrees that the terms and conditions of Consent Decree constitute a reasonable disposition of the matters asserted in the Administrative Complaint, and that such disposition adequately protects the public's health and safety. After review, the Commission also finds that this Consent Decree is a reasonable and appropriate disposition of the

matters asserted in the Administrative Complaint, and that the provisions of this Consent Decree will adequately protect public safety.

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.** This Consent Decree shall constitute a public record under the laws of the State of Alabama. This Consent Decree will be reported by the Board and/or the Commission to the Federal National Practitioner Data Bank ("NPDB") and the Federation of State Medical Boards' ("FSMB") disciplinary data bank. This Consent Decree may otherwise 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.

ORDER

It is **ORDERED, ADJUDGED, AND DECREED:**

1. That Respondent's application for reinstatement of her license to practice medicine in the State of Alabama is **GRANTED**, and Respondent is hereby issued a license to practice medicine in the State of Alabama, **RESTRICTED** as follows:

   a. Respondent shall practice medicine in the State of Alabama only pursuant to a practice plan that has been approved in advance by

the Commission. The following practice plan has been submitted by Respondent and is hereby **APPROVED**:

> "Respondent is to be employed by the Mobile County Health Department, practicing as a pediatric rheumatologist within the general pediatrics clinic, reporting to Dr. Stephen Michaels, Chief Medical Officer. Respondent's primary role will be pediatric rheumatology but the Health Department likely will ask Respondent to see some general pediatrics patients if her schedule allows. She will have direct on-site oversight from the pediatricians listed below as well as oversight from Dr. Cron (her preceptor) and CPEP. The following physicians will be working with Respondent: Stephen Michaels, M.D., Norma Roberts, M.D.; Debra Walks M.D., Rhonda Bedsole, M.D., and Shariene Wrights, M.D."

b. Respondent shall maintain an APHP Contract until at least August 15, 2027.

c. Respondent shall comply with the return-to-practice recommendations numbered 1-8 set forth on pages 22-23 of the Acumen Assessments Multidisciplinary Forensic Fitness for Duty Evaluation (December 16, 2022).

d. Respondent shall diligently pursue the development of an Educational Intervention Plan as described in the CPEP Assessment Report (December 15, 2022), and shall implement and complete all aspects of such Educational Intervention Plan. If an Educational Intervention Plan has not been formalized and commenced within 90 days of the date of this Consent Decree,

then the Commission may, by its own order, initiate further proceedings and take further actions as are deemed appropriate to effectuate this Consent Decree.

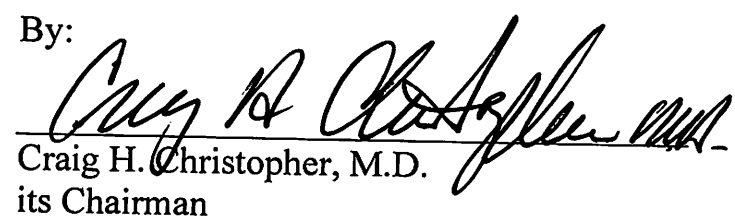
e. Respondent shall, within 12 months of the entry of this Consent Decree, complete a review course in general pediatrics (*e.g.*, a board examination review course) of at least 24 hours in length, approved by the Board.

2. Nothing in this Consent Decree is intended to restrict Respondent's ability to obtain a DEA registration or an Alabama Controlled Substances Certificate.

3. That no administrative fine nor costs of this proceeding are assessed against Respondent.

DONE on this the 31st day of October, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By: 

Craig H. Christopher, M.D.
its Chairman