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

November 20, 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
Pamela Varner, M.D.
Howard J. Falgout, M.D.
Paul M. Nagrodzki, M.D.

MEMBERS NOT PRESENT

Nina Nelson-Garrett, M.D.

MLC STAFF

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

BME STAFF

Buddy Chavez, Investigator
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
Tiffany Seamon, Director of Credentialing
William Perkins, Executive Director

Call to Order: 9:03 a.m.

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

OLD BUSINESS

Minutes October 31, 2023

Commissioner Alsip made a motion that the Minutes of October 31, 2023, be approved. A second was made by Commissioner Morris. The motion was approved by unanimous vote.

NEW BUSINESS

Full License Applicants

	Name	Medical School	Endorsement
1.	Asser Abou Elkassem	University of Alexandria	USMLE/CT
2.	Colm John Acuff	Kansas City College of Medicine & Surgery	COMLEX/OH
3.	Annkay Adkins Alexander	University of Alabama School of Medicine Birmingham	USMLE
4.	Hayder AlHashim	Royal College of Surgeons in Ireland	USMLE
5.	Donovon Caryal Allen	University of Nebraska College of Medicine	USMLE
6.	Ahmed Alnahhas	Ross University	USMLE
7.	Andrew William Ammons	Louisiana State University School of Medicine New Orleans	USMLE
8.	Nicholas Allen Andrews	University of Central Florida College of Medicine	USMLE
9.	Muhammad Areeb Ashfaq	Aga Khan Medical College, Aga Khan University	USMLE
10.	Gurpreet Gavin Atwal	Saba University School of Medicine	USMLE
11.	Mashal Awais	Allama Iqbal Medical College	USMLE
12.	Sabesan Balasinkam	Pontifical Catholic University of Chile	USMLE
13.	Heather Smith Barker	University of Louisville School of Medicine	USMLE/KY
14.	Hannie Sami Batal	Semmelweis University	USMLE/GA
15.	Blake Alexis Bauer	Saint Georges University	USMLE
16.	Jansen R Blackwell	Edward Via College of Osteopathic Medicine, Carolinas Campus	COMLEX
17.	Henry Vinson Bonner	University of Alabama School of Medicine Birmingham	USMLE
18.	Jeremie Daniel Bourget	Campbell University Jerry M. Wallace School of Osteopathic Medicine	COMLEX
19.	Garrett Austin Bourne	University of Texas at Austin	USMLE
20.	Thomas Allen Boyd	University of South Alabama College of Medicine	USMLE
21.	Brandon C Buchel	Ross University	USMLE/FL
22.	Christopher Minh Bui	University of Mississippi School of Medicine	USMLE
23.	Sarah Catherine Cagle	Louisiana State University School of Medicine New Orleans	USMLE
24.	Rosetta Christine Campbell	Sidney Kimmel Medical College at Thomas Jefferson University	USMLE

	Name	Medical School	Endorsement
25.	Margaret Nicole Catt	Mercer University School of Medicine	USMLE
26.	Malcolm B Chapman	University of North Carolina School at Chapel Hill School of Medicine	USMLE
27.	Evan Austin Chavers	University of South Alabama College of Medicine	USMLE
28.	Aaron James Chinners	University of South Alabama College of Medicine	USMLE
29.	James Robert Clark	Rosalind Franklin University of Medicine and Science	NBME/VA
30.	Riley David Coots	University of Kentucky College of Medicine	USMLE
31.	Gabrielle Rose Cordaro	Saba University School of Medicine	USMLE
32.	Matthew Cornelison	Augusta University	USMLE
33.	Miranda Kolby Crowell	University of South Alabama College of Medicine	USMLE
34.	Ian Colwill Cummins	University of Alabama School of Medicine Birmingham	USMLE
35.	Alexis Elise Cunningham	New York College of Osteopathic Medicine	COMLEX
36.	Mitchell Mackenzie Currie	Saba University School of Medicine	USMLE
37.	Igor Damasceno Vidal	Faculty of Medicine Federal University of Ceara	USMLE
38.	Amanda Christine Davis	Alabama College of Osteopathic Medicine	COMLEX
39.	Paris Delaney	University of Minnesota Medical School - Minneapolis	USMLE
40.	Hima Reddy Devarapalli	M S Ramaiah Medical College, Bangalore University	USMLE
41.	Christian Blake Dunaway	University of South Alabama College of Medicine	USMLE
42.	Hannah Shirley England	University of South Carolina School of Medicine	USMLE
43.	Hua Fang	University of Alabama School of Medicine Birmingham	USMLE
44.	Farzam Farahani	University of Texas Southwestern Medical Center at Dallas	USMLE
45.	Ana Paula Frambach Simao	Fluminense Federal University	USMLE
46.	Pranav Garlapati	Gandhi Medical College, Secunderabad	USMLE/OK
47.	Adil M Hussein Gasim	University of Khartoum	USMLE/NC
48.	Rima Ghamrawi	Edward Via College of Osteopathic Medicine-Auburn campus	COMLEX
49.	Patricia C Gonzalez Balaguer	Universidad Central Del Este (UCE)	USMLE
50.	Hilda M Gonzalez Bonilla	Autonomous School of Medical Sciences of Central America	USMLE/DC
51.	David Mark Gotlieb	University of Vermont College of Medicine	USMLE/NY
52.	Wilbur Wai Hung Hah	University of Texas Medical School at San Antonio	FLEX/TX
53.	Jared Ross Halstrom	University of Alabama School of Medicine Birmingham	USMLE
54.	Mia Jeanette Harris	University of Alabama School of Medicine Birmingham	USMLE
55.	Edward Alan Harris	University of Texas Medical School at San Antonio	USMLE
56.	Omar Hayek	Augusta University	USMLE
57.	Sherif Helmey	University of Alabama School of Medicine Birmingham	USMLE
58.	David Keith Helton	East Tennessee State Univ James H Quillen College of Medicine	FLEX/TN
59.	Aaron L High	University of Missouri Kansas City School of Medicine	USMLE/SC
60.	Shyla Renee Hossain	University of South Alabama College of Medicine	USMLE
61.	John Hunsicker	University of Alabama School of Medicine Birmingham	USMLE
62.	Taichi Imamura	Hokkaido University Medical College	USMLE/HI
63.	Neena Ann John	University of Tennessee Health Science Center College of Medicine	USMLE
64.	John Cameron Johnson	Texas Tech University Health Sciences Center School of Medicine	USMLE/AZ
65.	Nathanael Young Johnston	Brody School of Medicine at East Carolina University	USMLE
66.	Shilpa Joseph	St Georges University of London School of Medicine, Grenada	USMLE

	Name	Medical School	Endorsement
67.	Santhoshi Reddy Kariveda	Mahadevappa Rampure Medical College	USMLE
68.	Kyle Vincent Keinath	Philadelphia College of Osteopathic Medicine	COMLEX/VA
69.	Monica Jean Kessi	Oregon Health & Science University School of Medicine	USMLE/MO
70.	Sameer Khan	Edward Via College of Osteopathic Medicine-Auburn campus	COMLEX
71.	Muhammad Qasim Khan	American University of Antigua	USMLE
72.	Sandip Khatri	Edward Via College of Osteopathic Medicine, Carolinas Campus	COMLEX/TX
73.	Anas Khouri	University of Aleppo	USMLE
74.	Robert James Kidder	University of the Incarnate Word School of Osteopathic Medicine	COMLEX
75.	Connor Galloway Koch	University of Alabama School of Medicine Birmingham	USMLE
76.	Raunak Kollipara	Dr. P.S.I. Medical College	USMLE
77.	Varshitha Kondapaneni	Univ of Health & Sciences Siddhartha Medical College, Gunadala	USMLE
78.	Richard Frederick Kutner	Tulane University School of Medicine	FLEX/LA
79.	John Lax	Wright State University School of Medicine	USMLE/VA
80.	Thomas Jacob Lee Jr.	University of South Alabama College of Medicine	USMLE/IN
81.	Perry Yikai Lee	Eastern Virginia Medical School	USMLE/HI
82.	George Chun-Bong Ling	University of Miami Miller School of Medicine	USMLE
83.	Mackenzie Kellen Link	University of South Florida College of Medicine	USMLE
84.	Abigail G P Lorraine	University of Miami Miller School of Medicine	USMLE/FL
85.	Michelle Parsons Mallitz	Georgetown University School of Medicine	USMLE/VA
86.	Caleb Wilson Mason	Alabama College of Osteopathic Medicine	COMLEX/MS
87.	Kate Leigh McCarty	Augusta University	USMLE
88.	Caroline Anne McElhannon	Augusta University	USMLE
89.	Brian Joseph Moore	Kirksville College of Osteopathic Medicine	COMLEX/KY
90.	Hannah E Moreland	University of South Carolina School of Medicine	USMLE
91.	Andrew Eugene Morson	University of Tennessee Health Science Center College of Medicine	USMLE/LA
92.	Steven Gary Moss	Albert Einstein College of Medicine of Yeshiva University	NBME/PA
93.	Terrence Patrick Murphy	Rosalind Franklin University of Medicine and Science	NBME/IL
94.	Bradley Alton Murray	University of Mississippi School of Medicine	USMLE/MS
95.	Peyton Curtis Myers	University of Alabama School of Medicine Birmingham	USMLE
96.	Ramayee Shoba Nadarajan	Amrita School of Medicine	USMLE
97.	Fnu Nidhi Shankar Kikkeri	Rajiv Gandhi Medical College	USMLE
98.	Moozhan Nikpanah	Iran University of Medical Sciences	USMLE
99.	Peshitha Nimmagadda	Late Baliram Kashyap Memorial Government Medical College	USMLE
100.	Elizabeth Hodgkinson Olson	Tulane University School of Medicine	USMLE/LA
101.	Allen C Omo-Ogboi	Delta State University College of Health Sciences	USMLE
102.	Jordana Rose Owens	Augusta University	USMLE
103.	Yusuf Ozcelik	Istanbul University, Cerrahpasa	USMLE
104.	David Albert Patch	St. George's University School of Medicine, Grenada	USMLE
105.	Meet Nileshkumar Patel	Mercer University School of Medicine	USMLE
106.	Nandan Jay Patel	University of Alabama School of Medicine Birmingham	USMLE
107.	Chirag Y Patel	University of Alabama School of Medicine Birmingham	USMLE
108.	Collin James Pieper	University of Nebraska College of Medicine	USMLE

Name	Medical School	Endorsement
109.Brian Scott Planchard	Tulane University School of Medicine	USMLE/LA
110.Sarah M A Polistico	University of Santo Tomas	USMLE/IN
111.Sivani Bellam Reddy	University of Alabama School of Medicine Birmingham	USMLE
112.Britta Ramseth Reierson	University of Minnesota Medical School, Minneapolis	USMLE/MN
113.Carlos Alberto Ricotti	University of El Salvador	USMLE/TX
114.Daniel Overton Rosenblatt	Tulane University School of Medicine	USMLE/TN
115.Luis Antonio Sardina Pena	Central University of Venezuela - Jose Maria Vargas	USMLE/PA
116.Sejal Shah	Northwestern University Medical School	USMLE/MA
117.Trisha Miller Shattuck	University of Connecticut School of Medicine	USMLE/NC
118.Ashlyn Nicole Shields	University of Alabama School of Medicine Birmingham	USMLE
119.Andrew Simpson	University of Kentucky College of Medicine	USMLE
120.Adam Daniel Singer	Augusta University	USMLE/GA
121.Muhammad Sohaib	University of Health Sciences Lahore	USMLE/NJ
122.Ellie O'Neal Starnes	Louisiana State University Medical Center, Shreveport	USMLE
123.James Allen Stewart	University of Alabama School of Medicine Birmingham	USMLE
124.Keehn Strange	University of Alabama School of Medicine Birmingham	USMLE
125.Ian Sweitzer	Lincoln Memorial Univ Debusk College of Osteopathic Medicine	COMLEX
126.Courtney Jean Syfrett	Edward Via College of Osteopathic Medicine, Auburn	COMLEX
127.Phat Minh Tran	Ross University	USMLE
128.Joven Narag Tristeza	Louisiana State University School of Medicine New Orleans	USMLE
129.Christianna Lan Tu	University of Utah School of Medicine	USMLE
130.Madhusudan Vijayan	Kilpauk Medical College, University of Chennai	USMLE
131.Rongzhi Wang	China Medical University	USMLE
132.Daniel Lee Warren	University of South Alabama College of Medicine	USMLE
133.Emily Harrison Williams	University of Alabama School of Medicine Birmingham	USMLE
134.David Bradley Wilson	Indiana University School of Medicine Indianapolis	NBME/IN
135.Bernhard Wolmarans	University of Florida College of Medicine	USMLE
136.Brett Whalen Wright	University of Virginia School of Medicine	USMLE
137.Lingling Xian	Shihezi University	USMLE
138.Jeffrey Yang Xu	Alabama College of Osteopathic Medicine	COMLEX
139.Alexander Chuan Yang	Wayne State University School of Medicine	USMLE
140.Charles Yang Yi	University of Massachusetts Medical School	USMLE
141.Jesan Evne Zaman	American University of Antigua	USMLE
142.Melody Marie Zeidan	University of South Alabama College of Medicine	USMLE
143.Palghat V Mohan	Stanley Medical College, University of Chennai	FLEX/GA
144.*Elizabeth Rhodes Butler	University of Alabama School of Medicine Birmingham	USMLE
145.*Jillian Aileen Kelly	American University of Antigua	USMLE
146.*Tyler James Newell	University of Alabama School of Medicine Birmingham	USMLE
147.*Adaora Ifeyinwa Osakwe	Emory University School of Medicine	USMLE/GA
148.*Arsh Divyesh Patel	Edward Via College of Osteopathic Medicine-Auburn	COMLEX
149.Kristen Elsa Cain	Johns Hopkins University School of Medicine	FLEX/VA
150.Carrie Lynn Morris	University of Alabama School of Medicine Birmingham	USMLE/TN

Name	Medical School	Endorsement
151.*Jay Ramesh Bhula	University of Central Florida College of Medicine	USMLE/GA
152.*Zachary James Bryant	University of South Carolina School of Medicine	USMLE/TX
153.David Mitchell Hudson Jr.	University of Mississippi School of Medicine	USMLE/LA

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

A motion was made by Commissioner Aldridge with a second by Commissioner Alsip to approve applicant numbers one through one hundred fifty-three (1-153) for full licensure. The motion was approved by unanimous vote.

Limited License Applicants

	Name	Medical School	Endorsement	Location	License
1.	Gian Piero Carames	Universidad Del Norte	LL/AL	UAB Pathology	R
2.	Aysenur Gullu	Meram Faculty of Medicine	LL/AL	North Alabama IM	R
3.	Mina M T Iskander	Ain Shams Uni Faculty of Med	LL/AL	North Alabama IM	R
4.	Victor Ortiz-Soriono	Cayetano Heredia University	LL/AL	Brookwood IM	R
5.	Vibhu Parcha	Dr.Prasad Government Med College	LL/AL	UAB IM	R

A motion was made by Commissioner Alsip with a second by Commissioner Morris to approve applicant numbers one through five (1-5) 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 October 1, 2023, through October 31, 2023. A copy of this report is attached as Exhibit "A".

APPLICANTS FOR REVIEW

Kristin Dobay, M.D.

A motion was made by Commissioner Nagrodzki with a second by Commissioner Morris to defer any action on Dr. Dobay's application for licensure until after the conclusion of the Kentucky Board of Medical Licensure's proceedings, the Commission will at which point set a hearing in this

matter. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "B".

REPORTS

Physician Monitoring Report

The Commission received as information the physician monitoring report dated November 14, 2023. A copy of the report is attached as Exhibit "C".

Lauren E. Duensing, M.D.

The Commission received as information communication from CPEP regarding an education plan for Dr. Duensing.

REQUESTS

Amjad Butt, M.D.

The Commission considered a request filed by Dr. Butt to lift the restrictions placed on his Alabama medical license. A motion was made by Commissioner Alsip with a second by Commissioner Morris to enter an order setting a hearing for April 24, 2024. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "D".

Ramesh Babu Peramsetty, M.D.

The Commission considered a request filed by Dr. Peramsetty to withdraw his previously filed request and cancel the scheduled hearing. A motion was made by Commissioner Alsip with a second by Commissioner Varner to cancel the hearing and accept withdrawal of the request. The motion was approved by unanimous vote, with Commissioner Aldridge abstaining from the vote. A copy of the Commission's order is attached hereto as Exhibit "E".

DISCUSSION ITEMS

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

The Commission received as information the FSMB's Call for Comments: Strategies for Prescribing Opioids for the Management of Pain. A copy of the memorandum is attached hereto as Exhibit "F".

Appointment – BME/MLC Joint Consultant Group on Physician Sexual Misconduct

A motion was made by Commissioner Nagrodzki with a second by Commissioner Morris to accept the Chairman and Vice Chairman's nomination to appoint Commissioner Aldridge to serve on the Board of Medical Examiners and Medical Licensure Commission's Joint Consultant Group on Physician Sexual Misconduct. The motion was approved by unanimous vote. A copy of the memorandum is attached hereto as Exhibit "G".

BME Rules for Publication: Administrative Rule 540-X-7-.50, Qualifications of the Physician Anesthesiologist Supervising the Anesthesiologist Assistant.

The Commission received as information the BME's Rules for Publication: Administrative Rule 540-X-7-.50, Qualifications of the Physician Anesthesiologist Supervising the Anesthesiologist Assistant. A copy of the memorandum is attached hereto as Exhibit "H".

BME Rules for Publication: Administrative Rules 540-X-7-.29, 540-X-7-.62, 540-X-7, Appendix E, Concerning Advanced Practice

The Commission received as information the BME's Rules for Publication: Administrative Rules 540-X-7-.29, 540-X-7-.62, 540-X-7, Appendix E, Concerning Advanced Practice. A copy of the memorandum is attached hereto as Exhibit "I".

ADMINISTRATIVE FILINGS

Rubye Washington-Moore, M.D.

The Commission received an Administrative Complaint filed by the Alabama State Board of Medical Examiners. A motion was made by Commissioner Nagrodzki with a second by Commissioner Alsip to enter an order setting a hearing for January 24, 2024. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "J".

David Wayne Cole, M.D.

The Commission received as information an Administrative Complaint filed by the Alabama State Board of Medical Examiners. A copy of the Administrative Complaint is attached hereto as Exhibit "K".

At 10:04 a.m., the Commission entered closed session pursuant to Alabama Code § 34-24-361.1 to hear and consider the following matters:

CLOSED SESSION UNDER ALA. CODE 34-24-361.1

Shakir Raza Meghani, M.D.

The Commission received a proposed Joint Settlement Agreement and Consent Order between Dr. Meghani and the Alabama State Board of Medical Examiners. A motion was made by Commissioner Varner with a second by Commissioner Falgout 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".

David Wayne Cole, M.D.

The Commission received a proposed Joint Settlement Agreement and Consent Order between Dr. Cole and the Alabama State Board of Medical Examiners. A motion was made by Commissioner Morris with a second by Commissioner Nagrodzki 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".

Gary Royce Wisner, M.D.

The Commission received a proposed Joint Settlement Agreement and Consent Order between Dr. Wisner 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 "N".

Cosmin Dobrescu, M.D.

A motion was made by Commissioner Morris with a second by Commissioner Nagrodzki to continue Dr. Dobrescu's hearing until after the conclusion of the Alaska State Medical Board's proceedings, at which point the Commission will set a hearing in this matter. The motion was approved by unanimous vote. A copy of the Commission's order is attached hereto as Exhibit "O".

Meeting adjourned at 10:38 a.m.

PUBLIC MEETING NOTICE: The next meeting of the Alabama Medical Licensure Commission was announced for Wednesday, December 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

12/10/2023
Date Signed

EXHIBIT A

IMLCC Licenses Issued October 1, 2023 - October 31, 2023 (108)

Name	License Type	License Number	Status	Issue Date	Expiration Date	State of Principal Licensure
Todd Dylan Levine	MD	47472	Active	10/10/2023	12/31/2024	Arizona
Sonal Patel Brizendine	MD	47473	Active	10/10/2023	12/31/2024	Arizona
Dorcas Naa Ajeley Borley Lomo	MD	47474	Active	10/10/2023	12/31/2024	Arizona
Sheila Sudhaker	MD	47519	Active	10/25/2023	12/31/2024	Arizona
Jane Lyons	MD	47535	Active	10/30/2023	12/31/2023	Arizona
Hemant R Kade	MD	47467	Active	10/6/2023	12/31/2023	Colorado
Angela Marie Poppe Ries	MD	47469	Active	10/6/2023	12/31/2023	Colorado
Stephanie Alexandra Grail	MD	47475	Active	10/10/2023	12/31/2023	Colorado
Dennis Wayne Garver	MD	47481	Active	10/11/2023	12/31/2024	Colorado
Suhail Mohammed Salim	DO	3447	Active	10/12/2023	12/31/2024	Colorado
Moris Beachay Girgis	MD	47494	Active	10/18/2023	12/31/2023	Colorado
Patricia Ann Clancy	MD	47496	Active	10/18/2023	12/31/2023	Colorado
Ron K Her	MD	47505	Active	10/23/2023	12/31/2023	Colorado
Veronica Christina Grail	MD	47506	Active	10/23/2023	12/31/2023	Colorado
Michael Thad Pfannenstiel	MD	47515	Active	10/24/2023	12/31/2023	Colorado
Natosha Diane Canty-Johnson	MD	47465	Active	10/4/2023	12/31/2023	Georgia
Patrick Damian Datoc	MD	47466	Active	10/5/2023	12/31/2024	Georgia
Gregory Bracewell	MD	47479	Active	10/11/2023	12/31/2023	Georgia
Travis James Langley	MD	47480	Active	10/11/2023	12/31/2024	Georgia
Sipra Laddha	MD	47492	Active	10/18/2023	12/31/2023	Georgia
Aaron Gerald Mammoser	MD	47497	Active	10/18/2023	12/31/2023	Georgia
Tai Anh Do	MD	47498	Active	10/18/2023	12/31/2023	Georgia
Kadisha Roxanne Rodriques	MD	47501	Active	10/19/2023	12/31/2023	Georgia
James Sirleaf Jr.	MD	47503	Active	10/19/2023	12/31/2023	Georgia
Aja Elaine Pollard	MD	47507	Active	10/23/2023	12/31/2023	Georgia
Salman Siddiqui	MD	47508	Active	10/23/2023	12/31/2023	Georgia
Randy Warner	MD	47520	Active	10/25/2023	12/31/2023	Georgia
Laxmi Maturi Naik	MD	47530	Active	10/26/2023	12/31/2023	Georgia
Chinonso Ezike	DO	3455	Active	10/27/2023	12/31/2023	Georgia
Kimberly Gesnes Morris	MD	47592	Active	10/31/2023	12/31/2023	Georgia
Sarah Maria Daccarett	MD	47536	Active	10/30/2023	12/31/2024	Idaho
Jitendrakumar Sodvadiya	MD	47457	Active	10/2/2023	12/31/2023	Illinois
Syed Asif Masood	MD	47487	Active	10/16/2023	12/31/2024	Illinois
Sonal Dhupar Mittal	MD	47449	Active	10/2/2023	12/31/2023	Indiana
Charles Meric Janssens	DO	3445	Active	10/4/2023	12/31/2024	Indiana
Connie Jean Joylani	MD	47529	Active	10/25/2023	12/31/2024	Iowa
Monica Multani	DO	3449	Active	10/19/2023	12/31/2024	Kansas
Jared Jay Dirks	MD	47531	Active	10/27/2023	12/31/2023	Kansas
Noreen Mairead Flanagan	MD	47514	Active	10/24/2023	12/31/2024	Maine
Alexander Jean Antoniou	MD	47493	Active	10/18/2023	12/31/2023	Maryland

Laura Ann Arbogast	DO	3442	Active	10/3/2023	12/31/2023	Michigan
Sarah Secor-Jones	DO	3448	Active	10/16/2023	12/31/2023	Michigan
Susan Elizabeth Little-Jones	MD	47495	Active	10/18/2023	12/31/2024	Michigan
Tyler Grayson Jones	MD	47540	Active	10/30/2023	12/31/2024	Minnesota
Robert E Bowen	MD	47478	Active	10/11/2023	12/31/2023	Mississippi
Orhan Ilercil	MD	47541	Active	10/30/2023	12/31/2023	Mississippi
Marylin Fouche	MD	47550	Active	10/30/2023	12/31/2023	Mississippi
George David Fain	MD	47591	Active	10/31/2023	12/31/2023	Mississippi
Andrew Thomas Patterson	MD	47483	Active	10/12/2023	12/31/2024	Nebraska
Michael Christopher Hansen	MD	47488	Active	10/16/2023	12/31/2023	Nevada
Derric Allan Whiteside	DO	3454	Active	10/25/2023	12/31/2024	Nevada
Michael Joseph Lahey	MD	47463	Active	10/4/2023	12/31/2024	New Hampshire
Michael Keiichi Fujinaka	MD	47489	Active	10/16/2023	12/31/2023	New Hampshire
Jennifer Lynn Conroy Steichen	MD	47502	Active	10/19/2023	12/31/2023	New Hampshire
Michael William Donnino	MD	47518	Active	10/25/2023	12/31/2023	New Hampshire
Angela Marie Palitto	DO	3441	Active	10/2/2023	12/31/2023	Ohio
Beth Anne Rymeski	DO	3443	Active	10/3/2023	12/31/2023	Ohio
Petronella T Mbu	MD	47462	Active	10/4/2023	12/31/2023	Ohio
Matthew Lowe	DO	3446	Active	10/5/2023	12/31/2024	Ohio
Hassan Al-Shammaa	MD	47500	Active	10/19/2023	12/31/2024	Ohio
Phillip Michael Mele	DO	3450	Active	10/23/2023	12/31/2023	Ohio
Jon Edward Mendelsohn	MD	47512	Active	10/24/2023	12/31/2023	Ohio
Ahmed Fasihuddin Khan	MD	47588	Active	10/31/2023	12/31/2023	Ohio
Jay Lance Gregston	MD	47450	Active	10/2/2023	12/31/2023	Oklahoma
Darci R Hazelwood	DO	3444	Active	10/4/2023	12/31/2023	Oklahoma
Kelsey Marie Flynn	DO	3452	Active	10/23/2023	12/31/2023	Oklahoma
Annie Garcia	MD	47504	Active	10/20/2023	12/31/2023	Tennessee
Joshua Peter Roland	MD	47509	Active	10/23/2023	12/31/2023	Tennessee
Mhd Omar Subei	MD	47510	Active	10/23/2023	12/31/2023	Tennessee
Meredith Anne Humphreys	MD	47516	Active	10/24/2023	12/31/2023	Tennessee
Armenthry Zshvetta Jones	MD	47522	Active	10/25/2023	12/31/2023	Tennessee
Mahmoud Mohamed Refat Aboelfetouh Gaballa	MD	47468	Active	10/6/2023	12/31/2023	Texas
Alberto Gomez	MD	47471	Active	10/10/2023	12/31/2023	Texas
Henryk J Nikicicz	MD	47476	Active	10/10/2023	12/31/2023	Texas
Mehrad Adibi	MD	47486	Active	10/13/2023	12/31/2023	Texas
Elizabeth Yu Chiao	MD	47517	Active	10/24/2023	12/31/2023	Texas
Amy R Spallone	MD	47523	Active	10/25/2023	12/31/2023	Texas
John Nicholas Papadopoulos	MD	47524	Active	10/25/2023	12/31/2023	Texas
Ella Jazmin Ariza Heredia	MD	47525	Active	10/25/2023	12/31/2023	Texas
William Anthony Ross	MD	47526	Active	10/25/2023	12/31/2023	Texas
Andrea Magdalene Milbourne	MD	47527	Active	10/25/2023	12/31/2023	Texas
Elizabeth Joan Shpall	MD	47532	Active	10/27/2023	12/31/2023	Texas
Mary Thomas Austin	MD	47533	Active	10/27/2023	12/31/2023	Texas

Ara Asadur Vaporicyan	MD	47534	Active	10/27/2023	12/31/2023	Texas
Samuel Eduardo Rivera-Flores	MD	47537	Active	10/30/2023	12/31/2023	Texas
Samuel Ainslie Shelburne	MD	47538	Active	10/30/2023	12/31/2023	Texas
Eduardo Yepez Guevara	MD	47539	Active	10/30/2023	12/31/2023	Texas
Edward Carew	DO	3456	Active	10/30/2023	12/31/2023	Texas
Maria Alejandra Zarzour	MD	47542	Active	10/30/2023	12/31/2023	Texas
Valerae O Lewis	MD	47543	Active	10/30/2023	12/31/2023	Texas
Ariel David Szvalb	MD	47544	Active	10/30/2023	12/31/2023	Texas
Mark Jerome Levy	MD	47545	Active	10/30/2023	12/31/2023	Texas
Ajay Sheshadri	MD	47546	Active	10/30/2023	12/31/2023	Texas
Teny Mathew John	MD	47547	Active	10/30/2023	12/31/2023	Texas
Bruno Palma Granwehr	MD	47548	Active	10/30/2023	12/31/2023	Texas
George Michael Viola	MD	47549	Active	10/30/2023	12/31/2023	Texas
Harrys Antonio Torres	MD	47551	Active	10/30/2023	12/31/2023	Texas
Vicente Valero	MD	47552	Active	10/31/2023	12/31/2023	Texas
Kimberly Brooke Koenig	MD	47587	Active	10/31/2023	12/31/2023	Texas
Pablo Christian Okhuysen	MD	47589	Active	10/31/2023	12/31/2023	Texas
Michael Howard Kroll	MD	47590	Active	10/31/2023	12/31/2023	Texas
Jesse Rogoza Knight	MD	47490	Active	10/16/2023	12/31/2023	Washington
Rodney Steven Hagerman	DO	3451	Active	10/23/2023	12/31/2024	Washington
Carolyn Anne Salter	MD	47513	Active	10/24/2023	12/31/2023	Washington
Susan Elizabeth Seago	MD	47521	Active	10/25/2023	12/31/2023	Washington
Paul Berman	MD	47464	Active	10/4/2023	12/31/2024	Wisconsin
Muhammad Asim Aman	MD	47482	Active	10/11/2023	12/31/2023	Wisconsin
Gaurav Patel	MD	47528	Active	10/25/2023	12/31/2023	Wyoming

**Total licenses issued since April 2017- 3,451*

EXHIBIT B

In re: the matter of KRISTIN JOSEF DOBAY, M.D.	BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

ORDER

This matter is before the Medical Licensure Commission of Alabama on Dr. Dobay's application for a license to practice medicine in Alabama. The Commission notes that on January 5, 2023, the Kentucky Board of Medical Licensure entered an order denying the reinstatement of Dr. Dobay's license to practice medicine in Kentucky. Dr. Dobay is currently seeking judicial review of the Kentucky Order. Therefore, the Commission takes no action on Dr. Dobay's application for licensure at this time. After conclusion of the Kentucky proceedings, the Commission will set this matter for hearing as prescribed in Ala. Code § 34-24-360, *et seq.*

DONE on this the 22nd day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-22 14:32:49 CST

Craig H. Christopher, M.D.
its Chairman

EXHIBIT C

STATE *of* ALABAMA

MEDICAL LICENSURE COMMISSION

To: Medical Licensure Commission

From: Nicole Hardy

Subject: November Physician Monitoring Report

Date: 11/14/2023

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

Physician:	**Gary M. Bullock, D.O.**
Order Type:	MLC
Due Date:	6/27/2024
Order Date:	8/25/2023
License Status:	Active-Probation
Requirements:	Administrative Cost ($27,460.27) Administrative Fine ($20,000) Administrative Cost and Fine to be paid in full by 6/27/2024.
Received:	*No payment has been received.

Physician:	**Sharon G. Griffitts, M.D.**
Order Type:	MLC
Due Date:	12/31/2023
Order Date:	8/25/2023
License Status:	Active
Requirements:	Administrative Fine $10,000 to be paid in full by 12/31/2023.
Received:	*No payment has been received.

EXHIBIT D

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **AMJAD I. BUTT, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2013-005**

ORDER SETTING HEARING
On Respondent's Request for Relief from License Restrictions

The Medical Licensure Commission has received Respondent's request to lift the restrictions on his license imposed by our Orders of July 31, 2015 and October 13, 2016. The Commission is advised that the Board intends to oppose Respondent's request. Under the provisions of Ala. Code § 34-24-361(h)(9), this request triggers a contested case hearing. This Order shall serve as the Notice of Hearing prescribed in Ala. Admin. Code r. 545-X-3-.03(3), (4). The Commission's legal authority and jurisdiction to hold the hearing in this matter are granted by Article 8, Chapter 24, Title 34 of the Code of Alabama (1975), and the particular sections of the statutes and rules involved are as set forth in this Order.

1. **Service of This Order**

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

2. **Initial Hearing Date**

This matter is set for a hearing as prescribed in Ala. Code §§ 34-24-360, *et seq.*, and Ala. Admin. Code Chapter 545-X-3, to be held on Wednesday April 24, 2024, at 10:00 a.m., at 848 Washington Avenue, Montgomery, Alabama, 36104. Unless otherwise specified by the Commission, the hearing will be held in person. All parties and counsel are expected to appear and to be prepared for the hearing at this date, time, and place.

3. **Appointment of Hearing Officer**

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

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

4. **Rescheduling/Motions for Continuance**

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

5. **Case Management Orders**

The Hearing Officer is authorized, without further leave of the Commission, to enter such case management orders as he considers appropriate to the particular case. Among any other matters deemed appropriate by the Hearing Officer, the Hearing Officer may enter orders addressing the matters listed in Ala. Admin. Code r. 545-X-3-.03(5)(a)-(f) and/or 545-X-3-.08(1)(a)-(g). All parties will be expected to comply with such orders.

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

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

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

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

7. **Discovery**

Consistent with the administrative quasi-judicial nature of these proceedings, limited discovery is permitted, under the supervision of the Hearing Officer. *See* Ala. Code § 41-22-12(c); Ala. Admin. Code r. 545-X-3-.04. All parties and attorneys shall confer in good faith with one another regarding discovery. If disputes regarding discovery are not resolved informally, a motion may be filed with the Hearing Officer, who is authorized to hold such hearings as appropriate and to make appropriate rulings regarding such disputes.

8. Publicity and Confidentiality

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

9. Stipulations

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

10. Judicial Notice

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

11. Settlement Discussions

The Commission encourages informal resolution of disputes, where possible and consistent with public interest. If a settlement occurs, the parties should notify the Hearing Officer, the Commission's Director of Operations, and the Commission's General Counsel. Settlements involving Commission action are subject to the Commission's review and approval. To ensure timely review, such settlements must be presented to the Commission no later than the Commission meeting preceding the hearing date. Hearings will not be continued based on settlements that are not presented in time for the Commission's consideration during a monthly meeting held prior to the hearing date. The Commission Vice-Chairman may assist the parties with the development and/or refinement of settlement proposals.

12. Subpoenas

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

13. Hearing Exhibits

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

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

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

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

E. Index exhibits/documents for easy reference.

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

14. Appeals

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

DONE on this the 22nd day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-22 14:29:56 CST

Craig H. Christopher, M.D.
its Chairman

Distribution:

- Honorable William R. Gordon (incl. Respondent's written request and Board Opposition)
- Rebecca Robbins
- Respondent/Respondent's Attorney
- E. Wilson Hunter
- Aaron L. Dettling

EXHIBIT E

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **RAMESH BABU PERAMSETTY, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2017-305**

ORDER

This matter is before the Medical Licensure Commission on Respondent's written request, dated November 7, 2023, to withdraw his earlier request for modification of the terms of probation imposed by our Consent Order of July 23, 2019. Respondent's withdrawal of his request is ACCEPTED, and the hearing in this matter, previously scheduled for February 28, 2024, is CANCELLED.

DONE on this the 22nd day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-22 14:33:42 CST

Craig H. Christopher, M.D.
its Chairman

EXHIBIT F

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

fsmb *Integrity in Medical Regulation.* ***Trust in Care.***

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

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[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

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[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]

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[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

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[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

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[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.

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[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

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[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.

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[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

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[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 G

STATE *of* ALABAMA
MEDICAL LICENSURE COMMISSION

MEMORANDUM

To: Medical Licensure Commission

From: Rebecca Robbins

Subject: Appointment – BME/MLC Joint Consultant Group on Physician Sexual Misconduct

Date: November 14, 2023

Chairman Christopher and Vice-Chairman Alsip appoint Commissioner Kenneth Aldridge to serve on the Board of Medical Examiners and Medical Licensure Commission's Joint Consultant Group on Physician Sexual Misconduct. This position was previously held by Dr. Gary Hill.

EXHIBIT H

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: November 16, 2023

Re: Administrative Rules Approved for Publication

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

- Administrative Rule 540-X-7-.50, *Qualifications of the Supervising Anesthesiologist – Anesthesiologist Assistants*

In March 2023, the Board approved amending the rule concerning the qualifications of a supervising anesthesiologist to add a continuing medical education requirement. In May 2023, due to the educational program not being ready, the Board voted not to certify the rule for final adoption and to amend it at a later date.

The Advanced Practice Providers Department will now begin the amendment process. The effective date for the new CME requirement is January 1, 2025.

With an expected publication date of November 30, 2023, the public comment period ends January 4, 2024. The anticipated effective date is March 16, 2024.

Attachments:

Administrative Rule 540-X-7-.50, *Qualifications of the Supervising Anesthesiologist – Anesthesiologist Assistants*

APA-1

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control:	540
Department or Agency:	Alabama Board of Medical Examiners
Rule No.:	540-X-7-.50
Rule Title:	Qualifications Of The Supervising Anesthesiologist - Anesthesiologist Assistants (A.A.)
Intended Action	Amend

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety?	No
Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare?	Yes
Is there another, less restrictive method of regulation available that could adequately protect the public?	No
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved?	No

To what degree?: N/A

Is the increase in cost more harmful to the public than the harm that might result from the absence of the proposed rule?	NA
Are all facets of the rule-making process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public?	Yes
Does the proposed action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule?	No

Does the proposed rule have an economic impact? No

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer _____

Date _____

APA-2

ALABAMA BOARD OF MEDICAL EXAMINERS

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama Board of Medical Examiners

RULE NO. & TITLE: 540-X-7-.50 Qualifications Of The Supervising Anesthesiologist - Anesthesiologist Assistants (A.A.)

INTENDED ACTION: Amend

SUBSTANCE OF PROPOSED ACTION:
Add a requirement for a supervising anesthesiologist to have obtained continuing medical education not more than 48 months prior to or within 12 months of registration to an anesthesiologist assistant. This amendment meets the "protection of public health" exemption from the moratorium on rule amendments contained in Governor Ivey's Executive Order No. 735, Reducing "Red Tape" on Citizens and Businesses.

TIME, PLACE AND MANNER OF PRESENTING VIEWS:
All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Carla Kruger, Office of the General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or email (bme@albme.gov), until and including Jan. 4, 2024. Persons wishing to submit data, views, or comments in person should contact Carla Kruger by telephone (334-242-4116) during the comment period. Copies of proposed rules may be obtained at the Board's website, www.albme.gov.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:
Thursday, January 4, 2024

CONTACT PERSON AT AGENCY:
Carla Kruger

(Signature of officer authorized
to promulgate and adopt
rules or his or her deputy)

540-X-7-.50 Qualifications Of The Supervising Anesthesiologist - Anesthesiologist Assistants (A.A.).

The anesthesiologist to whom an anesthesiologist assistant is registered shall:

(1) Possess a current, unrestricted license to practice medicine in the State of Alabama and practice in the medical specialty of anesthesiology;

(2) On the date of the application, have satisfied one of the following experience requirements:

(a) Practice medicine for at least three years, including any practice as a licensed physician while enrolled in an internship, residency, or fellowship;

(b) Practice medicine as a licensed physician for at least one year, including any practice while enrolled in an internship, residency, or fellowship, and certified by the American Board of Anesthesiology (ABA) or by the American Osteopathic Board of Anesthesiology; or

(c) Practice medicine as a licensed physician for at least one year, including any practice while enrolled in an internship, residency, or fellowship, and the registration's practice site is limited solely to a general acute care hospital, a critical access hospital, or a specialized hospital licensed as such by the Alabama Department of Public Health.

(3) Effective January 1, 2025, have obtained continuing medical education prescribed by the Board of Medical Examiners regarding the rules and statutes governing supervised practice in Alabama, not more than forty-eight (48) months prior to or within twelve (12) months of registration to an anesthesiologist assistant.

(4) The Board, in its discretion, may waive the practice requirements in (2).

Author: 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 Replaced:** Filed July 23, 1999; effective August 27, 1999. **Amended:** Filed November 22, 1999; effective December 27, 1999. **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 (Rule Number Only):** Filed September 11, 2008;

effective October 16, 2008. **Amended:** Published January 31, 2022; effective March 17, 2022. **Amended:** Published January 31, 2023; effective March 17, 2023. Amended/Approved Nov. 16, 2023.

EXHIBIT I

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: November 16, 2023

Re: Administrative Rules Approved for Publication

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

- Administrative Rule 540-X-7-.29, *Continuing Medical Education – Physician Assistant*
- Administrative Rule 540-X-7-.62, *Continuing Medical Education – Anesthesiologist Assistant*
- Administrative Rule 540-X-7, Appendix E, *Physician Assistant / Anesthesiologist Assistant License Renewal*

At their October 2023 meeting, the Board approved amending the Assistants to Physicians rules to allow physician assistants and anesthesiologist assistants to complete 50 hours of AMA Category 1 CME every two years rather than requiring 25 hours annually.

Additionally, an amendment to the PA/AA license renewal application is requested to ask whether the applicant is certified by the National Commission on Certification of Physician Assistants (NCCPA) or the National Commission for Certification of Anesthesiologist Assistants (NCCAA) and, if so, to request the certification number and expiration date.

With an expected publication date of November 30, 2023, the public comment period ends January 4, 2024. The anticipated effective date is March 16, 2024.

Attachments:

Administrative Rule 540-X-7-.29, *Continuing Medical Education – Physician Assistant*
Administrative Rule 540-X-7-.62, *Continuing Medical Education – Anesthesiologist Assistant*
Administrative Rule 540-X-7, Appendix E, *Physician Assistant / Anesthesiologist Assistant License Renewal*

APA-1

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control: 540

Department or Agency: Alabama Board of Medical Examiners

Rule No.: 540-X-7-.29

Rule Title: Continuing Medical Education - Physician Assistant

Intended Action: Amend

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety? No

Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare? Yes

Is there another, less restrictive method of regulation available that could adequately protect the public? No

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved? No

To what degree?: N/A

Is the increase in cost more harmful to the public than the harm that might result from the absence of the proposed rule? NA

Are all facets of the rule-making process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public? Yes

Does the proposed action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule? No

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Does the proposed rule have an economic impact? No

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer _____

Date _____

APA-2

ALABAMA BOARD OF MEDICAL EXAMINERS

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama Board of Medical Examiners

RULE NO. & TITLE: 540-X-7-.29 Continuing Medical Education - Physician Assistant

INTENDED ACTION: Amend

SUBSTANCE OF PROPOSED ACTION:
Amend the continuing medical education requirement from 25 hours each calendar year to 50 hours every two calendar years. This amendment meets the "protection of public health" exemption from the moratorium on rule amendments contained in Governor Ivey's Executive Order No. 735, Reducing "Red Tape" on Citizens and Businesses.

TIME, PLACE AND MANNER OF PRESENTING VIEWS:
All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Carla Kruger, Office of the General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or email (bme@albme.gov), until and including Jan. 4, 2024. Persons wishing to submit data, views, or comments in person should contact Carla Kruger by telephone (334-242-4116) during the comment period. Copies of proposed rules may be obtained at the Board's website, www.albme.gov.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:
Thursday, January 4, 2024

CONTACT PERSON AT AGENCY:
Carla Kruger

_____

(Signature of officer authorized
to promulgate and adopt
rules or his or her deputy)

540-X-7-.29 Continuing Medical Education - Physician Assistant.

(1) (a) ~~Every physician assistant licensed by the Board must earn in each calendar year not less than twenty-five (25)~~Effective January 1, 2025, every two calendar years, each physician assistant licensed by the Board must earn not less than fifty (50) hours of AMA PRA Category 1 Credits™ or the equivalent as defined in this rule of continuing medical education as a condition precedent to receiving his or her annual renewal of license, unless he or she is exempt from the minimum continuing medical education requirement.

(b) For the purpose of compliance with the continuing medical education (CME) basic requirement stated in paragraph (a) for only the 2010 calendar year, credits earned in the 2009 calendar year which are not used to meet the 2009 calendar year CME requirement may be carried forward and used to meet the 2010 calendar year requirement. Carrying forward credits shall not be allowed thereafter.

(2) For the purposes of this chapter, AMA PRA Category 1 Credit™ continuing medical education shall mean those programs of continuing medical education designated as AMA PRA Category 1 Credit™ which are sponsored or conducted by those organizations or entities accredited by the Council on Medical Education of the Medical Association of the State of Alabama or by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor or conduct Category 1 continuing medical education programs.

(3) The following courses and continuing medical education courses shall be deemed, for the purposes of this Chapter, to be the equivalent of AMA PRA Category 1 Credit™ continuing medical education:

(a) Programs of continuing medical education designated as Category 1-A which are sponsored or conducted by organizations or entities accredited by the American Osteopathic Association to sponsor or conduct Category 1-A continuing medical education for osteopathic physicians.

(b) Programs of continuing medical education designated to confer "Prescribed credits" which are sponsored or conducted by organizations or entities accredited by the American Academy of Family Physicians to sponsor or conduct "Prescribed credit" continuing medical education activities.

(c) Programs of continuing medical education designated as such by the Alabama Board of Medical Examiners.

(d) Programs of continuing medical education designated to confer "ACOG Cognate Credits" which are sponsored or conducted by organizations or entities which are accredited by the American College of Obstetrics and Gynecology to sponsor or conduct approved ACOG Cognate Credit activities on obstetrical and gynecologic related subjects.

(e) Programs of continuing medical education designated as AAPA Category I CME Credits which are sponsored or conducted by those organizations or entities accredited by the Education Council of the American Academy of Physician Assistants to sponsor or conduct AAPA Category I continuing medical education programs.

(f) Effective January 1, 2014, nationally recognized advanced life support/resuscitation certification courses, not otherwise accredited for AMA PRA Category 1 Credit™, for a maximum of two (2) Category 1 credits for each course. Basic life support courses are excluded and are not deemed to be the equivalent of Category 1 continuing medical education.

(4) Every physician assistant subject to the minimum continuing medical education requirement established in these rules shall maintain records of attendance or certificates of completion demonstrating compliance with the minimum continuing medical education requirement. Documentation adequate to demonstrate compliance with the minimum continuing medical education requirements of these rules shall consist of certificates of attendance, completion certificates, proof of registration, or similar documentation issued by the organization or entity sponsoring or conducting the continuing medical education program. The records shall be maintained by the physician assistant for a period of three (3) years following the year in which the continuing medical education credits were earned and shall be subject to examination by representatives of the State Board of Medical Examiners upon request. Every physician assistant subject to the continuing medical education requirements of these rules must, upon request, submit a copy of such records to the State Board of Medical Examiners for verification. Failure to maintain records documenting that a physician assistant has met the minimum continuing medical education requirement, and/or failure to provide such records upon request to the Board is hereby declared to be unprofessional conduct and may constitute grounds for discipline of the physician assistant's license to practice as a physician

assistant, in accordance with the statutes and regulations governing the disciplining of a physician assistant's license.

(5) Every physician assistant shall certify annually that he or she has met the minimum annual continuing medical education requirement established pursuant to these rules or that he or she is exempt. This certification will be made on a form provided on the annual renewal of license application required to be submitted by every physician assistant on or before December 31st of each year. The Board shall not issue a renewed license to any physician assistant who has not certified that he or she has met the minimum continuing medical education requirement unless the physician assistant is exempt from the requirement.

(6) A physician assistant who is unable to meet the minimum continuing medical education requirement by reason of illness, disability or other circumstances beyond his or her control may apply to the Board for a waiver of the requirement for the calendar year in which such illness, disability or other hardship condition existed. A waiver may be granted or denied within the sole discretion of the Board, and the decision of the Board shall not be considered a contested case and shall not be subject to judicial review under the Alabama Administrative Procedure Act. If a waiver is granted, the physician assistant shall be exempt from the continuing medical education requirement for the calendar year in which the illness, disability or other hardship condition existed.

(7) A physician assistant receiving his or her initial license to practice medicine in Alabama is exempt from the minimum continuing medical education requirement for the calendar year in which he or she receives his or her initial license.

(8) A physician assistant who is a member of any branch of the armed forces of the United States and who is deployed for military service is exempt from the continuing medical education requirement for the calendar year in which he or she is deployed.

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:** Filed May 21, 2004; effective June 25, 2004. **Amended:** Filed November 18, 2009; effective December 23, 2009. **Amended:** Filed March 11, 2010; effective April 15, 2010. **Amended:** Filed April 12, 2013; effective May 17, 2013. **Amended:** Filed December 12, 2013; effective January 16, 2014. **Amended:**

Published November 30, 2020; effective January 14, 2021.
Amended/Approved Nov. 16, 2023.

APA-1

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control: 540

Department or Agency: Alabama Board of Medical Examiners

Rule No.: 540-X-7-.62

Rule Title: Continuing Medical Education - Anesthesiologist Assistant (A.A.)

Intended Action: Amend

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety? No

Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare? Yes

Is there another, less restrictive method of regulation available that could adequately protect the public? No

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved? No

To what degree?: N/A

Is the increase in cost more harmful to the public than the harm that might result from the absence of the proposed rule? NA

Are all facets of the rule-making process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public? Yes

Does the proposed action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule? No

---

Does the proposed rule have an economic impact? No

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer _____

Date _____

APA-2

ALABAMA BOARD OF MEDICAL EXAMINERS

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama Board of Medical Examiners

RULE NO. & TITLE: 540-X-7-.62 Continuing Medical Education - Anesthesiologist Assistant (A.A.)

INTENDED ACTION: Amend

SUBSTANCE OF PROPOSED ACTION:
Amend the continuing medical education requirement from 25 hours every year to 50 hours every two years. This amendment meets the "protection of public health" exemption from the moratorium on rule amendments contained in Governor Ivey's Executive Order No. 735, Reducing "Red Tape" on Citizens and Businesses.

TIME, PLACE AND MANNER OF PRESENTING VIEWS:
All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Carla Kruger, Office of the General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or email (bme@albme.gov), until and including Jan. 4, 2024. Persons wishing to submit data, views, or comments in person should contact Carla Kruger by telephone (334-242-4116) during the comment period. Copies of proposed rules may be obtained at the Board's website, www.albme.gov.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:
Thursday, January 4, 2024

CONTACT PERSON AT AGENCY:
Carla Kruger

_____

(Signature of officer authorized
to promulgate and adopt
rules or his or her deputy)

540-X-7-.62 Continuing Medical Education - Anesthesiologist Assistant (A.A.).

(1) (a) ~~Every anesthesiologist assistant licensed by the Board must earn or accrue in each calendar year not less than twenty-five (25)~~Effective January 1, 2025, every two calendar years, each anesthesiologist assistant licensed by the Board must earn not less than fifty (50) hours of AMA PRA Category 1 Credits™ or the equivalent as defined in this rule of continuing medical education as a condition precedent to receiving his or her annual renewal of license, unless he or she is exempt from the minimum continuing medical education requirement.

(b) For the purpose of compliance with the continuing medical education (CME) basic requirement stated in paragraph (a) for only the 2010 calendar year, credits earned in the 2009 calendar year which are not used to meet the 2009 calendar year CME requirement may be carried forward and used to meet the 2010 calendar year requirement. Carrying forward credits shall not be allowed thereafter.

(2) For the purposes of this chapter, AMA PRA Category 1 Credit™ continuing medical education shall mean those programs of continuing medical education designated as AMA PRA Category 1 Credit™ which are sponsored or conducted by those organizations or entities accredited by the Council on Medical Education of the Medical Association of the State of Alabama or by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor or conduct Category 1 continuing medical education programs.

(3) The following courses and continuing medical education courses shall be deemed, for the purposes of this Chapter, to be the equivalent of AMA PRA Category 1 Credit™ continuing medical education:

(a) Programs of continuing medical education designated as Category 1-A which are sponsored or conducted by organizations or entities accredited by the American Osteopathic Association to sponsor or conduct Category 1-A continuing medical education for osteopathic physicians.

(b) Programs of continuing medical education designated to confer "Prescribed credits" which are sponsored or conducted by organizations or entities accredited by the American Academy of Family Physicians to sponsor or conduct "Prescribed credit" continuing medical education activities.

(c) Programs of continuing medical education designated as such by the Alabama Board of Medical Examiners.

(d) Programs of continuing medical education designated to confer "ACOG Cognate Credits" which are sponsored or conducted by organizations or entities which are accredited by the American College of Obstetrics and Gynecology to sponsor or conduct approved ACOG Cognate Credit activities on obstetrical and gynecologic related subjects.

(e) Effective January 1, 2014, nationally recognized advanced life support/resuscitation certification courses, not otherwise accredited for AMA PRA Category 1 Credit™, for a maximum of two (2) Category 1 credits for each course. Basic life support courses are excluded and are not deemed to be the equivalent of Category 1 continuing medical education.

(f) Programs accredited by the Federation for Advancement of Anesthesia Care Team (FAACT) are deemed to be equivalent of Category 1 credits only for Anesthesiologist Assistants.

(4) Every anesthesiologist assistant subject to the minimum continuing medical education requirement established in these rules shall maintain records of attendance or certificates of completion demonstrating compliance with the minimum continuing medical education requirement. Documentation adequate to demonstrate compliance with the minimum continuing medical education requirements of these rules shall consist of certificates of attendance, completion certificates, proof of registration, or similar documentation issued by the organization or entity sponsoring or conducting the continuing medical education program. The records shall be maintained by the anesthesiologist assistant for a period of three (3) years following the year in which the continuing medical education credits were earned and shall be subject to examination by representatives of the State Board of Medical Examiners upon request. Every anesthesiologist assistant subject to the continuing medical education requirements of these rules must, upon request, submit a copy of such records to the State Board of Medical Examiners for verification. Failure to maintain records documenting that an anesthesiologist assistant has met the minimum continuing medical education requirement, and/or failure to provide such records upon request to the Board is hereby declared to be unprofessional conduct and may constitute grounds for discipline of the anesthesiologist assistant's license to practice as an anesthesiologist assistant, in accordance with the statutes and regulations governing the disciplining of an anesthesiologist assistant's license.

(5) Every anesthesiologist assistant shall certify annually that he or she has met the minimum annual continuing medical education requirement established pursuant to these rules or that he or she is exempt. This certification will be made on a form provided on the annual renewal of license application required to be submitted by every anesthesiologist assistant on or before December 31st of each year. The Board shall not issue a renewed license to any anesthesiologist assistant who has not certified that he or she has met the minimum continuing medical education requirement unless the anesthesiologist assistant is exempt from the requirement.

(6) An anesthesiologist assistant who is unable to meet the minimum continuing medical education requirement by reason of illness, disability or other circumstances beyond his control may apply to the Board for a waiver of the requirement for the calendar year in which such illness, disability or other hardship condition existed. A waiver may be granted or denied within the sole discretion of the Board, and the decision of the Board shall not be considered a contested case and shall not be subject to judicial review under the Alabama Administrative Procedure Act. If a waiver is granted, the anesthesiologist assistant shall be exempt from the continuing medical education requirement for the calendar year in which the illness, disability or other hardship condition existed.

(7) An anesthesiologist assistant receiving his or her initial license to practice medicine in Alabama is exempt from the minimum continuing medical education requirement for the calendar year in which he or she receives his initial license.

(8) An anesthesiologist assistant who is a member of any branch of the armed forces of the United States and who is deployed for military service is exempt from the continuing medical education requirement for the calendar year in which he or she is deployed.

Author: Alabama Board of Medical Examiners
Statutory Authority: Code of Ala. 1975, §§34-24-290, et. seq.
History: **New Rule**: Filed July 23, 1999; effective August 27, 1999. **Amended**: Filed November 22, 1999; effective December 27, 1999. **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**: Filed May 21, 2004; effective June 25, 2004. **Amended (Rule Number Only)**: Filed September 11, 2008; effective October 16, 2008. **Amended**: Filed November 18, 2009; effective December 23, 2009. **Amended**: Filed March 11, 2010; effective April 15, 2010. **Amended**: Filed April 12, 2013; effective May 17, 2013. **Amended**: Filed December 12, 2013; effective January 16, 2014. **Amended**: Published November

30, 2020; effective January 14, 2021. Amended/Approved Nov. 16, 2023.

APA-1

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control: 540

Department or Agency: Alabama Board of Medical Examiners

Rule No.: 540-X-7-Appendix-E

Rule Title: Physician Assistant/Anesthesiologist Assistant License Renewal

Intended Action: Amend

Would the absence of the proposed rule significantly harm or endanger the public health, welfare, or safety? No

Is there a reasonable relationship between the state's police power and the protection of the public health, safety, or welfare? Yes

Is there another, less restrictive method of regulation available that could adequately protect the public? No

Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved? No

To what degree?: N/A

Is the increase in cost more harmful to the public than the harm that might result from the absence of the proposed rule? NA

Are all facets of the rule-making process designed solely for the purpose of, and so they have, as their primary effect, the protection of the public? Yes

Does the proposed action relate to or affect in any manner any litigation which the agency is a party to concerning the subject matter of the proposed rule? No

---

Does the proposed rule have an economic impact? No

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of Section 41-22-23, Code of Alabama 1975.

Certification of Authorized Official

I certify that the attached proposed rule has been proposed in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Services Agency.

Signature of certifying officer _____

Date _____

APA-2

ALABAMA BOARD OF MEDICAL EXAMINERS

NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama Board of Medical Examiners

RULE NO. & TITLE: 540-X-7-Appendix-E Physician Assistant/ Anesthesiologist Assistant License Renewal

INTENDED ACTION: Amend

SUBSTANCE OF PROPOSED ACTION:
Amend form to conform with amended CME requirement in 540-X-7-.29 from 25 hours every year to 50 hours every two years; and to add questions regarding certification by the National Commission on Certification of Physician Assistants/ National Commission on Certification of Anesthesiologist Assistants. This amendment meets the "protection of public health" exemption from the moratorium on rule amendments contained in Governor Ivey's Executive Order No. 735, Reducing "Red Tape" on Citizens and Businesses.

TIME, PLACE AND MANNER OF PRESENTING VIEWS:
All interested persons may submit data, views, or arguments concerning the proposed new rule(s) and regulation(s) in writing to: Carla Kruger, Office of the General Counsel, Alabama State Board of Medical Examiners, Post Office Box 946, Montgomery, Alabama 36101-0946, by mail or email (bme@albme.gov), until and including Jan. 4, 2024. Persons wishing to submit data, views, or comments in person should contact Carla Kruger by telephone (334-242-4116) during the comment period. Copies of proposed rules may be obtained at the Board's website, www.albme.gov.

FINAL DATE FOR COMMENT AND COMPLETION OF NOTICE:
Thursday, January 4, 2024

CONTACT PERSON AT AGENCY:
Carla Kruger

_____

(Signature of officer authorized to promulgate and adopt rules or his or her deputy)

540-X-7-Appendix-E **Physician Assistant/Anesthesiologist Assistant License Renewal.**

ALABAMA BOARD OF MEDICAL EXAMINERS

APPENDIX E

PHYSICIAN ASSISTANT/ANESTHESIOLOGIST ASSISTANT LICENSE RENEWAL

20XX Physician Assistant/Anesthesiologist Assistant License Renewal Deadline: December 31, 20XX

Failure to apply for license renewal and pay renewal fee will result in the license automatically being placed in an inactive status, making it illegal for the holder to practice as a Physician Assistant/ Anesthesiologist Assistant effective January 1, 20XX.

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

CME Certification: (Select One)

I hereby certify that I have met or will meet by December 31 the ~~annual minimum continuing education requirement of 25 AMA PRA Category I Credits™ or equivalent continuing medical education for the calendar year 20XX~~minimum continuing education requirement of 50 AMA PRA Category I Credits™ or equivalent continuing medical education earned within the immediately preceding two calendar years and have or will have supporting documentation if audited.

I hereby certify that I am exempt from the minimum continuing medical education requirement for the following reason (Select One)

I received my initial license to practice in Alabama in the calendar year 20XX.

I am exempt from the CME requirement for the calendar year 20XX because I am a member of a branch of the armed services and I was deployed for military service in the calendar year 20XX.

I have obtained a waiver from the Board of Medical Examiners due to illness, disability or other hardship condition which existed in the calendar year 20XX.

National Commission on Certification of Physician Assistants (NCCPA):

Are you currently certified by NCCPA?

If your answer is "yes", provide your certification number and certification expiration date.

National Commission for Certification of Anesthesiologist Assistants (NCCAA):

Are you currently certified by NCCAA?

If your answer is "yes", provide your certification number and certification expiration date.

Professional Responsibility Certification
If any answer is "yes," please provide a detailed explanation in the space provided.

Legal:
1. Since your last renewal, have you been arrested for, cited for, charged with, or convicted of any crime, offense, or violation of any law, felony, or misdemeanor, including, but not limited to, offenses related to the practice of medicine or state or federal controlled substances laws?

*This question excludes minor traffic violations such as speeding and parking tickets but includes felony and misdemeanor criminal matters that have been dismissed, expunged, sealed, subject to a diversion or deferred prosecution program, or otherwise set aside.

2. Since your last renewal, have you been arrested for, cited for, charged with, or convicted of any sex offender laws or required to register as a sex offender for any reason?

3. Since your last renewal, have you had a judgment rendered against you or action settled relating to an action for injury, damages, or wrongful death for breach of the standard of care in the performance of your professional service ("malpractice")?

4. Since your last renewal, to your knowledge, as of the date of this application, are you the subject of an investigation or proposed action by any law enforcement agency?

Administrative/Regulatory:

5. Since your last renewal, have you had any Drug Enforcement Administration registration and/or state controlled substances registration denied, voluntarily surrendered while under investigation, or subject to any discipline, including, but not limited to revocation, suspension, probation, restriction, conditions, reprimand, or fine?

6. Since your last renewal, have you been denied a license to practice as an assistant to physicians in any state or jurisdiction or has your application for a license to practice as an assistant to physicians been withdrawn under threat of denial?

7. Since your last renewal, has your certification or license to practice as an assistant to physicians in any state or jurisdiction been subject to any discipline, including but not limited to revocation, suspension, probation, restrictions, conditions, reprimand, or fine?

8. Since your last renewal, have your privileges at any hospital or health care facility been revoked, suspended, curtailed, limited, or placed under conditions restricting your practice?

9. To your knowledge, as of the date of this application and since your last renewal, are you the subject of an investigation or proposed action by any federal agency, any licensing board/agency, or any hospital or health care facility?

Health:

10. Within the past two years, have you been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, or voyeurism?

11. Within the past two years, have you raised the issue of consumption of drugs or alcohol or the issue of a mental, emotional, nervous, or behavioral disorder or condition as a defense, mitigation, or explanation for your actions during any administrative or judicial proceeding or investigation; any inquiry or other proceeding; or any proposed termination by an educational institution; employer; government agency; professional organization; or licensing authority?

12. Since your last renewal, have you been convicted of driving under the influence (DUI), or have you been charged with DUI and been convicted of a lesser offense such as reckless driving?

13. Are you currently* engaged in the excessive use of alcohol or controlled substances or in the use of illegal drugs, or receiving any therapy or treatment for alcohol or drug use, sexual boundary issues, or mental health issues?

*The term "currently" does not mean on the day of, or even in the weeks or months preceding, the completion of this application. Rather, it means recently enough that the condition referred to may have an ongoing impact on one's functioning as an assistant to physicians within the past two years.

Notice: If you are an anonymous participant in the Alabama Professionals Health Program and are in compliance with your contract, you may answer "No" to this question. Such an answer for this purpose, upon certification, will not be deemed as providing false information to the Alabama Board of Medical Examiners.

13.a. IMPORTANT: The Board recognizes that licensees encounter health conditions, including those involving mental health and substance use disorders, just as their patients and other health care providers do. Licensees are expected to address their health concerns and ensure patient safety. Options include anonymously self-referring to the Alabama Professionals Health Program (334-954-2596), an advocacy organization dedicated to improving the health and wellness of medical professionals in a confidential manner. The failure to adequately address a health condition where the licensee is unable to practice with reasonable skill

and safety to patients can result in the Board taking action against the license to practice as an assistant to physicians.

_____Please initial to certify that you understand and acknowledge your duty as a licensee to address any such condition as stated above.

Practice Interruption:

14. Since your last renewal, has your professional education, training, or practice been interrupted or suspended, or have you ceased to engage in direct patient care, for a period longer than 60 days for any reason other than a vacation or for the birth or adoption of a child?

Review the following Registration Agreements (RA) (If any):
Is this Registration Agreement still Active?
How many hours per week do you work under this Registration Agreement?
Please provide a date of termination
What was the reason this Registration Agreement was terminated

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 could result in disciplinary action.

Author: Alabama Board of Medical Examiners
Statutory Authority: Ala. Code § 34-24-299
History: Amended/Approved: May 17, 2017. Effective date: September 5, 2017. Amended/Approved: November 16, 2017. Effective Date: April 9, 2018. Amended/Approved October 20, 2022. Certified Rule Filed December 20, 2022. Effective Date: February 13, 2023. Amended/Approved Nov. 16, 2023.

EXHIBIT J

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **RUBYE WASHINGTON-MOORE, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-236**

ORDER SETTING HEARING
For Contested Cases Initiated by Administrative Complaint

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

1. **Service of the Administrative Complaint**

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

2. **Initial Hearing Date**

This matter is set for a hearing as prescribed in Ala. Code §§ 34-24-360, *et seq.*, and Ala. Admin. Code Chapter 545-X-3, to be held on Wednesday, January 24, 2024, at 10:00 a.m., at 848 Washington Avenue, Montgomery, Alabama, 36104. Unless otherwise specified by the Commission, the hearing will be held in person. All parties and counsel are expected to appear and to be prepared for the hearing at this date, time, and place.

3. **Appointment of Hearing Officer**

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

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

4. Answer

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

5. Rescheduling/Motions for Continuance

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

6. Case Management Orders

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

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

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

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

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

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

8. **Discovery**

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

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

9. Publicity and Confidentiality

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

10. Stipulations

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

11. Judicial Notice

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

12. Settlement Discussions

The Commission encourages informal resolution of disputes, where possible and consistent with public interest. If a settlement occurs, the parties should notify the Hearing Officer, the Commission's Director of Operations, and Commission's General Counsel. Settlements involving Commission action are subject to the Commission's review and approval. To ensure timely review, such settlements must be presented to the Commission no later than the Commission meeting preceding the hearing date. Hearings will not be continued based on settlements that are not presented in time for the Commission's consideration during a monthly meeting held prior to the hearing date. The Commission Vice-Chairman may assist the parties with the development and/or refinement of settlement proposals.

13. Subpoenas

The Commission has the statutory authority to compel the attendance of witnesses, and the production of books and records, by the issuance of subpoenas. *See* Ala. Code §§ 34-24-363; 41-22-12(c); Ala. Admin. Code r. 545-X-3-.05. The

parties may request that the Hearing Officer issue subpoenas for witnesses and/or documents, and the Hearing Officer is authorized to approve and issue such subpoenas on behalf of the Commission. Service of such subpoenas shall be the responsibility of the party requesting such subpoenas.

14. Hearing Exhibits

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

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

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

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

E. Index exhibits/documents for easy reference.

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

15. Administrative Costs

The Commission is authorized, pursuant to Ala. Code § 34-24-381(b) and Ala. Admin. Code r. 545-X-3-.08(9) and (10), to assess administrative costs against the Respondent if he or she is found guilty of any of the grounds for discipline set forth in Ala. Code § 34-24-360. The Board of Medical Examiners **[X]has / [ ]has**

not given written notice of its intent to seek imposition of administrative costs in this matter.

16. **Appeals**

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

DONE on this the 22nd day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-22 14:35:09 CST

Craig H. Christopher, M.D.
its Chairman

Distribution:

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

EXHIBIT K

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,	)	
Complainant,	)	
v.	)	**CASE NO. 2023-275**
DAVID WAYNE COLE, M.D.,	)	
Respondent.	)	

ADMINISTRATIVE COMPLAINT

COMES NOW the Alabama State Board of Medical Examiners ("the Board"), by and through its counsel, and submits this Administrative Complaint seeking to reprimand the medical license of DAVID WAYNE COLE, M.D.'s ("Respondent"), under Ala. Code § 34-24-361.

JURISDICTION

1. On January 1, 2018, Respondent was duly licensed to practice medicine or osteopathy in the State of Alabama, having been issued license number MD.36481, and the same being currently active. Respondent maintained a license to practice medicine in Alabama at all times relevant to the matters asserted herein.

FACTS

2. On or about October 10, 2023, Respondent entered a plea of guilty in the Madison County Circuit Court, in case number 47-CC-2023-3702, to the felony offense of knowingly voting in the November 8, 2022, general election at a polling place where he had not been authorized to vote in violation of Ala. Code § 17-17-28. The Madison County Circuit Court adjudicated Respondent guilty of this offense and ordered him to serve 60 days in jail and to pay restitution in the amount of $52,885.79.

CHARGES

3. The Board has investigated Respondent and based on that investigation, has concluded that there is probable cause to believe that Respondent has violated Ala. Code § 34-24-360.

COUNT ONE – CONVICTION OF A FELONY

4. On or about October 10, 2023, DAVID WAYNE COLE, M.D., was convicted in the Circuit Court of Madison County, Alabama of the felony offense of knowingly voting at a polling place where he was not authorized to vote, a violation of Ala. Code § 17-17-28, in violation of Ala. Code § 34-24-360(4).

WHEREFORE, the Board moves the Medical Licensure Commission to set a hearing on this Administrative Complaint, and order that Respondent, DAVID WAYNE COLE, M.D., appear and answer the allegations contained herein. The Board further moves that, at the conclusion of the hearing, the Commission reprimand Respondent's license to practice medicine, impose the requirement that he complete continuing medical education in ethics and professionalism, and take such other actions as the Commission may deem appropriate based upon the evidence presented for consideration.

The Board is continuing the investigation of Respondent and said investigation may result in additional charges being prepared and filed as an amendment to this Administrative Complaint.

This Administrative Complaint is executed for and on behalf of the Board by its Executive Director pursuant to the instructions of the Board as contained in its resolution of November 16, 2023, a copy of which is attached hereto and incorporated herein.

EXECUTED this 17th day of November, 2023.

William M. Perkins, Executive Director
Alabama State Board of Medical Examiners

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

Alicia Harrison, Associate General Counsel
Alabama State Board of Medical Examiners
Post Office Box 946
Montgomery, Alabama 36101-0946
Telephone: 334-242-4116
Email: aharrison@albme.gov

STATE OF ALABAMA)
)
COUNTY OF MONTGOMERY)

Before me, the undersigned, personally appeared William M. Perkins, who being by me first duly sworn, deposes and says that he, in his capacity as Executive Director of the Alabama State Board of Medical Examiners, has executed the contents of the foregoing Complaint and affirms that the contents thereof are true and correct to the best of his knowledge, information, and belief.

William M. Perkins, Executive Director
Alabama State Board of Medical Examiners

SWORN TO AND SUBSCRIBED before me this 17th day of November, 2023.

Notary Public
My Commission Expires: 1/26/2027

STATE OF ALABAMA)

MONTGOMERY COUNTY)

AFFIDAVIT

Before me, the undersigned, personally appeared William M. Perkins, Executive Director of the Alabama State Board of Medical Examiners, who, being by me first duly sworn deposes and says as follows:

The Alabama State Board of Medical Examiners in session on November 16, 2023, a quorum of the members of the Board being present, conducted an investigation into the medical practice of DAVID WAYNE COLE, M.D. At the conclusion of the discussion, the Board adopted the following resolution:

> David W. Cole, M.D., Madison, AL After consideration of investigative information, the Credentials Committee recommended that an Administrative Complaint be filed with the Medical Licensure Commission simultaneously with a Joint Settlement Agreement seeking a reprimand against Dr. Cole's medical license and requiring that he complete continuing medical education, and any post-course components, in the topic of professionalism and ethics. The motion was adopted without objection.

I further certify that the foregoing resolution was adopted by the Alabama State Board of Medical Examiners on the 16th day of November, 2023.

William M. Perkins, Executive Director
Alabama State Board of Medical Examiners

SWORN TO AND SUBSCRIBED before me this the 17th day of November, 2023.

Notary Public
My commission expires: 1/20/2027

EXHIBIT L

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

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, Shakir Raza Meghani, 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 his rights to an administrative hearing before the Commission, to be represented by an attorney at such hearing, and to further notice and formal adjudication by the Commission of the charges arising from the Administrative Complaint. Respondent has also validly waived any and all rights to judicial review of this Consent Decree pursuant to Ala. Code § 34-24-367, the Alabama Administrative Procedure Act, Ala. Code §§ 41-22-1, *et seq.*, by extraordinary writ, or otherwise.

3. **Public Documents.** The Settlement Agreement and this Consent Decree shall constitute public records under the laws of the State of Alabama. The Settlement Agreement and this Consent Decree 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 July 29, 1999, having been issued license no. MD.22917. Respondent was so licensed at all relevant times.

2. Respondent appeared for an interview with the Board's Credentials Committee on February 15, 2023. Prior to his interview, Respondent was asked to

provide his continuing medical education ("CME") documentation from the calendar year 2022. Upon review of the 2022 CME documents provided on behalf of Respondent, the Board found Respondent to be compliant with the CME requirement for 2022.

3. In addition to providing his 2022 CME documentation, Respondent voluntarily provided his CME documentation from calendar year 2021. Unfortunately, Respondent was not compliant with the requirements for that year. Respondent did not obtain 25 credits of CME by December 31, 2021. Instead, he only acquired 21 valid credits.

4. On or about December 27, 2021, Respondent submitted, or caused to be submitted, an Alabama medical license renewal application for calendar year 2022, wherein Respondent certified that the annual minimum CME requirement of 25 credits had been met or would be met by December 31, 2021. Respondent further represented that supporting documents could be produced if audited.

5. On February 15, 2023, Respondent was interviewed by the Board's Credentials Committee in connection with an investigation of his medical practice. Specifically, Respondent was questioned about allegations that he pre-signed prescriptions and/or prescribed controlled substances to Patient 1 other than for a legitimate medical purpose and outside the usual course of professional practice. Under questioning, Respondent denied talking to Patient 1 on the phone about the

controlled substance prescriptions. He denied ever talking to her about the prescriptions and stated he had not spoken to her since 2016. Respondent admitted that he did not consider Patient 1 to be a patient and that he did not keep a chart. However, the Board possessed a recording of a phone conversation between Respondent and Patient 1 which, in the opinion of the Board, contradicts his testimony. In addition, the Alabama Board of Nursing found that Respondent had issued Patient 1 "numerous signed prescriptions." Respondent reported Patient 1 to the Board and to the Board of Nursing after learning that she continued to have prescriptions filled without his knowledge and consent. Respondent left practice at the medical facility where he met Patient 1 in 2016.

6. Respondent has denied the allegations made in the Administrative Complaint. Respondent does not concede that he does not have defenses he could raise or evidence he could offer in defense and mitigation. Likewise, this Agreement is not a concession by the Board that its claims are not well-founded. However, the Parties enter into this Agreement as a matter of compromise and to eliminate further risks, expenses, litigation, and issues between them related to the allegations set out in the Board's Administrative Complaint.

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(23) and Ala. Admin. Code r. 545-X-5-.02, as charged in Count One of the Administrative Complaint.

3. The Commission concludes, as a matter of law, that the determined facts constitute a violation of Ala. Code § 34-24-360(17), as charged in Count Two of the Administrative Complaint.

4. The Commission concludes, as a matter of law, that the determined facts constitute a violation of Ala. Code § 34-24-360(17), as charged in Count Three of the Administrative Complaint.

5. The Commission concludes, as a matter of law, that the determined facts constitute violations of Ala. Code § 34-24-360(22) and Ala. Admin. Code r. 545-X-4-.09, as charged in Count Four 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, Two, Three, and Four of the Administrative Complaint;

2. That Count Five of the Administrative Complaint is DISMISSED WITH PREJUDICE;

3. That Respondent's license to practice medicine in the State of Alabama is REPRIMANDED;

4. Respondent is ASSESSED an administrative fine of fifteen thousand dollars ($15,000), due and payable in monthly installments of $1,250.00 beginning on January 2, 2024, with the total sum to be paid in full on or before December 31, 2024.

5. 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.

6. That Respondent shall abide by all state and federal laws and state and federal regulations related to the practice of medicine, and that the Board shall monitor Respondent's compliance with the requirements of this Consent Decree. Specifically, but without limitation, for every controlled substance prescription written, Respondent shall strictly comply with the risk and abuse mitigation requirements of Ala. Admin. Code r. 540-X-4-.09, the requirements for prescriptions

outlined in 21 C.F.R. Part 1306 and Ala. Admin. Code r. 540-X-4-.06, and the inventory and dispensing record requirements outlined in 21 C.F.R. Part 1304.11, 21 C.F.R. Part 1304.22, and Ala. Admin. Code r. 540-X-4-.04. In carrying out its obligations to monitor Respondent's compliance with this Consent Decree, the Commission directs that the Board's Physician Monitor shall examine Respondent's PDMP activity at least monthly, and shall examine Respondent's inventory and dispensing records in person at least quarterly, for the next thirty-six (36) months.

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

DONE on this the 20th day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-20 19:03:18 CST

Craig H. Christopher, M.D.
its Chairman

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,	)	
Complainant,	)	
v.	)	
SHAKIR RAZA MEGHANI, M.D.,	)	**CASE NO.: 2023-061**
Respondent.	)	

JOINT SETTLEMENT AGREEMENT

COME NOW, the Alabama State Board of Medical Examiners ("the Board") and Shakir Raza Meghani, M.D., ("Respondent") (hereinafter collectively referred to as "the Parties") and enter into this Joint Settlement Agreement ("Agreement") to resolve the disciplinary charges filed against Respondent's medical license. In support thereof, the Parties state as follows:

JURISDICTION

1. Respondent was first licensed to practice medicine in Alabama on July 29, 1999, under license number MD.22917. He has maintained licensure at all times material to this agreement.

STIPULATIONS

2. Respondent appeared for an interview with the Board's Credentials Committee on February 15, 2023. Prior to his interview, Respondent was asked to provide his continuing medical education ("CME") documentation from the calendar year 2022. Upon review of the 2022 CME documents provided on behalf of Respondent, the Board found Respondent to be compliant with the year's requirement.

3. In addition to providing his 2022 CME documentation, Respondent voluntarily

provided his CME documentation from calendar year 2021. Unfortunately, he was not compliant with the requirements for that year. Respondent did not obtain 25 credits of CME by December 31, 2021. Instead, he only acquired 21 valid credits.

4. On or about December 27, 2021, Respondent submitted, or caused to be submitted, an Alabama medical license renewal application for calendar year 2022, wherein Respondent certified that the annual minimum CME requirement of 25 credits had been met or would be met by December 31, 2021. Respondent further represented that supporting documents could be produced if audited.

5. On February 15, 2023, Respondent was interviewed by the Board's Credentials Committee in connection with an investigation of his medical practice. Specifically, Respondent was questioned about allegations that he pre-signed prescriptions and/or prescribed controlled substances to Patient 1 not for a legitimate medical purpose and outside the usual course of professional practice. Under questioning, Respondent denied talking to Patient 1 on the phone about the controlled substance prescriptions. He denied ever talking to her about the prescriptions and stated he had not spoken to her since 2016. He admitted that he did not consider Patient 1 to be a patient and that he did not keep a chart. However, the Board possessed a recording of a phone conversation between Respondent and Patient 1 which, in the opinion of the Board, contradicts his testimony. In addition, the Alabama Board of Nursing found that Respondent had issued Patient 1 "numerous signed prescriptions." Respondent reported Patient 1 to the Board and to the Board of Nursing after learning that she continued to have prescriptions filled without his knowledge and consent. Respondent left practice at the medical facility where he met Patient 1 in 2016.

6. Respondent has denied the allegations made in the Administrative Complaint. Respondent does not concede that he does not have defenses he could raise or evidence he could

offer in defense and mitigation. Likewise, this Agreement is not a concession by the Board that its claims are not well-founded. However, the Parties enter into this Agreement as a matter of compromise and to eliminate further risks, expenses, litigation, and issues between them related to the allegations set out in the Board's Administrative Complaint.

7. Respondent acknowledges the authority of the Commission to exercise jurisdiction in this matter. He consents and agrees to the entry by the Commission of a consent order consistent with the terms of this Agreement and agrees to be bound by the findings of fact, conclusions of law, and terms and conditions stated therein. Respondent waives his right to an administrative hearing before the Commission, his right to be represented at such hearing by counsel of his choice and agrees to waive any and all rights to further notice and formal adjudication by the Board and the Commission of charges arising from the facts stated herein. Further, Respondent waives his right to judicial review of the consent order agreed to herein under applicable provisions of the Alabama Administrative Procedure Act, Ala. Code §41-22-1, *et. seq.* If the consent order imposes any term of probation and/or restrictions on Respondent's license to practice medicine in Alabama, then Respondent acknowledges that such term of probation and/or restrictions are mutually negotiated and bargained-for terms, and Respondent waives any right to apply to the Commission for modification of those terms and any right to a hearing under Ala. Code § 34-24-361(h)(9). Respondent understands and acknowledges that the Agreement and Consent Order, if approved and executed by the parties, shall constitute a public record under the laws of the state of Alabama.

8. Respondent acknowledges and agrees that the Agreement and Consent Order constitute a public record of the Board and will be reported by the Board to the Federal National Practitioner Data Bank ("NPDB") and the Federation of State Medical Boards ("FSMB")

disciplinary data bank. This Agreement and Consent Order may be released by the Board to any person or entity requesting information concerning the licensure status in Alabama of Respondent.

9. The Board stipulates and agrees that the terms and conditions of the Agreement and resulting Consent Order entered by the Commission constitute a reasonable disposition of the matter stated herein, and that such disposition protects the public's health and safety.

TERMS OF AGREEMENT

10. Respondent consents to the entry of a consent order by the Commission finding that he committed the violations alleged in Counts One, Two, Three, and Four of the administrative complaint. In exchange, the Board agrees to the dismissal of Count Five of the administrative complaint without prejudice.

11. Respondent consents to the entry of an order by the Commission reprimanding his medical license and assessing an administrative fine in the amount of $15,000, due and payable in monthly installments of $1,250 beginning on January 1, 2024, with the total sum to be paid on or before December 31, 2024.

12. Respondent further consents to the entry of an Order by the Commission requiring him to obtain ***25 additional credits*** of continuing medical education prior to December 31, 2023. Respondent understands that he will have to show competition of fifty (50) hours of AMA PRA Category 1 Continuing Medical Education credits obtained during the 2023 calendar year to satisfy both his existing CME obligation and the additional hours imposed by the terms of this agreement.

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

14. Respondent acknowledges and understands that the Commission shall retain jurisdiction in this matter to enter any such orders as may be necessary to implement or enforce this Agreement or its own orders.

18. Respondent understands that the Board will monitor his compliance with this Agreement. Respondent understands that the Board reserves the right to file a new administrative complaint in the event that Respondent fails to abide by any term of this Agreement or new violations of state or federal laws and regulations are discovered. Respondent understands that a violation of this Agreement or the Commission's order may constitute unprofessional conduct, a violation Ala. Code § 34-24-360(2). The Parties acknowledge that Respondent will receive notice and opportunity for a fair hearing consistent with the Alabama Administrative Procedures Act and Commission rules prior to any final action adjudicating an alleged violation.

STIPULATED AND AGREED this 28th day of October, 2023.

ACKNOWLEDGEMENTS

Respondent's Understanding

I have read and understand the provisions of this Joint Settlement Agreement. I have discussed it with my attorney and agree and approve of all the provisions of this Joint Settlement Agreement, both individually and as a total binding agreement. I have personally and voluntarily signed this Joint Settlement Agreement for the express purpose of entering into this Joint Settlement Agreement with the Board.

10/24/23.
DATE

SHAKIR RAZA MEGHANI, M.D.

Counsel's Acknowledgement

I have discussed this case with my client in detail and have advised my client of all my client's rights and possible defenses. My client has conveyed to me that she understands this Joint Settlement Agreement and consents to all its terms. I believe this Joint Settlement Agreement and the disposition set forth herein is appropriate under the facts of this case.

10/26/2023
DATE

RICHARD CRUM, ESQ.
Counsel for Respondent

Board's Acknowledgement

I have reviewed this matter and this Agreement and concur that the disposition set forth herein is appropriate and adequately protects the public's health and safety.

10/28/2023
DATE

E. WILSON HUNTER
General Counsel
Alabama State Board of Medical Examiners

EXHIBIT M

ALABAMA STATE BOARD OF MEDICAL EXAMINERS, **Complainant,** **vs.** **DAVID WAYNE COLE, M.D.,** **Respondent.**	**BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA** **CASE NO. 2023-275**

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") on November 17, 2023. The Board and the Respondent, David Wayne Cole, 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. **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. The Commission notes, however, that its decision to approve the Settlement Agreement in this case rests in part upon the considerable penalties, noted below, that the sentencing Court has already imposed upon Respondent.

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. If this Consent Decree imposes any term of probation and/or restrictions on Respondent's license to practice medicine in Alabama, then Respondent acknowledges that such term of probation and/or restrictions are mutually negotiated and bargained-for terms, and Respondent waives

any right to apply to the Commission for modification of those terms and any right to a hearing 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 January 1, 2018, having been issued license no. MD.36481. Respondent was so licensed at all relevant times.

2. On or about October 10, 2023, Respondent pleaded guilty to a felony offense of knowingly voting in the November 8, 2022 general election at a polling place where he had not been authorized to vote, in violation of Ala. Code § 17-17-28, a Class C felony. The Madison County Circuit Court adjudged Respondent guilty of this felony offense and ordered Respondent to spend 60 days in jail, followed by two years and 10 months of unsupervised probation. The Court also ordered Respondent to resign from his seat in the Alabama House of Representatives, and to pay restitution in the amount of $52,885.79. *See State of Alabama v. David Wayne Cole*, No. 47-CC-2023-003702.00 (Madison Co. Circuit Court, Oct. 10, 2023).

3. Respondent's conviction of a felony offense violates Ala. Code § 34-24-360(4).

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 Medical Licensure Commission is authorized to impose professional discipline upon any Alabama physician upon conviction of any felony offense, whether or not the felony conviction is related to the practice of medicine in this State. Ala. Code § 34-24-360(4).

3. The Commission concludes, as a matter of law, that the determined facts constitute a violation of Ala. Code § 34-24-360(4) as charged in Count One 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 charge alleged in Count One of the Administrative Complaint;

2. That in view of the disrepute to which Respondent's actions have brought upon the profession of medicine in Alabama, Respondent's license to practice medicine in the State of Alabama is due to be and is hereby REPRIMANDED.

3. That Respondent is ORDERED, within 180 days of the date of this Order, to complete the Medical Ethics and Professionalism continuing medical education course (ME-22 Extended) presented by PBI Education.

4. That Respondent is ORDERED to comply with all state and federal laws and state and federal regulations related to the practice of medicine.

5. That the Board is DIRECTED to monitor Respondent's compliance with this Order.

DONE on this the 22nd day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-22 14:32:07 CST

Craig H. Christopher, M.D.
its Chairman

EXHIBIT N

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

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") on May 8, 2023. The Board and the Respondent, Gary Royce Wisner, 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. **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 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. If this Consent Decree imposes any term of probation and/or restrictions on Respondent's license to practice medicine in Alabama, then Respondent acknowledges that such term of probation and/or restrictions are mutually negotiated and bargained-for terms, and Respondent waives any right to apply to the Commission for modification of those terms and any right to a hearing 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 April 29, 1996, having been issued license no. MD.19841. Respondent was so licensed at all relevant times.

2. On or about June 13, 2018, the Board received correspondence from Respondent stating that he was scheduled to be arrested in San Joaquin County, California on September 12, 2018, for four felonies related to his treatment of worker's compensation patients from four specific insurance companies in California. He further stated that he only practiced medicine in California despite being licensed in four other states, including Alabama.

3. About a month later, on July 17, 2018, the Board received a second letter from Respondent stating that he was scheduled to be "booked and released at the Sacramento jail on July 14, 2018, for Medi-Cal billing fraud related charges to ten felonies." He explained these charges were related to the four previously-described worker's compensation billing fraud charges that he disclosed to the Board in June 2018.

4. On or about June 18, 2022, the Board received correspondence from Respondent stating that he was convicted on June 16, 2022, of ten felony counts

related to billing fraud against Medi-Cal and Medicare. He stated that he was no longer treating patients at his clinic in California, which was closed, and requested to retain his Alabama medical license.

5. On or about November 4, 2022, the Board received correspondence from Respondent informing the Board of the automatic suspension of his California medical license.

6. Respondent emailed the Alabama Medical Licensure Commission on December 16, 2022, notifying the Commission of his sentencing in Sacramento County, California. Respondent informed the Commission that he was then incarcerated, but was scheduled to be released in September of 2023. He further stated that he pleaded guilty to four counts of worker's compensation billing fraud in San Joaquin County, California, and that his sentences were to be served concurrently.

7. On or about December 12, 2022, Respondent entered into a stipulated surrender of his medical license with the California Medical Board. He had previously been charged with committing acts of gross negligence against eight (8) patients, failing to keep adequate medical records, and unprofessional conduct. Under the terms of the agreement, Respondent's surrender of his medical license is considered a disciplinary action by the California Medical Board. The surrender became effective on or about January 30, 2023.

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 Medical Licensure Commission is authorized to impose professional discipline upon any Alabama physician upon conviction of any felony offense, whether or not the felony conviction is related to the practice of medicine in this State. Ala. Code § 34-24-360(4). The Commission may also impose professional discipline based upon "disciplinary action taken by another state." Ala. Code § 34-24-360(15).

3. The Commission concludes, as a matter of law, that the determined facts constitute violations of Ala. Code § 34-24-360(4) as charged in Counts One and Two of the Administrative Complaint, and a violation of Ala. Code § 34-24-360(15) as charged in Count Three of the 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, Two, and Three of the Administrative Complaint;

2. That Respondent's license to practice medicine in the State of Alabama is due to be and is hereby REPRIMANDED;

3. That Respondent is ASSESSED administrative fines of five thousand dollars ($5,000.00) as to each of Counts One, Two, and Three, separately and severally, for a total administrative fine of fifteen thousand dollars ($15,000.00), and that 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]

4. 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 twenty-four (24) months, conditioned as follows: that Respondent shall comply with all provisions of this Consent Decree; that Respondent shall comply with all applicable provisions of federal and state law; and that Respondent shall not engage in solo medical practice or in any practice in which he has responsibility for medical billing;

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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).

5. That Respondent is ORDERED, within 180 days of the date of this Order, to complete the Intensive Course in Medical Ethics, Boundaries, and Professionalism presented by Case Western Reserve University School of Medicine;

6. That the Board is DIRECTED to monitor Respondent's compliance with this Order; and

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

DONE on this the 27th day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-27 17:31:37 CST

Craig H. Christopher, M.D.
its Chairman

BEFORE THE MEDICAL LICENSURE COMMISSION OF ALABAMA

ALABAMA STATE BOARD OF MEDICAL EXAMINERS,	)	
Complainant,	)	
v.	)	
GARY ROYCE WISNER, M.D.,	)	**CASE NO.: 2018-155**
Respondent.	)	

JOINT SETTLEMENT AGREEMENT

COME NOW, the Alabama State Board of Medical Examiners ("the Board") and Gary Royce Wisner, M.D., ("Respondent") (hereinafter collectively referred to as "the Parties") and enter into this Joint Settlement Agreement ("Agreement") to resolve the disciplinary charges filed against Respondent's medical license. In support thereof, the Parties state as follows:

JURISDICTION

1. Respondent was first licensed to practice medicine in Alabama on April 29, 1996, under license number MD.19841. He has maintained licensure at all times material to this agreement.

STIPULATIONS

2. On or about June 13, 2018, the Board received correspondence from Respondent stating he was scheduled to be arrested in San Joaquin County, California on September 12, 2018, for four felonies related to his treatment of worker's compensation patients from four specific insurance companies in California. He further stated that he only practices medicine in California despite being licensed in four other states, including Alabama.

3. About a month later, on July 17, 2018, the Board received a second letter from Respondent stating that he was scheduled to be "booked and released at the Sacramento jail on July 14, 2018, for Medi-Cal billing fraud related charges to ten felonies." He explained these charges were related to the four previously described worker's compensation billing fraud charges that he reported in June 2018.

4. On or about June 18, 2022, the Board received correspondence from Respondent stating that he was convicted on June 16, 2022, of ten felony counts related to billing fraud against Medi-Cal and Medicare. He stated he was no longer treating patients at his clinic in California, which is now closed, and requested to retain his Alabama medical license.

5. On or about November 4, 2022, the Board received correspondence from Respondent informing the Board of the automatic suspension of his California medical license.

6. Respondent emailed the Alabama Medical Licensure Commission ("the Commission") on December 16, 2022, notifying them of his sentencing in Sacramento County, California, and stated he is currently incarcerated; scheduled to be released in September of 2023. He further stated that he pleaded guilty to four counts of workman's compensation billing fraud in San Joaquin County, California. These sentences are to be served concurrently.

7. On or about December 12, 2022, Respondent entered into a stipulated surrender of his medical license with the California Medical Board. He had previously been charged with committing acts of gross negligence against eight (8) patients, failing to keep adequate medical records, and unprofessional conduct. Under the terms of the agreement, Respondent's surrender of his medical license is considered a disciplinary action by the California medical board. The surrender became effective on or about January 30, 2023.

8. The Parties enter into this Agreement as a matter of compromise and to eliminate further litigation and issues between them related to the allegations set out in the Board's Administrative Complaint.

9. Respondent acknowledges the authority of the Commission to exercise jurisdiction in this matter. He consents and agrees to the entry by the Commission of a consent order consistent with the terms of this Agreement and agrees to be bound by the findings of fact, conclusions of law, and terms and conditions stated therein. Respondent waives his right to an administrative hearing before the Commission, his right to be represented at such hearing by counsel of his choice and agrees to waive any and all rights to further notice and formal adjudication by the Board and the Commission of charges arising from the facts stated herein. Further, Respondent waives his right to judicial review of the consent order agreed to herein under applicable provisions of the Alabama Administrative Procedure Act, Ala. Code §41-22-1, *et. seq.* If the consent order imposes any term of probation and/or restrictions on Respondent's license to practice medicine in Alabama, then Respondent acknowledges that such term of probation and/or restrictions are mutually negotiated and bargained-for terms, and Respondent waives any right to apply to the Commission for modification of those terms and any right to a hearing under Ala. Code § 34-24-361(h)(9). Respondent understands and acknowledges that the Agreement and Consent Order, if approved and executed by the parties, shall constitute a public record under the laws of the state of Alabama.

10. Respondent acknowledges and agrees that the Agreement and Consent Order constitute a public record of the Board and will be reported by the Board to the Federal National Practitioner Data Bank ("NPDB") and the Federation of State Medical Boards ("FSMB") disciplinary data bank. This Agreement and Consent Order may be released by the Board to any

person or entity requesting information concerning the licensure status in Alabama of Respondent.

11. The Board stipulates and agrees that the terms and conditions of the Agreement and resulting Consent Order entered by the Commission constitute a reasonable disposition of the matter stated herein, and that such disposition protects the public's health and safety.

TERMS OF AGREEMENT

10. Respondent admits to Counts One, Two, and Three of the Administrative Complaint filed in this case and consents to the entry of a consent order by the Commission finding that he committed each of the violations as alleged in Counts One, Two, and Three.

11. Respondent consents to the entry of an order by the Commission reprimanding his medical license and assessing an administrative fine in the amount of $15,000, due and payable within 30 days of the Commission's order issued pursuant to this Agreement.

12. Respondent further consents to the entry of an Order by the Commission revoking his medical license, suspending said revocation, and placing his license on probation for a term of twenty-four (24) months, conditioned as follows: that Respondent shall comply with all provisions of the Consent Decree entered by the Medical Licensure Commission; that Respondent shall comply with all applicable provisions of federal and state law; and that Respondent shall not engage in solo medical practice or in any practice in which he has responsibility for medical billing.

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

14. Respondent shall completed the Intensive Course in Medical Ethics, Boundaries, and Professionalism presented by Case Western Reserve University School of Medicine within 180 day of the Commission's order issue pursuant to this Agreement.

15. Respondent acknowledges and understands that the Commission shall retain jurisdiction in this matter to enter any such orders as may be necessary to implement or enforce this Agreement or its own orders.

16. Respondent understands that the Board will monitor his compliance with this Agreement. Respondent understands that the Board reserves the right to file for revocation of his probation or a new administrative complaint in the event that Respondent fails to abide by any term of this Agreement or new violations of state or federal laws and regulations are discovered. Respondent understands that a violation of this Agreement or the Commission's order may constitute unprofessional conduct, a violation Ala. Code § 34-24-360(2). The Parties acknowledge that Respondent will receive notice and opportunity for a fair hearing consistent with the Alabama Administrative Procedures Act and Commission rules prior to any final action adjudicating an alleged violation.

STIPULATED AND AGREED this 22 day of November 2023.

ACKNOWLEDGEMENTS

Respondent's Understanding

I have read and understand the provisions of this Joint Settlement Agreement. I have discussed it with my attorney and agree and approve of all the provisions of this Joint Settlement Agreement, both individually and as a total binding agreement. I have personally and voluntarily signed this Joint Settlement Agreement for the express purpose of entering into this Joint

Settlement Agreement with the Board.

11/22/2023
DATE

GARY ROYCE WISNER, M.D.

Counsel's Acknowledgement

I have discussed this case with my client in detail and have advised my client of all my client's rights and possible defenses. My client has conveyed to me that she understands this Joint Settlement Agreement and consents to all its terms. I believe this Joint Settlement Agreement and the disposition set forth herein is appropriate under the facts of this case.

11/22/23
DATE

IAN KENNEDY, ESQ.
Counsel for Respondent

Board's Acknowledgement

I have reviewed this matter and this Agreement and concur that the disposition set forth herein is appropriate and adequately protects the public's health and safety.

11/22/2023
DATE

E. WILSON HUNTER
General Counsel
Alabama State Board of Medical Examiners

EXHIBIT O

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

ORDER

This matter is before the Medical Licensure Commission of Alabama on the Board's motion to continue, which was made orally at the Commission's regular business meeting of November 20, 2023. Respondent has indicated his concurrence with the requested continuance via e-mail to the Commission's General Counsel.

The Motion to Continue is granted, and the hearing in this matter is continued generally. The parties are requested to advise the Commission when proceedings before the Alaska State Medical Board have been concluded.

DONE on this the 22nd day of November, 2023.

THE MEDICAL LICENSURE
COMMISSION OF ALABAMA

By:

E-SIGNED by Craig Christopher, M.D.
on 2023-11-22 14:30:45 CST

Craig H. Christopher, M.D.
its Chairman