Alabama Board of Medical Examiners
Newsletter and Report
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Inside:

Avoid common prescription problems

A physician has several ways to provide a patient with medications outside of a healthcare facility – administering medication in the physician's office or practice site, providing a supply of medication for a patient to use away from the practice site, and, the most common, writing a prescription to be filled by a pharmacist.

Administration of a medication, such as an injection, in a physician's practice site requires adequate documentation in the patient's record of the rationale for the medicine, the dosage and the method of administration. If the administered drug is a controlled substance, the physician must maintain appropriate controls as enumerated in Board Rule 540-X-4-.03. *[See the Newsletter Links section at www.albme.org.]*

A physician who gives medicines from the office to be taken or used by a patient off site requires documentation similar to the previous situation. If controlled substances are purchased for dispensing for off-site use, the physician must register with the Board as a dispensing physician and follow the Alabama Department of Public Health reporting requirements for dispensing physicians. *[See the Newsletter Links section at www.albme.org.]* When a physician gives only prepackaged samples of controlled substances to a patient, registration and reporting are not required. In either case, the controlled substances must be maintained with appropriate controls and according to Board Rule 540-X-4-.03.

Tamper-proof prescription pads will be required for all written Medicaid prescriptions as of Oct. 1, 2007.

See the notice on page 6 for more details.

Never leave signed blank prescriptions anywhere.

Presently, using a written or electronic prescription is the most common way to provide a patient with medication. A prescription is a written, verbal or electronic request to the pharmacist to supply the patient with a described medicine, in a described strength, and in a described amount, with instructions on how to take it and with the physician's signature indicating responsibility. All physicians learn the basics of prescribing medicine in medical school. When a physician goes astray, it is often through haste, compassion for a patient or family member, lack of understanding newly introduced drugs or lack of appreciation of new techniques for prescribing. The few, fortunately a small number, physicians who use prescribing as a way to increase their income, cause the need for many rules that all physicians must follow.

This article will review some problems frequently seen by the Board related to physicians' prescriptions.

Never, never leave signed blank prescriptions anywhere: not in the office, car, or medical care facility. A physician's signature is a privilege to write for prescriptive medicines. Physicians who leave signed blank prescriptions so that medications can be given to their patients in their absence generate temptations to

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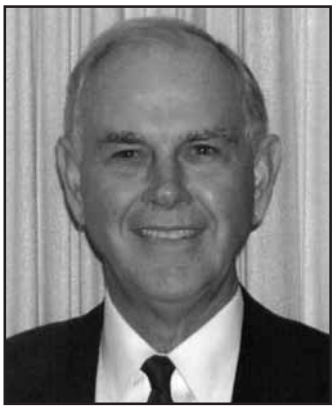
A Message from the Executive Director
2007 Legislative Update

by Larry Dixon


Larry Dixon

The 2007 Regular Session came to an end at the stroke of midnight on June 7. Other than the State's General Fund and the Education Trust Fund Budgets, very few bills received final approval from both houses. However, there were some bills which ultimately were passed by the Legislature and signed into law by the governor that impact physicians and the Board of Medical Examiners.

- Act #2007-402 contains a number of changes and updates to the Alabama Medical Practice Act. One important change is the increase in punishment for persons found guilty of practicing medicine or osteopathy without a license. Under the old law (*Code of Alabama*, § 34-24-51), such an act was classified as only a misdemeanor with a possible punishment of up to six months in jail and a fine not to exceed $1,000. The new law classifies the unauthorized act as a Class C Felony, which carries with it a period of jail time from one to ten years and a fine up to $10,000. This increased punishment will better serve as a deterrent to those who may choose to practice medicine unlawfully and will also help ensure that the citizens of Alabama are afforded better protection from such persons.

- Several changes concern the implementation of fees by the Board of Medical Examiners. Currently, a physician licensed in Alabama is required to renew his or her license on or before Dec. 31 of each year. However, the license remains in effect during a "grace period" from Jan. 1 through Jan. 31. Of course, licenses not renewed by Jan. 31 become inactive. The new law will now require a physician to pay a late fee of up to $200 for any renewal application filed during the grace period.

- An increasing number of physicians are participating in collaborative practices with certified registered nurse practitioners (CRNPs). Consequently, the BME has directed more of its resources and time to monitoring these arrangements. The new law allows for the BME to charge a fee in an amount not to exceed $200 to physicians participating in a collaborative practice to help offset the increased expenses incurred by the BME in this regard. The Board has set that fee at $100 per individual collaboration. *(See notice on page 6.)*

Under Alabama law, the Board of Medical Examiners certifies that applicants for a license to practice medicine in Alabama meet certain statutory requirements. In addition, the BME is charged with investigating and reviewing complaints against practitioners and pursuing disciplinary action when appropriate. These are responsibilities your BME does not take lightly. The Board works hard to ensure that physicians maintain and practice appropriately with high quality standards in providing medical care and treatment to the citizens of Alabama. The aforementioned changes and new laws will allow the BME to continue to ensure that physicians in this state maintain the high quality standards of practice that our citizens have come to know and rightfully deserve.

Highlights from the FSMB annual meeting

The Federation of State Medical Boards (FSMB) is a national not-for-profit organization representing the 70 medical boards of the United States and its territories. Its mission is the continual improvement in the quality, safety and integrity of healthcare through the development and promotion of high standards for physician licensure and practice. *(Federation of State Medical Boards website, www.fsmb.org/mission.html.)* The Alabama Board of Medical Examiners participates in the FSMB's activities and frequently benefits from the information and processes that the Federation provides to its members.

In May 2007, the Federation held its annual meeting. While much of the meeting was devoted to presentations specifically addressed to members of medical boards, several concepts were brought forth that may be of interest to all physicians.

Systemic administration of healthcare

Three or four generations ago, medical care was a direct physician to patient event. The physician listened to the patient and family, examined the patient, made the diagnosis and compounded a treatment in the office or at the home bedside. Due to technological advances and societal changes, medical care now is given by a health care system. The system includes numerous components – the patient and the patient's personal physician, consultants, laboratory personnel, radiology exams, nurse practitioners, physician assistants, pharmacists, hospital services, payers, government regulations, office and hospital records, etc.

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Problems with Prescribing

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anyone who has access to these pre-signed prescriptions. A signed blank prescription violates Board Rule 540-X-4-.05-(8) and can result in an administrative fine up to $10,000 for each separate violation.

Do not use pre-printed prescriptions for controlled substances. Pre-printed prescription pads for controlled substances invite theft by patients, visitors and staff. With a copy of the signature of one of the physicians in the group listed on the prescription, the thief can forge a signature for the prescription.

When writing a prescription, consider how many doses the patient needs for their particular condition. Often a physician, by habit, prescribes a number of pills based upon the drug, and not the particular condition under treatment. For an expensive medication, such as some antibiotics, a single large prescription can be disastrous for a family with marginal economic resources, especially if the patient shows an idiosyncratic or allergic reaction to it and the unused doses are wasted. Even more common is prescribing more doses of a controlled substance than should be necessary. Teenagers have been found to take only a few of the hydrocodone tablets prescribed for a medical or post-surgical condition, then sell the remainder on the street, even obtaining refills, not for a medical need, but to sell.

Do not use pre-printed prescriptions for controlled substances.

Do not prescribe medications for immediate family members for a chronic medical problem. Good medical care requires objectivity. The *AMA Code of Medical Ethics*, Section E-19, addresses the concerns about treating family members. Parts of that section are:

> Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. … When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician. Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care. It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In

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Problems with Prescribing

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addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

Do not prescribe controlled substances for an immediate family member except for an urgent situation and for not more than 48 hours' dosing. If a physician prescribes a controlled substance in the name of an immediate family member or for personal use, a red flag rises to the possibility of diversion or substance abuse by the physician. Further, due to family dynamics, it is difficult for the physician to critically assess how much controlled substance is truly necessary.

New technology, particularly electronic medical records, has created a new method for transporting the physician's prescription to the pharmacist. For legend drugs, the requirements are the same as for **written** prescriptions. For controlled substances, specific laws govern the way that prescriptions can be submitted. A Class II narcotic may not be filled by the pharmacist in any way except by a written prescription. It must be **currently dated** and **signed contemporaneously by the physician**.

Federal Code for Class III, IV and V controlled substances

Title 21, Chapter II, Part 1306 – Prescriptions; Section 1306.21 Requirement of prescription

(a) A pharmacist may dispense directly a controlled substance listed in Schedule III, IV or V which is a prescription drug as determined under the Federal Food, Drug and Cosmetic Act, only pursuant to either:
(1) A written prescription signed by a practitioner; or
(2)A facsimile of a written, signed prescription transmitted by the practitioner or the practitioner's agent to the pharmacy; or
(3) Pursuant to an oral prescription made by an individual practitioner and promptly reduced to writing by the pharmacist containing all of the information required in Sec. 1306.05, except for the signature of the practitioner.

Do not use pre-printed prescriptions for a controlled substance.

The Alabama Board of Pharmacy Administrative Rule, 680-X-3-.10 Facsimile Prescription Drug Orders for Controlled Substances:

4 (a) A pharmacist may dispense directly a controlled substance listed in Schedule III, IV or V which is a prescription drug, or any legend drug, only pursuant to:
(1) A written prescription signed by a prescribing individual; or
(2) A facsimile of a written signed prescription transmitted directly by the prescribing practitioner, or the practitioner's agent, to the pharmacy; or
(3) Pursuant to an oral prescription made by a prescribing individual practitioner, or the practitioner's agent, and promptly reduced to writing by the pharmacist.

According to both state and Federal Codes, an electronic prescription (e-prescription) for a controlled substance is not allowed, even with an electronic "signature." E-prescribing is electronically transmitting a prescription from a physician's notebook computer, hand-held device or other such instrument directly to the pharmacy. *(See Q&A on page 8.)*

A physician may not issue an e-prescription for a controlled substance.

A physician may not issue an e-prescription for a controlled substance under any circumstance. Pharmacists in Alabama have complained that they have to remind physicians continuously that they cannot accept an e-prescription for a controlled substance. The Alabama Board of Pharmacy has stated that it will enforce its rules against pharmacists who accept e-formatted controlled substance prescriptions.

Except when covering for another physician or treating an established patient, a prescription should not be provided in any form without a personal interview, examination, and a presumptive diagnosis on which to base a treatment plan that will include the medication prescribed. Providing prescriptions for medication via the Internet is common, but in Alabama it is against Board Rules. *[Rule 540-X-9-.11. See the Newsletter Links section at www.albme.org.]* Also, see the *BME Newsletter*, (Volume 21, Issue 3, 2006).

Patients with real pain deserve treatment; but the management of pain requires an orderly methodology. Because many patients were being treated for chronic pain without a reasonable examination, treatment plan and follow-up procedures, the Board adopted guidelines for management of chronic pain. These are consistent with the guidelines accepted by the Federation of State Medical Boards. The full set of guidelines is available from the Board upon request or at the Board's website, www.albme.org, Rules 540-X-4-.07. *[See the Newsletter Links section of www.albme.org.]*

FSMB Annual Meeting

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With the growth to systemic delivery of care, there are multiple interfaces where a problem may arise and disrupt the patient's continuity of care, treatment and outcome. Ideally, the system would be under continual review, problems identified and corrective solutions implemented. This would require non-punitive reporting of problems, errors and near-errors, the way that the U.S. air traffic control system works. Under our present tort system, such reporting is unlikely to occur.

With the administration of healthcare by system, adherence to processes may override the primary reason for the action – the needs of the patient. Physicians must maintain patient-centered care within the systemic maze. As long as a patient-physician relationship exists, the patient looks to the physician to direct care. The physician receives accolades for good outcomes, but often is blamed if there is a problem in the system.

What are the paths currently available to improve the system and to give patients access to safe and quality care? These paths might include seeking patient involvement in their care, treating the patient with respect and coordinating their care with others involved by sharing information.

Access to care can be enhanced for patients by giving clear instructions on how to receive after hours care, especially if arrangements have been made with other physicians for coverage. Discussing a diagnosis and assessment with a patient and encouraging questions brings the patient into the management process and shows respect for their desires, fears and uncertainties. Communicating with others involved in the care of the patient assists in having a smooth treatment process. According to statistics quoted from the Commonwealth Fund International Health Policy Survey, when a primary care physician referred a patient to a specialist, 67 percent had no information from the referring physician by the time the patient was seen. And when primary care physicians referred a patient for consultation, in 25 percent of the cases they had received no information from the consulting physician within four weeks of the visit.

Although the patient-physician relationship is still present, currently healthcare is provided by a system.

Because the Alabama Board is totally composed of practicing physicians, it recognizes the challenges in coordinating the systemic administration of medical care. Many complaints against physicians are actually a break in the system, but the patient identifies with the physician. When such events occur, or nearly occur, the perceptive and quality-minded physician will ask that the process be examined to try to prevent future occurrences.

Proactive education of physicians

Traditionally, physicians have been left to manage their practices in ways they found most effective for themselves. If and when they deviated significantly from accepted standards, disciplinary measures were imposed. Because of changes in social expectations, legal requirements, technology and treatment options, it is easier now for a physician to encounter a situation where medical board intervention occurs. With this in mind, the Federation is developing means to proactively educate physicians about potential problems rather than imposing punishment after the event. Studies are ongoing to discern which physicians are more likely to have problems so that intervention options may be offered early. The Alabama Board of Medical Examiners recognized this some years ago and, through the changes in the *BME Newsletter*, is informing licensed physicians of common problems and mistakes. Further, the BME frequently encourages educational avenues for physicians involved with a problem rather than simply invoking punishment.

Emergency treatment across jurisdictions

Following Hurricane Katrina, a serious impediment to full medical care was highlighted – physicians may practice medicine only in the jurisdictions where they are licensed. When the catastrophe spans several states, organizing and credentialing medical personnel for the affected area can be a confusing and challenging process. Alabama, being affected by the Katrina disaster, has been involved with ideas to develop emergency reciprocity of medical licenses. The Federation is reviewing this concept for consideration in a national scope.

Your Medical License

As a physician, your license to practice medicine in the State of Alabama is one of your most important assets. It allows you to apply what you learned during years of school and post-graduate training to earn a livelihood to support your family. Exercise care to protect this asset.

Notices

Medicaid prescriptions:

New CMS rule requires use of tamper-proof prescription pads as of Oct. 1

A new rule by the Centers for Medicare and Medicaid Services (CMs) will affect every physician in the country who has Medicaid patients – Medicaid will not reimburse for prescription medications unless tamper-proof prescription pads are utilized. The prescriptions must be watermarked so that if the prescription is duplicated the bold word "VOID" appears.

The full text of the new rule is:

Requirement For Use Of Tamper-Resistant Prescription Pads Under The Medicaid Program. –

Section 1903(i) of the Social Security Act (42 U.S.C. 1396b(i)) is amended... by inserting the following paragraph (23):

(i) Payment under the preceding provision of this section shall not be made –

(23) with respect to amounts expended for medical assistance for covered outpatient drugs (as defined in section 1927(k)(2)) for which the prescription was executed in written (and non-electronic) form unless the prescription was executed on a tamper-resistant pad.

(2) Effective Date – The amendments made by paragraph (1) shall apply to prescriptions executed after September 30, 2007.

(See page 132 at: http://www.rules.house.gov/110/special_rules/hr2206_senate/hr2206_amnd1_senate.pdf)

Botox seminars

Attendance of seminars does not qualify nurse practitioners to administer Botox, Restalyn or Collagen

The Alabama Board of Medical Examiners has received information that seminars for certified registered nurse practitioners (CRNPs) are being conducted with the implication that attendance qualifies the attendee to perform Botox injections. At its May 16, 2007, meeting, the Board authorized sending a letter to the Alabama Board of Nursing with a suggestion that the Board of Nursing notify their licensees that nurses and nurse practitioners can not administer Botox, Restalyn or Collagen in the state of Alabama.

Collaborative Agreements

Annual Fee to accompany collaborative practice registration

As of Sept. 1, 2007, a new law will be in effect for physicians engaged in a collaborative practice agreement. An annual fee of $100 will be assessed for each collaborative agreement a physician has established. Detailed notification letters will be mailed in late August to every physician with a collaborative practice agreement.

A fee notice for each collaborative practice agreement will be sent with the physician's annual medical license and Alabama controlled substance certificate renewals in early October 2007. The CRNP collaboration fee is due by Dec. 31, 2007, for the 2008 year. There is no grace period for late payment. The physician will receive an approval notice and a certificate of collaborative practice registration upon receipt of the fee.

Skin biopsies by physician assistants

Board defines procedures allowed for physician assistants (PAs)

On May 16, 2007, the Board of Medical Examiners approved the following:

- PAs are allowed to perform shave excisions/biopsies on the face, not to exceed 5mm in diameter and not to extend below the dermis.
- Shave excisions/biopsies on anatomically sensitive areas, such as eyes and ears, must be evaluated by the physician prior to treatment.
- Punch biopsies to the face can not exceed 5 mm in diameter.

Do You Perform Surgery, Treatments or Examinations with any Sedation?

If so, you may be required to register with the Alabama Board of Medical Examiners and maintain specific equipment, procedures and records in your office or clinic. Check the Newsletter Links section of the Alabama Board of Medical Examiners website at www.albme.org to determine whether your practice is required to register.

Board welcomes new member

Paul Nagrodzki, MD, became a member of the Alabama Board of Medical Examiners, replacing Brewton pediatrician Marsha D. Raulerson, MD, who completed her term on the Board in April 2007.

Dr. Nagrodzki is an Alabama native who graduated from the University of Alabama School of Medicine and completed an anesthesia residency at UAB. For the past 23 years he has been in the private practice of anesthesiology in Birmingham.

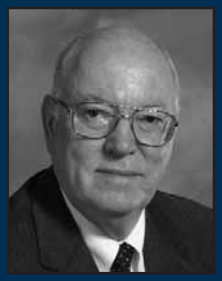
Dr. Nagrodzki participates in many local charitable activities, and in frequent mission trips to Honduras with a team that repairs cleft palates in Honduran children.

Additionally, he has earned an associate degree in culinary arts. He uses this training to donate dinners for charity.

Dr. Nagrodzki is married to Glenda and is the father of two children, ages 24 and 21.

Paul Nagrodzki, MD

From the Editor...



Arthur F. Toole III, MD

During the years I was in the clinical practice of medicine, I had very little knowledge of what the Board of Medical Examiners did and of the many rules that govern the practice of medicine in Alabama. While I may think that I was just "lucky" not to run afoul of a rule, actually, very few physicians will have a problem if they exercise good judgment and focus their efforts on the proper care for their patients.

The Board of Medical Examiners sees complaints of many types but a significant portion of the problems can be found in three areas:

1) Failure to comply with the rules for physician extenders;
2) Communication issues with their patients and/or their patients' families; and
3) A laxity in prescribing medicines, particularly controlled substances.

The rules are not present to hinder the physician; they actually ensure that the physician is in charge of patient care and are a guide to providing that care. Unfortunately, busy physicians spend most of their time providing care for their patients and the physicians' professional reading interests are related to their clinical work, direct patient care and their continuing medical education. Because physicians do not have the time to familiarize themselves with Alabama laws and rules concerning medicine, we are trying to provide this information to you concisely.

Alabama law recognizes that physicians are the managers of healthcare for Alabama citizens. The statutes that allow a physician to work collaboratively with a certified registered nurse practitioner (CRNP) or to register a physician assistant (PA) recognize that the physician is responsible for patients treated in that practice and require that the physician be involved in the care of patients managed by the mid-level practitioner. The Board has gone to great lengths to help Alabama medical licensees understand the physician's role in these practices by setting up workshops, sending mailouts and with articles in the *BME Newsletter*.

Physician-patient communication problems that the Board sees frequently were enumerated in the *BME Newsletter*, Issue 4, 2006. Communication problems probably lead to more patient-based complaints to the Board than any other type.

The current issue visits commonly seen prescribing problems and explains why each situation is important.

Additionally, the *BME Newsletter* is a vehicle for Alabama physicians to learn about new laws and rules in a timely manner. Because of the potential for patient harm from the use of medical lasers, a committee of varied specialists and with various degrees developed administrative rules to govern the use of these instruments. These rules were published and a public hearing was held on April 27, 2007. The Board considered all written and public comments received for deliberation. Following a complete and careful review, changes were made in the proposed rules which were then published in the June 28, 2007, *Alabama Administrative Monthly*. The comment period will end on Aug. 3, 2007. Only written comments will be accepted; there will not be another public hearing. When final changes to the rules are approved, a summary will appear in the *BME Newsletter*.

Meanwhile, the latest edition of the proposed rules can be accessed from the Board's website, www.albme.org, under "What's New?" for anyone interested.

As I have mentioned before, we welcome questions and comments.

BME Q & A

[Because this Issue of the BME Newsletter *has an emphasis on prescriptions, the following are questions and answers about electronically transmitted prescriptions that were composed by Joyce C. Altsman, R.Ph., Director of Compliance, Alabama State Board of Pharmacy, and Loren T. Miller, Chief, Policy Unit Liaison and Policy Section of the Office of Diversion Control, Drug Enforcement Administration.*]

QUESTION: May a pharmacist fill a prescription for a Class III, IV or V controlled substance that is "electronically transmitted" from a physician's laptop, hand-held device, notepad, etc., indicating an electronic signature?

ANSWER: No. See Title 21, Sec. 1306.21 and Title 20, 680-X-3-.10.

QUESTION: May a pharmacist fill a prescription for a Class III, IV or V controlled substance that is "electronically transmitted" from a physician's laptop, hand-held device, notepad, etc., to a pharmacy fax machine indicating an electronic signature?

ANSWER: No. See Title 21, Sec. 1306.21 and Title 20, 680-X-3-.10.

QUESTION: May a pharmacist fill a prescription for a Class III, IV or V controlled substance that is "electronically transmitted" from a physician's laptop, hand-held device, notepad, etc. that has been printed and faxed from the physician's office to the pharmacy fax machine indicating an electronic signature?

ANSWER: No. See Title 21, Sec. 1306.21 and Title 20, 680-X-3-.10.

QUESTION: May a pharmacist fill a prescription for a Class III, IV or V controlled substance that is "electronically transmitted" from a physician's laptop, hand-held device, notepad, etc. that has been printed and faxed from the physician's office to the pharmacy fax machine indicating an electronic signature and also a written signature of the practitioner?

ANSWER: Yes. See Title 21, Sec. 1306.21 and Title 20, 680-X-3-.10.

QUESTION: With how many certified registered nurse practitioners (CRNPs) may I collaborate?

ANSWER: Based on changes to the rules in September 2003, there is no longer a specified numerical limit for CRNPs. Instead the emphasis has been placed on an FTE (full-time equivalent) limit. This is set at the equivalent of three full-time practitioners. Rule 540-X-6-.04 currently states: *"The physician shall not collaborate with or supervise any combination of certified registered nurse practitioners, certified nurse midwives and/or assistants to physicians exceeding one hundred and twenty (120) hours per week (three full-time equivalent positions) unless an exemption is granted under Rule 540-X-8-.12. One full-time equivalent (FTE) is herein described as a person/persons collectively working forty (40) hours a week, excluding time on call."*

Theoretically, a physician could collaborate with 120 nurse practitioners working one hour each. However, the requirement for quality assurance and collaboration time remains in effect for each of those practitioners and this could become burdensome. The one exception to the FTE rule is that no physician may collaborate with more than four certified nurse midwives at any time (Rule 540-X-8-.26, Limitations Upon Utilization of Certified Nurse Midwives) and is still subject to the 120 hour FTE limit.

Any questions regarding any facet of collaborative practices, please contact the BME Nurse Inspectors, Cheryl Thomas, MSM, RN, and Patricia Enfinger, RN.

Notice regarding Questions and Answers:

The Board of Medical Examiners and the Medical License Commission welcome questions and comments. A comment or question will be published with the physician's name who submits the item unless the physician expresses a desire that the name be withheld. If a topic is presented that may be of very broad interest, the editor may paraphrase the question or comment, and print it as a clarification. The Board will not respond to anonymous or unsigned comments or questions.

For Your Information…

Are you prepared for the unexpected closing of your practice?

Editor's note: This article is, by no means, an authoritative guide but is a reminder for physicians to plan for unexpected problems. Numerous guides cover the basic and general concepts; you should review your specific situation with your own legal and accounting advisors.

Most physicians anticipate leaving their practices through retirement in an orderly process. Unfortunately, a few will have to close their practices hastily, due to sudden or unexpected death, an unpredicted severe disability, or other causes. For this reason it is prudent for every physician to make contingency plans for closure of their practices and to have these plans in writing for the survivors and/or executor of the estate.

For those in a partnership or group practice, the procedures are less extensive. Be certain an agreement is in place that:

- Outlines the steps to transfer the departing physician's assets in the practice,
- Provides for continued coverage of patients, and
- Addresses the custody of patients' medical records.

Keep a written copy of this document, and any subsequent changes, in a safe place and instruct family members and/or the executor about it.

For physicians in solo practice the tasks may be especially daunting, particularly with the overlay of the family's grief. A written list of suggestions for the executor should be kept in a safe place. The list should include:

It is prudent for every physician to make contingency plans for an unexpected closure of a practice.

- Agencies to notify of the physician's death:
  - Medical Boards in every state the physician was issued a medical license,
  - Drug Enforcement Agency (DEA),
  - Hospital staffs,
  - Medical liability insurance carrier, and
  - Medical organizations to which the physician belongs.
- A sample letter of how to notify patients, and, if another physician has been arranged to assume the patients' care, such an agreement should be noted.
- Finally, consider how custody of the patients' medical records will be handled - Who will take custody of the patient's charts, - Where charts will be stored and - How will patients obtain charts so that the original or a copy may be sent to their new physician.

If there are no such arrangements, leave suggestions of preferences on how patients should receive continued medical care.

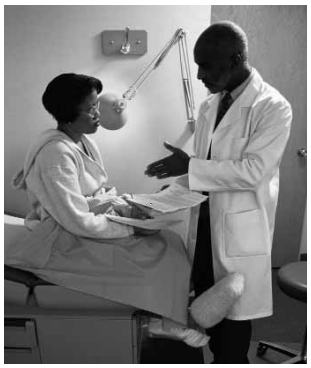
While such planning may be uncomfortable, no one knows the future. Prudent preparation for this unlikely event will be as helpful to survivors as the review of a will, financial plan, and life insurance policies.

Pain Management Guidelines can be found at the Board of Medical Examiners' website, www.albme.org.

Follow the Newsletter Links section.

The most important difference between a good and indifferent clinician lies in the amount of attention paid to the story of a patient.

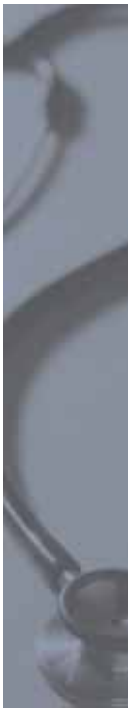
– Sir Farquhar Buzzard
Lancet, 1933



OPINIONS OF THE ALABAMA BOARD OF MEDICAL EXAMINERS
can be found in the Newsletter Links section of www.albme.org.

Ensuring Quality in the Collaborative Practice: The 2007 Series

Responsibilities and Resources for Physicians and Nurse Practitioners



A CME program presented by:
The Medical Association of the State of Alabama
The Alabama Board of Medical Examiners
The Alabama Board of Nursing

Course Details

Who should attend?
Doctors of Medicine and Osteopathy, and Advanced Practice Nurses including Certified Registered Nurse Practitioners and Certified Nurse Midwives involved in a collaborative practice agreement.

What will you learn?
1. The application, approval and renewal requirements for CRNP/CNMs and required credentials.
2. The responsibilities of both physicians and nurses in a collaborative practice. Common problems seen and methods to correct them.
3. The regulations for prescribing drugs, quality assurance review, remote sites and specific practice settings.

Tuition is only $75 and includes all course materials. In addition, each attendee will receive a resource manual containing the laws governing collaborative agreements, sample forms, checklists, and QA resources!

Course Registration Form

Name _____

Address _____

City/State/Zip _____

Phone _____ **Email** _____

Payment: ❑ **Check (made payable to MASA)** ❑ **Charge** **Amount**

Card #_____ **Exp. Date** _____ **Security Code**

Session you will attend: (check one)

August 30 – Dothan, Holiday Inn	❑ **1 – 4 p.m.**	**OR**	❑ **6 – 9 p.m.**
November 1 – Montgomery, Montgomery Country Club	❑ **1 – 4 p.m.**	**OR**	❑ **6 – 9 p.m.**

Copy this form and send to:

MASA Education Department
19 South Jackson Street
Montgomery, AL 36104
Phone: (334) 954-2500 • (800) 239-6272 • Fax: (334) 269-5200

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

Medical Licensure Commission April 2007

None to date.

Board of Medical Examiners April 2007

- On April 11, 2007, the Board accepted the voluntary surrender of the certificate of qualification and license to practice medicine in Alabama of **Samuel W. Beenken, MD**, license number MD.15438, Montevallo, AL.

- On April 20, 2007, the Board entered an Order removing all restrictions on the certificate of qualification for a license to practice medicine in Alabama of **Joe Frank Howell, MD**, license number MD.5737, Prattville, AL.

- On March 31, 2007, **Oliver Wilson Crawford Jr., MD**, license number MD.28100, Ozark, AL, entered voluntary restrictions against his certificate of qualification for a license to practice medicine in Alabama. This action was effective April 25, 2007, the date of initial licensure.

Medical Licensure Commission May 2007

- On May 16, 2007, the Commission entered an Order terminating the probationary status of the license to practice medicine in Alabama of **William J. Lupinacci, MD**, license number MD.10601, Bessemer, AL.

- On May 22, 2007, the Commission entered a Consent Order placing on probation the license to practice medicine or osteopathy in Alabama of **Paul A. Brundage, DO**, license number DO.699, Cleveland, TN.

- On May 24, 2007, the Commission granted the application for reinstatement of license of **Janie T. Bush Teschner, MD**, license number MD.14227, Gadsden, AL, subject to the condition that she shall not actively engage in the practice of medicine except within the confines of a residency or other training program.

Board of Medical Examiners May 2007

- On May 16, 2007, the Board denied the application for a certificate of qualification to practice medicine in Alabama of **John T. Mazzeo, MD**, Irving, TX. Dr. Mazzeo has appealed the Board's decision to the Medical Licensure Commission.

Medical Licensure Commission June 2007

- On June 11, 2007, the Commission entered an Order removing the probationary status of the license to practice medicine in Alabama of **Julian H. Fields, MD**, license number MD.23125, Gilbertown, AL, subject only to the condition that he shall not practice obstetrics.

Board of Medical Examiners June 2007

- On June 20, 2007, the Board accepted the voluntary surrender of the certificate of qualification and license to practice medicine in Alabama of **Samuel Nick Shaw, MD**, license number MD.23886, Brandon, MS. Dr. Shaw is no longer authorized to practice medicine in Alabama.

For some patients, though conscious that their condition is perilous, recover their health simply through their contentment with the goodness of the physician.

– Hippocrates

Notice regarding CME:

Physicians and PAs are required to maintain documentation of CME attendance and hours earned for a minimum of three years. More information can be obtained from the Newsletter Links section of the Board's website, www.albme.org.

Alabama State Board of Medical Examiners
Newsletter and Report

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

Look inside for

important news

from the

Board of Medical Examiners

that pertains to your license

to practice medicine

in Alabama.

Change of Address

The code of the state of Alabama requires that every licensed physician notify the Board of Medical Examiners in writing within 15 days of a change of the physician's practice location address and/or mailing address.