Alabama

Controlled Substance Prescription Guidelines for Physicians

From the newsletter of the Alabama Board of Medical Examiners

Board of Medical Examiners Rule 540-X-4-.05, Controlled Substance Prescription Guidelines for Physicians, has been amended, with an effective date of October 24, 2002. All physicians who prescribe controlled substances should be familiar with and strictly adhere to these Rules. The Board may assess an administrative fine of up to $10,000 for each separate violation or failure to comply with the prescription guidelines provided in this Rule.

540-X-4-.05 Controlled Substances Prescription Guidelines for Physicians.

1. All prescriptions for controlled substances shall meet the following requirements:
   a. The prescription shall be dated as of, and signed on, the day when issued;
   b. The prescription shall bear the full name and address of the patient to whom the drug is prescribed;
   c. The prescription shall bear the drug name, strength, dosage form, and quantity prescribed;
   d. The prescription shall bear directions for use of the drug;
   e. The prescription shall bear the name, address and Alabama Controlled Substances Certificate number of the physician prescribing the drug;

2. Where an oral order is not permitted, prescriptions for controlled substances shall be written with ink or indelible pencil or typewriter and shall be manually signed by the physician issuing the prescription. For purposes of this rule, “manually signed” requires a non-electronic, handwritten signature. Oral orders are not permitted for prescriptions for Schedule II and Schedule IIN controlled substances.

3. A prescription issued by a physician may be communicated to a pharmacist by an employee or agent of the prescribing physician.

4. A prescription may be prepared by an employee or agent of the physician for the signature of the prescribing physician; however, the prescribing physician is ultimately responsible for ensuring that the prescription meets the requirements of this regulation.

5. When a physician prescribes a controlled substance, he or she shall not delegate the responsibility of determining the type, dosage form, frequency of application and number of refills of the drug prescribed.

6. Every written prescription for a controlled substance issued by a physician shall contain two signature lines. Under one signature line shall be printed clearly the words "dispense as written." Under the other signature line shall be printed clearly the words "product selection permitted." The prescribing physician shall communicate instructions to the pharmacist by entering his or her non-electronic, handwritten signature on the appropriate line.

7. It is improper for any prescription for a controlled substance to be signed by any person in the place of or on behalf of the prescribing physician.

8. It is improper, under any circumstances, for a physician to pre-sign blank prescription pads or forms and make them available to employees or support personnel.

9. It is improper for a physician to utilize blank prescription pads or forms upon which the signature of the physician has been mechanically or photostatically reproduced.

10. The Board may assess an administrative fine not to exceed ten thousand dollars ($10,000) for each separate violation or failure to comply with the prescription guidelines provided in this rule.

Upon an initial determination by the Board that any physician may have violated these rules and regulations the attorney for the Board shall serve upon the physician, either in person or by registered mail, an administrative complaint setting forth the specific violation or failure to comply, and shall advise the physician of his right to a hearing before the Board under the provisions of the Alabama Administrative Procedure Act §41-22-1 et. seq. Code of Alabama, 1975. The Administrative Complaint will further advise the physician that he may voluntarily execute and deliver to the Board a waiver
of hearing and consent to the imposition of an administrative fine in an amount previously established by the Board. If the physician executes the voluntary waiver and consent then the Board shall be authorized to immediately assess the established administrative fine. If the physician declines to execute the voluntary waiver and consent or makes no response then the Board shall set a hearing to be held at least thirty (30) days after the Service of the Administrative Complaint. The hearing shall be considered a contested case and shall be conducted under the provisions of §41-22-12 Code of Alabama, 1975.

All fines assessed by the Board shall be due and payable to the Board within thirty (30) days from the date the fine is levied or assessed unless a request for judicial review under Code of Ala. 1975, §§41-22-20, is filed, in which event the fine is due and payable to the Board thirty (30) days after the final disposition of the judicial review process. The name of any physician more than sixty (60) days delinquent in the payment of a fine which has been assessed by the Board which is not subject to judicial review shall be forwarded to the Medical Licensure Commission with a request that the annual certificate of registration of that physician not be renewed until the fine has been paid and satisfied in full.

All administrative fines received by the Board shall be deposited to the general revenues of the Board and may be expended for the general operation of the Board and for the development, administration and presentation of programs of continuing medical education for physicians licensed to practice medicine in Alabama.

CALIFORNIA

MAJOR LEGISLATION SIGNED AFFECTING BOARD

From Action Report, a publication of the Medical Board of California

The California State Legislature passed, and the Governor signed, Senate Bill 1950 (Figueroa) in the 2002 legislative session. SB 1950 enacts a number of provisions related to the Medical Board of California and its licensing and regulatory processes. Many of its provisions become effective immediately, while others will be implemented as regulations are adopted. Following is a summary of the major provisions of SB 1950 affecting physicians. You may review the entire bill at www.leginfo.ca.gov, click on "Bill Information" and enter bill number. SB 1950 calls for:

- The public disclosure of malpractice settlements for the first time in California. Beginning on January 1, 2003, if a physician in a low-risk specialty has three malpractice settlements in a 10-year period, that will become a matter of public record, disclosable on the Medical Board’s Web site. For physicians in a high-risk specialty, disclosure will occur following four settlements. The Medical Board will adopt, by regulation, the designation of specialties as low or high risk. This law will not apply to settlements entered prior to Jan. 1, 2003.

The disclosure of settlements will not specify the actual dollar amount, but will place the amount in context as it relates to the malpractice payment average for other physicians in that specialty.

- The Medical Board to adopt, in regulation, standard terminology to describe disciplinary actions it discloses to the public.

- The prioritization of complaints upon which investigative and prosecutorial resources of the Board are expended as follows.

  1. Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to a patient.
  2. Drug or alcohol abuse by a physician involving death or serious bodily injury to a patient.
  3. Repeated acts of clearly excessive prescribing or furnishing of controlled substances, or repeated acts of prescribing or furnishing controlled substances without a good faith prior examination and medical indication.
  4. Sexual misconduct with one or more patients in the course of treatment.
  5. Practicing medicine while under the influence of drugs or alcohol.

- The appointment of an Enforcement Monitor for a two-year period to review the Enforcement and Diversion Programs of the Medical Board and to make recommendations to the Legislature which may improve the operations of these programs.

- A finding of repeated or multiple acts of sexual exploitation to require that an Administrative Law Judge render, and cannot stay, a decision of license revocation.

- The addition of two public members to the Board’s Division of Medical Quality.

- The expedited activation of inactive licenses during times of declared state or national disaster.
The Medical Board to recognize applicants who are licensed in another state and are board certified as meeting the educational and examination requirements contained in Business and Professions Code sections 2089, 2089.5, 2089.7 and 2170.

The Medical Board of California is committed to the early and effective implementation of SB 1950 to usher in the coming era of physician licensure and regulation. Adoption of the regulations and policies necessary to operationalize these, and other, provisions of SB 1950 will be reported in future issues of the Action Report.

MINNESOTA

NEW MINNESOTA LAW REGULATES THE PRACTICE OF TELEMEDICINE

From Update, a publication of the Minnesota Board of Medical Practice

The Governor has signed into law a bill giving the state authority over physicians residing and licensed outside Minnesota, who are directly treating patients in Minnesota by some telemedic means.

The bill, proposed by the Board, was authored in the Senate by former Board member, Senator Steve Kelley, and authored in the House by former Board member, Representative Richard Mulder, MD.

It requires physicians residing and licensed in other states to register with the Board prior to providing direct patient care in Minnesota. In order to register, a physician must provide the Board with verified evidence that he or she holds a full and undisciplined license in another state, and pay a nominal application fee and a registration fee to cover the Board's verification costs.

Such registration allows the physician to practice via telemedic means only. Practice in residence in Minnesota requires a full Minnesota license. Registration also makes the physician subject to all the laws, rules and courts of Minnesota. Failure to register prior to treating a Minnesota patient makes the physician subject to penalties.

This legislation allows patients, especially those in underserved areas, to have access to medical services which would otherwise be unavailable. At the same time, it places physicians engaged in telepractice under the same performance requirements as a physician working and licensed in Minnesota.

Prior to this legislation, telemedic care provided by physicians unlicensed in Minnesota was unregulated. With this legislation, Minnesota patients, the Minnesota medical community and the state have the same legal and regulatory recourses with regard to this type of care as is available for care rendered by Minnesota licensed physicians.

The Board wishes to take this opportunity to thank the chief authors of the legislation and all who supported its passage.

IDAHO

BOUNDARIES

From the newsletter of the Idaho Board of Medicine

The buzzword for physician-patient relationship issues continues to be boundaries. While the physician-patient relationship is ideally a collaborative relationship, the power is always vested in the physician. As with any power, it comes with a lion’s share of responsibility and accountability. A responsibility to be receptive to the patient’s needs with clinical compassion and respect for the patient and accountable to oneself, the profession and society to use that power appropriately and wisely.

There are few people today who are not aware of the obvious boundary violations by work supervisors, and health care providers. The media will focus on the individual who violates a sexual boundary with a subordinate or a patient, but what about the boundary violations that occur before the sexual relationship, the little, apparently innocent, steps that bring someone to an investigation or action for boundary issues?

Usually boundary violations are insidious. What are the warning signs of a boundary issue?

As the supervisor of office staff or other health care professionals, it is often your responsibility to identify impediments to performance such as marital problems, or psychological problems. It may also be your responsibility to identify resources for the resolution or treatment of these problems. It is not the responsibility of the supervisor to become the marriage counselor or the therapist for those he or she supervises.

Some warning signs of boundary issues may include the very caring that identifies the health care profession. When does someone care too much? Most professions identify the loss of neutrality as the point of being too involved. The point when you recognize that “you like this individual more than others,” they are “special” or they make you feel good about being their supervisor or provider.
A mutual exchange of family stories, information about spouses, details about personal relationships or anecdotes and information about other employees or patients may occur. Gifts and or favors may be exchanged. Social contact may be planned or occur accidentally. Billing, payment, appointment, or established policies are changed or overlooked because of these special feelings about this individual.

There are no early warning systems that beep and warn you, “DANGER, DANGER, BOUNDARY VIOLATION AHEAD,” but if any of the above are occurring, you may want to look again and re-establish mutual trust and respect by establishing boundaries. In the physician-patient relationship, patients may be seductive, difficult, or manipulative and unable or unwilling to establish or respect boundaries. A clear office policy, written handouts about your office policy and clear directions to the office staff will help everyone to recognize boundaries. Naive or illogical exceptions to appointment, billing, payment or other established procedures and failure to enforce policies blur the boundaries for everyone.

Idaho Code 54-1814 22 identifies as grounds for discipline engaging in any conduct which constitutes an abuse or exploitation of a patient arising out of the trust and confidence placed in the physician by the patient. While sexual contact is the most obvious violation it is usually the final step in a series of boundary issues. The Committee on Professional Discipline and Board of Medicine continue to have zero tolerance for violations of this code.

TEXAS

BOARD APPROVES PROFICIENCY REQUIREMENT

From Medical Board Report, a publication of the Texas State Board of Medical Examiners

The Texas State Board of Medical Examiners (TSBME) became the first state medical board to formally endorse implementation of a program requiring periodic demonstration of current proficiency by all physicians with adoption of a resolution on August 16.

New legislation would be required to enable the board to begin using the proficiency requirement. Implementation could occur no earlier than 2005. Stakeholders will advise TSBME on the exact structure and details of the procedure.

Currently the board is complaint-driven, identifying and remediating competency problems only after patients or peers have filed a complaint with the board. This process identifies problems after they occur, and the board is trying to better fulfill its mission of public protection by more proactively determining that all licensees are fully qualified.

Out-of-state physicians seeking licensure in Texas must have demonstrated proficiency by passing a nationally recognized examination within the last 10 years. The proposed plan would extend that requirement to all licensed Texas physicians.

Other states are considering implementation of some sort of proficiency testing for physicians, while other professions on which the public depends for safety have long required continued re-testing. The Federal Aviation Administration has a range of requirements for pilot re-testing, depending on types of aircraft flown and amounts of flying time logged.

Proposals for methods of re-testing for physicians began appearing in the early 1980s. The Statewide Health Coordinating Council was the first Texas body to address the issue in the Texas State Health Plan 1999-2004: Ensuring a Quality Health Care Workforce for Texas. The Texas report echoed recommendations of a report published in 1995 by the Pew Health Professions Commission’s Taskforce on Health Care Workforce Regulation, which said that regulated health professionals should periodically demonstrate competence through appropriate testing mechanisms. The report also said that continuing education courses have not proven to be an effective way of assuring continuing competency.

In its 1999 report on medical errors, “To Err is Human,” the Institute of Medicine recommended that “Health professional licensing bodies should implement periodic re-examinations and relicensing of doctors, nurses, and other key providers based on both competence and knowledge of safety practices.”

The American Board of Medical Specialties has had a recertification policy since 1975, but since each of its 24 boards is a separate entity, implementation has varied. Most boards began issuing time-limited certificates in the 1980s and 1990s, and all member boards now issue time-limited certificates, although certification requirements may vary from board to board. The time for recertification also varies from seven to 10 years.

Fiscal impact on the agency is expected to be minimal and may be offset by conversion to a system of biennial registration, which would reduce the staff time spent on administering annual registration.