TEXAS STATE BOARD OF MEDICAL EXAMINERS

Staff Report

to the

Sunset Advisory Commission

Legislative Budget Office
Program Evaluation
P. O. Box 13066, Capitol Station
Austin, Texas 78711

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FOREWORD

The Texas Sunset Act (Article 5429k V.A.C.S.) terminates named agencies on specific dates unless continued. The Act also requires an evaluation of the operations of each agency be conducted prior to the year in which it terminates to assist the Sunset Commission in developing recommendations to the legislature on the need for continuing the agency or its functions.

To satisfy the evaluation report requirements of Section 1.07, Subsection (3) of the Texas Sunset Act, the Program Evaluation section of the Legislative Budget Board has evaluated the operations of the Texas State Board of Medical Examiners, which will terminate on September 1, 1981 unless continued by law.

Based on the criteria set out in the Sunset Act, the evaluation report assesses the need to continue the agency or its function and provides alternative approaches to the current method of state regulation. The material contained in the report is divided into seven sections: Summary and Conclusions, Background, Review of Operations, Alternatives and Constraints, Compliance, Public Participation, and Statutory Changes. The Summary and Conclusions section summarizes the material developed in the report from the standpoint of whether or not Sunset criteria are being met, assesses the need for the agency or the agency's functions relative to the findings under the various criteria and develops alternative approaches for continued state regulatory activities. The Background section provides a brief history of legislative intent and a discussion of the original need for the agency. The Review of Operations section combines, for the purposes of review, the sunset criteria of efficiency, effectiveness, and the manner in which complaints are handled. The Alternatives and Constraints section combines the sunset criteria of overlap and duplication, potential for consolidation, less restrictive means of performing the regulation, and federal impact if the agency were modified or discontinued. The Compliance Section combines the Sunset criteria relating to conflicts of interest, compliance with the Open Meetings Act and the Open Records Act, and the equality of employment opportunities. The Public Participation section covers the sunset criterion which calls for an evaluation of the extent to which the public participates in agency activities. The final section, Statutory Changes, deals with legislation adopted which affected the agency, proposed legislation which was not adopted and statutory changes suggested by the agency in its self-evaluation report.

This report is intended to provide an objective view of agency operations based on the evaluation techniques utilized to date, thus providing a factual base for the final recommendations of the Sunset Commission as to the need to continue, abolish or restructure the agency.

I. SUMMARY AND CONCLUSIONS

Medical practices can be traced to the early periods of man's recorded history. In general, the practice of medicine includes the diagnosis and treatment "of any disease or disorder, mental or physical, or any physical deformity or injury, by any system or method, to effect cures thereof." To practice medicine, a person must follow rigid educational avenues, lasting from four to ten years for entry into practice, pass carefully structured examinations, and maintain an adherence to numerous laws and human expectations.

The regulation of the medical profession has a long history in both the United States and Texas. While various controls had been placed on American physicians as early as 1639, the first medical licensing examinations were not given until 1760 in New York City. The history of licensing in Texas began almost eighty years later in 1837 while Texas was still a republic. This effort was short-lived, ending in 1848 when Texas became a state. However, twenty-five years later Texas was credited with ushering in the period of "modern" regulation with the passage of the first modern medical practice act in 1873.

Regulation in general was undertaken in response to a proliferation of medical schools of dubious quality graduating persons with questionable skills during the late 1800s. Additionally, various sects and cults were offering their own questionable versions of "non-regular" medicine virtually uncontrolled.

These conditions stimulated strong reactions from the increasingly powerful practitioners of "regular" or established medicine. First-rate medical schools and medical societies and groups such as the American Medical Association began to push for higher standards of entry into the profession by the 1870s. This reaction appears to have stemmed from several factors. Practitioners of regular medicine,

which had made large scientific strides as a result of European research in the mid 1800s, were alarmed at the potential for public harm inherent in the practice of medicine by incompetent or unskilled individuals. In addition, the skilled practitioners were concerned with their public image as well as with the more practical economic problems resulting from the large number of medical school graduates pushing down the income of physicians.

The 1873 Texas effort at medical regulation has changed significantly since its origination. Most dramatically, the single Board of Medical Examiners, established in 1907, is still in place today and increased emphasis has been placed on applicant qualifications and enforcement abilities.

The current board, composed of twelve licensed physicians, regulates approximately 33,000 licensees through licensing and enforcement functions and is supported by fees charged licensees and applicants for licensure.

Review of board operations shows that the regulatory activities of the board generally serve to ensure an adequate level of public protection. In the area of administration, the review shows that documents are processed by the board staff in an orderly and timely fashion, records are adequately organized and accessible, and procedures related to mail processing are adequate. Five areas do exist, however, where improvements can be made. First, the board must operate with a board member and an active practitioner of medicine as its administrative head. This statutory requirement should be modified to require a full-time executive director, who is not a board member. Second, almost half of board budgeted funds (46.7%) are not in the State Treasury and therefore are not subject to the legislative appropriations process. These funds should be placed in the State Treasury to ensure accountability and improved funds management. Third, board member per diem claims should be limited to actual attendance at board or board

committee meetings or at association or medical school liaison meetings when they are officially representing the board. This approach will eliminate claims for "preparation" for board or board committee meetings. Fourth, only the secretary-treasurer (or board-appointed designee) should be required to sign disbursements of board funds. Fifth, cash control procedures should be modified to ensure the physical security of all currency received by the board.

With regard to licensing, the board's procedures can be broken down into three general areas: examination, reciprocity and registration (renewal). Although the licensing functions operate in a generally efficient manner, four areas do exist where improvements can be made.

The board's statute, the Medical Practice Act, presents general problems in organization. The fee structure is confusing, exam language is outdated, two sections duplicate other sections of the Act and the grounds for applicant or licensee disqualification need revision. As the statute is modified during the next legislative session, these areas of confusion or duplication should be corrected.

Second, the requirement that the board verify applicant transcripts for "Basic Science" background areas should be eliminated. This presents an unreasonable barrier to certain foreign applicants and the expected knowledge is tested through the national "FLEX" examination.

Third, the board's delinquency renewal process should be restructured so that the license be suspended upon expiration with a grace period of ninety days for renewal payment (currently $15) without penalty. After ninety days, the exam fee (currently $150) would be required with current reinstatement procedures and after two years the board should require reexamination or continuing education courses as prescribed by the board in conjunction with its current reinstatement review process.

Fourth, rules relating to physician assistants (PAs) should be modified to increase public notice of their activities and make consistent for all PAs educational or experience and competency testing requirements. These modifications would require: 1) that physicians utilizing physician assistants develop and maintain written descriptions of the types of services delivered by these individuals, with such descriptions available to the public and board investigators upon request; and 2) that any physician assistant utilized by a board licensee must have certain educational or equivalent experience qualifications and have passed the national certification exam for physician assistants.

With regard to enforcement activities, the board has devoted considerable time and personnel in the active investigation of the numerous complaints received annually. Three general areas do exist, however, where improvements can be made.

Complaint Processing

First, the board should notify parties to complaints at least every six months of the status of the complaint unless such notification would jeopardize an on-going investigation. Second, the complaint receipt and processing operations should be automated through data processing assistance to enhance the accountability and general management of the investigation division.

Intra Office and Hearing Procedures

First, the investigation division should develop written guidelines or materials for the various processes it conducts. These include: 1) complaint processing; 2) reinstatement applications; 3) physician assistant permits; and 4) malpractice and peer review report processing. Further, training materials for investigators should be expanded to cover general legal issues related to medical practice, law enforcement procedures and investigation techniques, etc.

Second, board rules and regulations should be adopted regarding the purpose, conduct, etc. of the board's Administrative Sanction Hearings. Further, written notice should be given to persons requested to attend such hearings concerning the nature of complaints or allegations against them.

Third, board rules and regulations developed for the District Review Committees should be expanded to fully address the purpose, general activities, proper conduct of committee hearings and the scope of the committee's authority.

Scope of Board's Enforcement Authority

First, the board has made recommendations of the need for additional enforcement powers. Two of these appear to have significant merit. First, the board should be able to discipline physicians: 1) who have been disciplined by regulatory boards in other states and 2) through the imposition of fines for violations of the Act.

Second, the Medical Liability and Insurance Improvement Act (Article 4590i) has established permissive reporting provisions for the board to receive reports from "peer review committees" (e.g. hospital staffs) and "professional societies" (e.g., County Medical Societies) concerning physician incompetence or disciplinary actions against physicians. The board has been able to use the reports received under the permissive provisions (eighteen total) and such reporting should be mandatory to improve the board's ability to act in cases related to illegal activities of physicians.

Need to Regulate

As in the case of other regulated activities, regulation of physicians should be undertaken by the state only when there is a continuing need to protect the public health, safety, or welfare.

The review indicates that a current need exists to regulate the activities of physicians. Such persons, due to educational and training experiences and societal expectations, are allowed to make decisions and execute highly technical procedures which can result in the life or death of persons entrusted to their care. The state does have a significant interest in ensuring that persons allowed to "practice medicine" have met established training standards and that they are subject to continuing enforcement sanctions should their skills diminish dangerously.

The regulation of physicians can be accomplished through means other than an independent board. However, a review of organizational alternatives available in Texas did not reveal any feasible alternatives to the current situation. One regulatory alternative, requiring continuing medical education, does present a possible alternative to current license renewal processes.

Alternatives

If the legislature determines that the regulatory function and/or board should be continued, the following alternatives should be considered:

1. **MAINTAIN THE BOARD WITH INTERNAL CHANGES.**

   a) modify the statute to provide for the following board composition (page 53):

      1) 9 Medical Doctors (MDs)
      2) 3 Public Members
      3) 2 Osteopaths (DOs)
      4) 1 Physician Assistant (PA)

   b) modify the statute to require that all funds utilized by the board be placed in the State Treasury (page 18);

   c) modify the statute to require specific provisions relating to conflicts of interest relating to (page 49):

      1) board members and
      2) board legal counsel;

d) limit the per diem claims made by board members to those related to actual board or board committee meetings, association and medical school liaison meetings when representing the board in an official capacity (page 20);

e) modify the statute to eliminate the requirement that the board's secretary-treasurer act as the agency's chief administrative officer and provide for a full-time executive director (page 17);

f) modify the statute to require only the secretary-treasurer's (or board designee's) signature on vouchers prepared by the board (page 21);

g) modify cash control procedures to insure security of all currency received by the board (page 22);

h) modify the board's statute to:

1) allow the board to establish necessary and reasonable fees, with such fees being set in rule (when all board funds are placed in the State Treasury) (page 25);

2) update the language of the statute to reflect current requirements of licensees regarding examinations (Art. 4503 V.A.C.S.) (page 26); and

3) delete repeat sections added to the Act through Penal Code transfers (page 27);

i) modify the statute so that grounds for disqualifying an applicant from sitting for an examination and grounds for removal of a license are: 1) easily determined and 2) currently existing conditions (page 27);

j) modify the statute to eliminate the board's Basic Science verification requirement and transfer remaining funds of the Basic Science Board designated for the medical board to the General Revenue Fund (page 28);

k) amend the statutory provision regarding delinquent license renewals so that: 1) the renewal of licenses expired for more than 90 days would require payment of the examination fee, and 2) the renewal of licenses expired for more than two years would require re-examination or continuing education as determined by the board. The board's current reinstatement procedures would be required at each point (page 29);

l) modify board rules relating to physician assistants to require: 1) that physicians utilizing physician assistant's develop and maintain written descriptions of the types of services delivered by these individuals, with such descriptions available to the public and board investigators upon request; and 2) that any physician assistant utilized by a board licensee must have certain educational qualifications or equivalent experience and have passed the national certification exam for physician assistants (page 29);

m) modify the statute (Sections 2.03 and 2.02, Art. 4590i, V.A.C.S.) to mandate reporting of disciplinary actions or knowledge of physician incompetency by professional medical societies and peer review committees respectively (page 38);

n) adopt formal board rules and regulations relating to the purpose, general activities, conduct of hearings and scope of authority of the board's District Review Committees (page 36);

o) modify the statute to provide for increased board authority to discipline physicians (page 37):

   1) who have been disciplined by regulatory boards in other states and

   2) through the imposition of fines for violations of the Act;

p) develop internal written procedures for all activities of the Investigation Division to include (page 33):

   1) complaint processing;

   2) physician assistant permits;

   3) malpractice and peer review reporting; and

   4) investigator training materials;

q) modify board activities relating to Administrative Sanction Hearings to (page 35):

   1) adopt formal board rules and regulations regarding the purpose, conduct and possible consequences of such hearings; and

   2) provide licensees requested to attend the hearings with written notification of the general complaints or allegations against them;

r. modify the statute to require that parties to complaints received by the board be informed every six months concerning the status of the complaint until its resolution unless such notification would jeopardize an ongoing investigation (page 32);

s) automate complaint receipt, filing and maintenance procedures through interagency contract services (page 33);

t) modify board directory to include (page 52):

1) an alphabetical and geographical listing of licensees;

2) a summary description of board duties;

3) the Medical Practice Act and related statutes; and

4) the board's rules and regulations.

This directory or separate publications including the above and the board's newsletter should be available upon request and distributed to all public libraries.

2. NO ORGANIZATIONAL OPTION CONSIDERED PROVIDED A REASONABLE ALTERNATIVE TO THE BOARD'S CURRENT STRUCTURE. HOWEVER, ONE REGULATORY ALTERNATIVE REQUIRING CONTINUING MEDICAL EDUCATION (CME) FOR PHYSICIANS PRIOR TO LICENSE RENEWAL, DOES PRESENT A FEASIBLE OPTION. CURRENTLY, TWENTY-ONE STATES REQUIRE CME TO PROMOTE CONTINUED COMPETENCE IN RAPIDLY CHANGING, HIGHLY TECHNOLOGICAL FIELDS OF MEDICAL PRACTICE (page 47).

II. BACKGROUND

Historical Perspective

The regulation of the medical profession has a long history in both the United States and Texas. While various controls had been placed on American physicians as early as 1639, the first medical licensing examinations were not given until 1760 in New York City. The history of licensing in Texas began almost 80 years later in 1837 while Texas was still a republic. This effort was short-lived, ending in 1848 when Texas became a state. However, 25 years later Texas was credited with ushering in the period of "modern" regulation with the passage of the first modern medical practice act in 1873.

A review of available literature shows that there were at least two major conditions leading up to the modern era of regulation that began with the Texas act. First, between 1820 and 1870, medical schools proliferated in the United States as a result of the medical demands of a rapidly growing country and the availability of students. Many of these institutions, as well as their students and graduates, were not of top quality. Second, various sects and cults practiced their own questionable versions of "non-regular" medicine with virtually no controls placed on them in many states.

These conditions stimulated strong reactions from the increasingly powerful practitioners of "regular" or established medicine. First-rate medical schools and medical societies and groups such as the American Medical Association began to push for higher standards of entry into the profession by the 1870s. This reaction appears to have stemmed from several factors. Practitioners of regular medicine, which had made large scientific strides as a result of European research in the mid 1800s, were alarmed at the potential for public harm inherent in the practice of

medicine by incompetent or unskilled individuals. In addition, the skilled practitioners were concerned with their public image as well as with the more practical economic problems resulting from the large number of medical school graduates pushing down the income of physicians.

As a result of such pressures, Texas undertook regulation of the medical profession in 1873. Regulation, however, was carried out by boards in each county of the state rather than by a single state board. While the organizational framework for regulation changed several times in the next thirty years, in 1907 the state changed over to the approach still in use today with the establishment of the Board of Medical Examiners as the sole agency regulating the medical profession. The board was given the authority to test and license applicants, while the authority to suspend or revoke a license was given to the district courts.

Since 1907 the authority of the board has been modified many times. The most significant changes relating to the scope of board authority have occurred in the area of enforcement. In 1953 the power to revoke, suspend, or cancel a license was extended from the judicial system to the agency. In recent years the agency's range of disciplinary powers was again broadened with the passage of legislation in 1977. Board disciplinary action authorized by this legislation included the issuance of public or private reprimands and the requiring of a set period of education or supervised practice. Over time, the grounds for taking such disciplinary action have become more numerous as well as more specific. These changes in authority have been taken to help protect the public in a period where medical technology and skills have become increasingly sophisticated.

The current board is composed of twelve members appointed by the governor and confirmed by the senate for six-year terms. For fiscal year 1980, the agency has a total of forty-two budgeted positions and operates with a budgeted amount of

approximately $1.3 million. Slightly over half of this amount is appropriated to the agency out of the Medical Registration Fund in the State Treasury. The remaining amount is maintained by the board outside the Treasury in a local bank account and is not subject to the state appropriations process.

Comparative Analysis

To determine the pattern of the regulation of the practice of medicine within the United States, a survey of the fifty states was conducted.

The need to regulate the occupation of physicians is currently recognized through licensing requirements imposed by all fifty states. From the standpoint of organization patterns, twenty-two states, including Texas, utilize an independent Board of Medical Examiners, to regulate the practice of medicine. In twenty-eight states, the regulation of medical doctors is carried out through a board associated with a state agency charged with multiple regulatory functions. Responsibility for the regulation of medicine rests with a board associated with a state health department in nine states. In fifteen states, osteopaths are regulated by an independent board composed entirely of osteopaths.

Board members are appointed by the chief executive in forty-two states, as in Texas, and confirmed by the legislature in twenty states. Boards in twenty-six states indicate that they are funded through general revenue appropriations. The Texas board is not funded through general revenue appropriations. In seven states, including Texas, the administrative head of the agency is required to be a physician.

Licensing boards composed entirely of medical doctors administer regulatory activities in seven states. In thirty states, as in Texas, the regulation of physicians is achieved through a board composed of medical doctors and other physicians or

health professionals. Public members serve on the board of thirty states, not including Texas. Boards in thirty-eight states indicate that they regulate more than one profession.

Board of medical examiners conduct investigations in response to consumer complaints in thirty-nine states, as in Texas. In all states but eight, the board has the responsibility of conducting disciplinary hearings. Thirty states utilize non-adversarial administrative hearings to resolve certain disciplinary matters, as does Texas. Twenty-one states, not including Texas, require continuing medical education prior to relicensing physicians. All boards of medical examiners surveyed indicate the need to perform the basic regulatory functions of administration, testing, license issuance, and enforcement.

III. REVIEW OF OPERATIONS

The material presented in this section combines several sunset criteria for the purpose of evaluating the activities of the agency. The specific criteria covered are the efficiency with which the agency operates; the objectives of the agency and the manner in which these objectives have been achieved; and the promptness and effectiveness with which the agency disposes of complaints concerning persons affected by the agency.

Organization and Objectives

The Texas State Board of Medical Examiners is mandated through the Medical Practice Act and related statutory provisions to regulate the practice of medicine. The board's stated objectives are: 1) to license physicians to practice medicine in the state by reciprocity or examinations; 2) to register licensed physicians annually; and 3) to enforce the laws prohibiting the unlawful practice of medicine in the state. In order to achieve its objectives, the board performs three major functions: administration, licensing, and enforcement.

The board is composed of twelve physicians appointed by the governor and confirmed by the senate for six-year overlapping terms. To be qualified, individuals must be "legal and active" practitioners of medicine in the state for three years prior to their appointment on the board. Additionally, no member can be a stockholder, member of the faculty or a member of a board of trustees of any medical school. Board duties required or authorized by statute include the promulgation of rules and regulations, the review and examination of qualified applicants, the issuance of licenses to practice medicine, the certification of certain health organizations, the conduct of license suspension, cancellation or revocation hearings, the initiation of actions to enjoin violations of the Act and the

general administration of efforts to enforce the statute.

Staff for the board consists of its secretary-treasurer as administrator and thirty-six full-time employees. Activities generally performed by the staff in the traditional areas of administration, licensing and enforcement include receiving and accounting for agency funds, checking reciprocity and examination applications for completeness, verification of applicant Basic Sciences background, processing registration renewals, maintaining records and assisting the board in the administration of examinations and investigations of violations of the Act.

Funding for the board is provided exclusively from the fees it is authorized to collect. The board maintains two separate funds, one within the State Treasury and one deposited in local banks. Fees collected through the annual renewal or registration process are deposited in the Treasury (Medical Registration Fund 055) and are subject to the state appropriations process. All other fees collected by the board are deposited in checking, savings, or other interest-bearing accounts in banks in Austin. These funds are not subject to state appropriations procedures.

Evaluation of Agency Activities

As with most other licensing agencies, the operations of the Texas State Board of Medical Examiners can be broken down into three basic activities: administration, licensing, and enforcement. Below, each of these activities are reviewed to determine the degree to which agency objectives have been met. To make this determination, the evaluation focuses on whether the board has complied with statutory provisions, whether these provisions facilitate accomplishment of the objectives, whether agency organization, rules and procedures are structured in a manner that contributes to cost-effective accomplishment of the agency's tasks and whether procedures provide for fair and unbiased decision-making.

Administration

The general objective of any administration activity is to provide for the efficient operation of all agency functions. The review of agency activities indicated that licensee and accounting records are complete and well organized. The agency has automated many facets of its licensing procedures and continues to increase the portions of the accounting system assisted through data processing. While agency management functions adequately, several aspects of the current process can be improved.

The first aspect concerns the current administrative and management structure set out by the board's statute. Section 3., Article 4498a, V.A.C.S. reads in part:

> In performing the duties devolved by this Act upon the Board of Medical Examiners, said Board shall act through the Secretary-Treasurer of the Board of Medical Examiners ...

Article 4495 requires that the board consist of "twelve men, learned in medicine, legal and active practitioners in the State of Texas . . ." These provisions effectively establish that the activities of the state agency be governed by: 1) a member of its board and 2) an active practitioner of medicine.

The provision establishing the secretary-treasurer as administrative head was enacted in 1931. The first state auditor's report on the board indicates that in 1940 the agency licensed some 7,000 physicians, employed six personnel and expended approximately $27,800 in the conduct of its duties. Currently, the board licenses over 30,000 physicians, budgets for forty-two employees and expends over $1.2 million per year. As the workload has increased, however, the same structure requiring a board member and an active physician to administer the agency has remained in place. Currently, the secretary-treasurer estimates that he is able to spend ten to fifteen hours per week at the board office while spending some forty to fifty hours per week working on board business.

Problems associated with this structure have occurred. In 1975, the State Auditor's Office noted that unusual payroll changes (merit salary increases and a promotion) were approved which might not have been had full-time administrative attention been available. Additionally, the secretary-treasurer's ability to act in full capacity as a board member is hampered due to the role he must play as administrator. The secretary-treasurer must abstain from discussion and voting on all investigative hearings due to prior knowledge of the elements of the cases gained during the decision-making processes leading to board disciplinary actions. This effectively limits the voting members of the board to eleven rather than the twelve established by statute.

Finally, no other state regulatory board is required to utilize a board member and an active practitioner as its administrative head. Based on the preceding review, the board's statute should be modified to eliminate the requirement that the board's secretary-treasurer act as the agency's administrative officer and to provide for a full-time executive director.

A second area of concern results from the fact that the agency currently maintains a portion of its funds outside the Treasury and all of its expenditures are therefore not subject to the appropriations process. The board maintains approximately $608,000 or 47 percent of its budgeted funds in local bank accounts. The original board statute (Senate Bill No. 26, Thirtieth Legislature, 1907) established a fund for fees collected by the board to be "applied first to the payment of necessary expenses of the Board of Examiners; any remaining funds shall be applied by the order of the board to compensating members of the board in proportion to

their labors." In 1931, the Forty-second Legislature established an annual "registration" or renewal process for all physicians holding a Texas license. The fees derived from this process were to be deposited in the State Treasury to the credit of the "Medical Registration Fund". The purpose of the fund was outlined to allow the board to:

> . . . employ and compensate . . . employees and such other persons as may be found necessary to assist the local prosecuting officers of any county in the enforcement of all laws of the State prohibiting the unlawful practice of medicine . . .

Attempts to determine the proper utilization of these separate funds caused sufficient confusion in 1942 to prompt the state auditor to request an opinion clarifying the perplexing statutory fund structure. The attorney general responded (Attorney General Opinion O-3711) that fees collected to compensate the board members are "not collected for the State, they are not 'public monies', need not be turned over to the State Treasurer and do not require a biennial appropriation as a condition precedent to their expenditure."

Present statutory guidelines generally follow those originally enacted, although board members are no longer "compensated . . . in proportion to their labors" except through per diem and travel allocations. Currently, the board budgets for fifteen personnel, pays board members' expenses, examination costs, consulting attorney fees, and miscellaneous office costs out of its "local fund." State funds are budgeted for twenty-seven personnel (including the secretary-treasurer and top administrative and investigative personnel) as well as employee expenses, postage, data processing, etc. Aside from difficulties caused by statutory confusion (for example, should the board's accountant be paid from state fees collected to "employ and provide such clerks and employees as may be necessary to assist the Secretary-Treasurer . . ." or from other fees collected for

"payment of all necessary expenses of the Board"?) the current fund structures present numerous problems. First, the board has had to establish two separate payroll and accounting systems. Second, board member expenses, although generally in compliance with appropriation bill guidelines are not subject to comptroller voucher approval. Third, board investment of local funds is not closely monitored. Funds ($216,502 as of May 30, 1980) are invested in certificates of deposit yeilding six to nine percent interest while many money market certificates could yield as much as seventeen percent interest for the same period of time.

To ensure that the management of this agency adheres to general standards established for efficient and accountable state operations, all funds utilized by the medical board should be included in the appropriations process. This approach is consistent with the Sunset Commission's position that provisions requiring agency inclusion in the appropriations process be recommended on an across-the-board basis.

A third concern in the area of administration relates to the types of activities for which board members receive per diem. By statute (Article 4502, V.A.C.S.) a board member may be compensated ($100 per day -- up to sixty days per calendar year) when the member "may be active in business of the Board, whether such business consists of regular meetings, committee work for the Board, grading papers, or any other function which is a legitimate and proper function held to be necessary" by the board. This general provision has been interpreted to include many different activities such as board representation at association meetings and preparation for board or committee meetings. Interviews with board members and staff indicate that per diem may be claimed for phone calls made by board members concerning board business and that no general guidelines have been established to delineate what does or does not constitute an acceptable per diem claim.

A review of claims made by board members of twelve other licensing boards in Texas indicates that members of eight boards claim per diem only for actual board meetings, members of two boards claim per diem for other than board meetings (hearings, exam grading and enforcement activities) and members of two boards claim per diem for activities similar to those claimed by the members of the Board of Medical Examiners; however, none claim for "preparation" for board or committee meetings. The preparation claimed by medical board members generally consists of reading material prepared by board staff prior to a meeting. During fiscal year 1979, all members claimed a total of ninety-eight days per diem for preparation for board meetings (8.2 days per member) and five members claimed a total of thirty-seven days for preparation for board committee meetings (7.4 days per member).

The variety of activities for which board members may claim per diem is not in keeping with generally followed practices of other state boards. Particular concern is raised in the claims made for "preparation" for board or board committee meetings (payment total $13,500 for fiscal year 1979) when members of other boards do not make such claims. The board should restrict per diem claims to those days when actually attending board or board committee meetings or representing the board in an official capacity at association or medical school liaison meetings concerning the regulation of the practice of medicine.

A fourth concern relating to administrative activities involves the statutory requirement that all disbursements from the "Medical Registration Fund" (State Treasury funds) be made only upon "written approval of the president and secretary-treasurer" of the board. Board staff report that the requirement of the president's (the current president lives in Houston) signature slows voucher processing down from one to two weeks and it does not appear to add to funds

accountability. The statute should be amended to provide only for the secretary-treasurer's or a board appointed designee's signature authorizing disbursement of board funds.

A fifth concern relating to administrative activities concerns the board's handling of cash (currency). Board staff will accept currency for payment of certain fees and estimate that between $25 to $100 is received daily. Although general fiscal control procedures are adequate, during the review unattended currency was observed on the receptionist's desk while guests were in the reception area. Procedures should be modified to avoid such occurrences in the future.

Licensing

The general objective of the licensing activity of the Board of Medical Examiners is to ensure the minimum competency of physicians practicing medicine in this state. To accomplish this objective, the board is directed by statute to issue new licenses by exam and reciprocity (endorsement) and renew registrations of licensed physicians. The board has established three general divisions (examination, reciprocity and renewal) to accomplish each of the above tasks. Exhibit III-1 depicts the number of licenses and renewals issued during the general review period.

Exhibit III-1

NUMBER OF PHYSICIANS LICENSED
1976-1979

	1976	1977	1978	1979
By Examination	733	841	1,009	1,204
By Endorsement	1,126	1,418	1,779	1,426
By Renewal	24,409	25,905	27,684	30,153
Reinstatements	11	13	16	22
TOTAL	26,279	28,177	30,488	32,805
Percentage Increase Over Preceding Year	-	7.2%	8.2%	7.6%

As can be seen, the number of physicians licensed by the board is steadily increasing with a significant portion (approximately sixty percent) of newly licensed physicians entering through endorsement. Exhibit III-2 provides a breakdown of physicians licensed in Texas by location of the medical school they attended and whether they practice in or out of state.

Exhibit III-2

MEDICAL SCHOOL ORIGIN OF TEXAS LICENSEES*

	In-state	Out of State	Total
Texas Medical Graduate	9,387	3,723	13,110 (39.5%)
United States Medical Graduate	8,863	4,749	13,612 (41.1%)
Foreign Medical Graduate	3,842	2,593	6,435 (19.4%)
TOTAL	22,092 (66.6%)	11,065 (33.4%)	33,157 (100.0%)

*As of March 21, 1980.

Of the 11,065 persons holding a Texas license and practicing out of state, almost all practice in the United States. Eight hundred thirty licensees are currently located outside the United States.

Foreign medical graduates (FMG) licensed in Texas come from a variety of countries. As of March 1980, 6,313 of the 6,435 FMGs have come from twenty different foreign countries. The top five countries include Canada (936), Mexico (788), India (688), Cuba (435) and the Philippines (418).

The licensing examination utilized by the board is the national exam known as the FLEX or Federation Licensing Examination. This exam, prepared by the Federation of State Medical Boards in conjunction with the National Board of

Medical Examiners, is now utilized by all states as the physician qualifying exam. The board is also directed by statute to administer a Jurisprudence exam to cover legal issues related to the practice of medicine. Exhibit III-3 provides the pass/fail rate for current and past board exams during 1976-1979. As noted, the FLEX appears to provide an adequate test of physician knowledge and is neither overly restrictive nor overly permissive. The Jurisprudence exam, however, does not appear to provide a significant screen to licensure.

Exhibit III-3

LICENSING EXAMINATIONS PASS/FAIL RATES
1976-1979

	1976	1977	1978	1979	Total
Board Exam					
Total	206	2	-	-	208
Failed	8	0	-	-	8
% Failed	3.9%	-	-	-	3.8%
FLEX					
Total	656	1,025	1,254	1,358	4,293
Failed	121	186	245	154	706
% Failed	18.4%	18.1%	19.5%	11.3%	16.4%
Jurisprudence					
Total	862	1,027	1,254	1,358	4,501
Failed	2	26	30	15	73
% Failed	.23%	2.5%	2.4%	1.1%	1.6%

The preceding figures and discussion indicate that the physician population holding Texas licenses comes from many sources. Board procedures and rules in place to screen, license and register applicants and licensees appear reasonable and adequately organized. Four areas do exist, however, where improvement can be made.

First, the board's statute, the Medical Practice Act, presents general problems in organization. The fees noted throughout the statute are confusing. For example, fees relating to the exam differ in three separate places: 1) Article 4501 requires a $50 exam fee; 2) Article 4511a provides for a supplemental exam fee of $100; and 3) the board's schedule of fees provides for a $150 exam fee. Although the board's interpretation of the provisions (adding fees in Article 4501 and Article 4511a together to result in the $150 fee) appears correct, any applicant depending on the statute to clearly indicate the amount of exam fee would be in a difficult position. Further, the specification of fees by statute does not afford an agency sufficient flexibility to adjust to rapid cost escalations. The board estimates that its current exam application process actually costs $176, but the board is only allowed to charge $150 due to statutory limitations. As all board funds are placed in the State Treasury, the board's statute should be modified to eliminate specific fee references and to allow the board to establish a workable fee structure by official board rules and regulations. The current fee structure used by the board is shown below in Exhibit III-4.

Exhibit III-4

FEE STRUCTURE

Type of Fee	Statutory Limit	Current Fee
Annual Registration	$ 30	$ 15
Institutional Permits (Interns and Residents)	26	25
Licensure by Reciprocity	200	200
Temporary License	25	25
Duplicate License	35	35
Endorsement	25	25
Reinstatement	100	100
Certification to other Boards of Grades in Basic Science Examination	25	25
Verification of Basic Science Grades for Licensures	50	50
Licensure by Examiantion (FLEX-full)	$ 150	$150
First day only - repeat	*	30
Second day only - repeat	*	35
Third day only - repeat	*	85
Jurisprudence only - repeat	*	25
Partial Examination		
Preclinical	100	**
Clinical	50	**

*no limit
**not in use

A second statutory concern relates to the description of the board exam (Article 4503). The language describes the process involved in taking the old state board exam which the board stopped using in 1978. It is felt that a minimal description of the exam and applicant requirements, as used by most licensing boards, would eliminate applicant confusion regarding the exam to be taken.

A third statutory concern involves a problem resulting from the transfer of certain Penal Code provisions to the Medical Practice Act in 1973. Two sections, Article 4498.1 (Physicians to register) and 4504a (Exceptions) duplicate like provisions of the Medical Practice Act, Articles 4498 and 4504, respectively. These duplicate articles should be removed.

A fourth statutory concern involves the statutory framework developed for this agency concerning grounds for refusal to allow an individual to sit for an examination and the grounds for removal of a license once issued. This framework contains the same confusion of thought and vagueness of terminology found in the statutes of many other licensing agencies.

The statute erroneously requires the licensing board in many cases to act essentially as a court of competent jurisdiction in determining the legal status of an individual and requires the board to define and apply terms which may have no legal basis. To correct this situation and to place the licensing board in an appropriate setting, the statute dealing with the grounds for disqualification should be structured in such a manner that each of the grounds meets a two-part test. First, the grounds for disqualification should be clear and related to the practice of the profession. As a second part of the test, the grounds for disqualification should be stated in terms of a currently existing condition rather than an absolute condition which exists throughout the lifetime of the individual.

Review of the grounds for disqualification to sit for examination set out in the board's statute shows that several fail to meet the test stated above. For example, the applicant is required to be of "good moral character" to be licensed. In addition, the board may refuse to issue a license or may cancel, revoke, or suspend a license for: a felony or misdemeanor which involves moral turpitude; or habits of intemperance or drug addiction. The statute should be restructured so that such provisions comply with the two criteria.

A second general concern in the licensing area relates to the board's statutory requirement to verify an applicant's background in the "Basic Sciences." Article 4590c - 1 requires the Board of Medical Examiners to verify through reviewing a "transcript of credits" that the person has at least sixty college hours (at an average of seventy-five percent or better) in the following areas: anatomy, physiology, chemistry, bacteriology, pathology, hygiene and public health. This verification requirement was transferred to the board and the Board of Chiropractic Examiners for their respective applicants for licensure when the State Board of Examiners in the Basic Sciences was abolished in 1979 by the Sixty-sixth Legislature. Surplus funds of the Basic Science Board are to be divided between the medical and chiropractic boards.

The verification requirement does present problems. First, in accordance with an attorney general opinion, the board is unable to use any means but actual transcript verification to evaluate applicants. Applicants from foreign countries, such as Vietnam, are sometimes unable to secure actual transcripts and therefore are not eligible for licensure. Second, the sixty hours must have been gained in courses transferable to The University of Texas at Austin. Since UT-Austin no longer maintains a numerical grading system (it is now A, B, C, D, F, etc.), it is difficult to determine what can be transferred at a "75 percent average." Third, aside from the mechanical problems involved in the process, all applicants are tested for Basic Science knowledge during the first day of the FLEX (Federation Licensing Exam) which can serve as a more effective screening tool than a transcript review. Finally, a review of other states indicates that only four states (not including Texas) still require a Basic Science review and that seven have repealed such requirements since 1970. Based on the preceding, the requirement that the Board of Medical Examiners verify a candidate's Basic Science background

should be eliminated. Funds earmarked for transfer to the Medical Board from the Board of Basic Science Examiners for carrying out this verification process should be deposited in the General Revenue Fund.

A third general concern involves the board's current renewal delinquency procedures. License renewals are due January 1st each year. A registered letter is mailed to each physician who has not renewed by March 1st. Another registered letter is mailed to the person if renewal is not received within fifteen days of the first registered letter and the person's license is suspended. If the license is not renewed within thirty days of the second notice, then the statute requires the cancellation of the license. Board practice has been to wait until the next regular board meeting to cancel licenses after this last thirty days which is usually held in June. This effectively allows a five- to six-month period to elapse after the January 1 deadline for license renewal. Additionally, considerable expense is incurred as each registered letter costs approximately $1.70 and as many as 1,400 letters are sent during the two notice process. The number of licenses that the board officially cancels per year ranges from 200 to 250.

The current system should be revised to specify that a license is suspended upon expiration but allow a ninety-day period for payment of the renewal fee (currently $15). Between ninety days and up to two years after expiration of the license, the person should be allowed to renew upon payment of the examination fee (current $150) and completion of the board's current reinstatement process. After two years, the board should require the person to complete the reinstatement process and either retake the licensing exam or complete certain continuing education requirements as specified by the board.

The fourth area of concern related to licensure involves board activities surrounding physician assistants. Article 4512a, V.A.C.S. gives the board broad

authority to establish "standards to regulate the extent to which a physician licensed may delegate his or her responsibilities as a physician to a physician assistant." The physician assistant is not directly regulated but is authorized to practice when his or her supervising physician registers with the board. Since the process was authorized in 1976, the board reports that 310 physician assistants (PAs) have been registered by their supervising physicians through fiscal year 1979.

Under the standards developed by the board, two general problems are noted. First, board rules require that a notice be posted in each participating physician's office to indicate that the physician utilizes a PA and "the functions delegated to the physician assistant." However, no requirement is made to develop written guidelines on the types of functions the PA may perform within the office. Due to the important nature and variety of the work a PA can perform, it is felt that an additional requirement that each physician develop guidelines on how a PA is used in his or her office should be in place and that such guidelines be available to the public and board investigators upon request.

Second, PAs can become recognized physician assistants in two ways: 1) through completion of a two year PA training program approved by the Council on Medical Education of the American Medical Association (there are three such programs in Texas); and 2) by passing the examination given by the National Commission on the Certification of Physician's Assistants. To ensure adequate educational and tested competency for physician assistants in the state, it is felt that they should be required to have the accepted educational or equivalent experiences background and have passed the recognized national exam for physician assistant certification.

Enforcement

The basic objective of the enforcement activity is to protect the public by identifying, and where necessary, taking appropriate action against persons not complying with statutory provisions or board rules. The board pursues this objective through the allocation of nineteen authorized staff positions to the Investigation Division. Of these nineteen, four (three currently employed) are administrative and clerical assistants and thirteen (ten currently employed) are field investigators located in nine cities in the state and two provide investigator direction and supervision from the board's Austin office.

The board's Investigation Division receives complaints concerning the practice of medicine from numerous sources which include consumers, board licensees, licensees of other boards, other regulatory boards and law enforcement agencies (by statute the board is authorized to receive criminal records from any source or law enforcement agency). The workload associated with the enforcement efforts of the division is substantial and the number of complaints received by the board has maintained a relatively constant level over the last three fiscal years ranging from 1,014 in 1976 to 966 in 1979. Board disciplinary actions resulting from complaints is depicted in Exhibit III-5.

Exhibit III-5

DISCIPLINARY ACTIONS
1976-1979

Type of Action	1976	1977	1978	1979
Board Hearings				
Revocation/Cancellation	3	2	8	4
Suspension/Probation	5	2	3	8
Suspension	1	-	-	-
Administrative Hearings				
DEA/TCS Regis.Restriction	9	12	11	11
Conciliation Affidavit	33	17	7	15
Reprimand	-	-	2	-
Voluntary Surrender of License	-	3	1	5
Minor Violation Warnings	40	113	96	100
District or County Court Cases*	9	7	8	2

*Filed in relation to violations of Medical Practice Act.

The review of agency enforcement activities indicates that the board has devoted considerable time and personnel in pursuit of illegal practitioners of medicine. However, numerous concerns have been encountered in enforcement areas related to complaint processing, the division's office and hearing procedures, and the scope of the board's regulatory authority.

Complaint Processing

Regarding the handling of complaints, two areas of concern have been noted. First, the board does not routinely notify parties to complaints of the complaint's status. Although fifty-eight percent of the respondents (72) to a Sunset staff complaint questionnaire felt that complaints were adequately investigated, a significant portion (38%) felt they were not adequately informed regarding the

status of the complaint in which they were involved. The agency should implement the across-the-board recommendations of the Sunset Commission with regard to complainant notification. However, no notice should be required to be sent to a person when such notice might jeopardize an on-going investigation.

The second area of concern relating to complaint processing regards the current manual procedures in place to receive, classify, file and generate statistical reports on complaints. As can be noted in the agency's Self-evaluation Report to the Sunset Commission (pp. 104-107), figures on the source and disposition of complaints could only be estimated in general percentages. No central document or register is maintained on complaints received and files are established by the name of the physician or person involved in a cumulative fashion for as many as ten years. Board staff indicate that automation of the complaint system has been considered to help improve accountability, general management, etc., but that concerns about security of the information have impeded action. Currently, the State Purchasing and General Services Commission's Automated Services Division is reviewing the board's data processing needs and indicates that a sufficient password system can be built into the programs to ensure comparable security and confidentiality of investigation records currently maintained. Since many improvements in complaint processing could be gained through automation of current records and procedures, and measures to ensure security can be taken, the board should convert its manual complaint records processing to an automated system.

Division's Office and Hearing Procedures

Three general concerns have been encountered relating to the Investigation Division's intra-office and hearing procedures. First, the director of investigations reports that no written procedural guidelines have been established for the

execution of the division's general duties. These duties include the processing of complaints, applications for reinstatements, physician assistant permits, and malpractice and peer review reports. In keeping with the action of the board's other major divisions (examination, reciprocity and registration), written procedures for the activities of the Investigation Division should be developed to serve as orientation and training tools for new employees and references for all employees to ensure consistent treatment of all materials and persons handled by the division.

A related concern involves the lack of training materials for investigators. The investigators act as the general enforcement personnel of the board and their activities range from undercover narcotic purchasers to trial and hearing witnesses to general record keepers. Activities currently in place to train new investigators include approximately two weeks of office training to familiarize the person with records and documentation requirements, another two weeks spent with an experienced investigator, and approximately one week working alone on routine complaints. After these steps are completed, the person returns to the Austin office to discuss his or her general performance. Once the director of investigations is satisfied with the person's progress, the investigator is placed on permanent assignment in the field.

Board staff have prepared a general compilation of instructions on how to maintain complaint report forms, record travel expenses, report daily time use, request advance funds for undercover work, etc. General meetings for investigative staff are held three to four times per year to discuss problems, new policies or procedures, and in general, answer any questions the investigators may have. These actions do help ensure that forms are filled out correctly and filed on a timely basis. However, the lack of general "educational" or training materials raises concerns related to consistency of training needed to carry out any serious

enforcement activity. Given the size and geographical distribution of the field investigation staff, regular supervision cannot be maintained. Further concerns relate to the complexity of the laws related to the practice of medicine and the body of case law addressing medical issues. Within this difficult area of law, the investigators are required to act as general enforcement or "police" agents on a daily basis and must be cognizant of the rights of individuals with whom they are dealing.

In light of the above, the board staff should pursue its stated objective of developing training and procedural materials for investigator training and reference. This manual should address or contain at least the following elements: 1) a general synopsis of attorney general opinions and case law regarding the practice of medicine in Texas; 2) guidelines concerning acceptable interview procedures and techniques and cautionary materials on general law enforcement problems (e.g. entrapment, rights violations, etc.); and 3) guidelines on the sufficiency of evidence for filing cases and procedures needed to secure drugs purchased through undercover work.

A second general concern involves current division and board policies regarding the conduct of "administrative sanction hearings" for disciplining physicians. These hearings, authorized under the Administrative Procedures Act, are generally conducted by board staff at the Austin office. The physician is requested by letter to appear regarding alleged violations of the Medical Practice Act and the hearing is conducted by the board's legal counsel. Upon presentation of testimony and evidence, the physician may choose to sign an affidavit stipulating that certain agreed areas of practice restrictions will be observed or that no further violations of the Medical Practice Act will occur. At the next board meeting, the director of investigations makes a report on each hearing conducted

and their results and the board can choose to approve the agreements or disapprove the agreements and require that the matter be brought before the full board.

Although the process appears to be an efficient and effective way to handle certain disciplinary cases, two modifications should be made. In keeping with the Administrative Procedures Act, the board should formally adopt rules and regulations outlining the authority for the hearings, general procedures followed and the possible consequences of such hearings. General guidelines have been established for the conduct of the hearings, but these are not generally made available until the physician appears at the board. Further, the letter sent to the physician is insufficient in that no notice is given of the types of complaints or allegations concerning the physician's practice the board has received and intends to discuss at the administrative hearings. Although this information can be obtained by the physician by telephoning the board, it appears that written notice of the general areas of concerns should be provided when the person is notified of the board's desire to hold an administrative hearing.

A third general concern relates to the lack of board rules and regulations concerning the activities of its District Review Committees. These bodies, established under the Medical Liability and Insurance Improvement Act (Subchapter C, Article 4590i, V.A.C.S.), can provide assistance and advice to the board in reviewing complaints, questionable applications, and malpractice cases, as well as other duties determined by the board. They can take no final action and until recently have been basically inactive. However, current responsibilities include the review of malpractice cases reported to the board to determine their relevance in pursuing enforcement action against named physicians. Rules of the board adopted to date merely set the configuration of the districts, stipulate appropriate per diem claims and that they may not take any final action on an assignment made

by the board secretary. These committees can play an important role in providing local assistance and expertise in reviewing physician conduct, competence, etc. The lack of published rules, however, on the general areas of district review committee activity, the conduct of hearings and the authority they exert on behalf of the board is not in keeping with the Administrative Procedures Act and the permissive authority of the board to adopt such rules found in the "Malpractice" Act (Section 3.08, Article 4590i, V.A.C.S.). Amendments should be made to the current board rules on district review committees to address at least the areas noted above.

Scope of Board's Enforcement Authority

Generally, two areas of concern or issues relate to the scope of the board's enforcement authority: 1) the board has made certain recommendations on additional grounds for disciplinary action and 2) the authority of the board to receive reports from peer review committees and medical societies.

First, in the board's Self-evaluation Report, the board has made a number of recommendations concerning the need for additional enforcement powers. Two of these recommendations appear to have significant merit. The board recommends that it be allowed to take action against a licensee based on disciplinary action taken against the person by a medical board in another state. Currently, the board must build its own case against a physician who may have moved to Texas to escape disciplinary action pending or finalized in his or her home state. The board reports that information has been received on at least six current practitioners of medicine in Texas who have had action taken against them by another state. The authority to pursue action against such persons should be granted as long as the board can ascertain that the offense in the other state is also an offense in Texas,

and that the disciplinary action taken by the other state is final and meets due process requirements.

The board also suggests that it be allowed to discipline a physician through imposition of fines, up to $1,000 per count or violation. This approach has been utilized by the Board of Pharmacy ($250 per count) and appears to be a useful addition to its enforcement powers.

A second major area of concern relates to the board's authority to receive reports on disciplinary actions against physicians taken by medical peer review committees and medical societies. Currently, under Sections 2.02 and 2.03, Article 4590i, V.A.C.S., such bodies may report to the board if they have knowledge relating to a physician that "reasonably raises a question with respect to his or her competency" (Section 2.02 relating to Peer Review Committees), or if formal disciplinary action is taken against a member relating to "professional ethics, medical incompetency, moral turpitude, or drug or alcohol abuse" (Section 2.03 relating to a medical society). Through this permissive reporting system, the board has received eighteen reports (eight from medical societies, nine from hospitals and one from a physician) and two have been used to aid in suspension or revocation hearings held by the board.

This system provides potential for a number of improvements in the enforcement activities of the board. However, the permissive nature of the reporting system is inadequate as other entities involved in the "regulation" of medicine are not required to report all disciplinary actions taken against physicians to the board which has the general authority to prohibit the incompetent or dangerous practice of medicine. Further, the nature of the reports received thus far indicate that these bodies do receive information and take actions that address areas of concern

to the board. For example, one of the reports utilized by the board to suspend a license related to a physician's "excessive, addictive use of medication and the development of a manic depressive psychosis complicated by drug abuse." Although certain reports relate to matters which the board cannot pursue (such as certain types of advertising), efforts to increase the reporting of incidents such as the one above by the several hundred hospitals, nursing homes, health care facilities and one hundred plus county medical societies in the state should be taken.

Summary

The State Board of Medical Examiners is a twelve-member board appointed by the governor with the advice and consent of the senate for six-year overlapping terms. The board is directed by statute to regulate the practice of medicine.

Board operations can be categorized into three activities: administration, licensing, and enforcement. With regard to administration, functions are carried out in a generally acceptable manner, although five concerns have been identified.

The first concern relates to the board's current administrative/management structure set out by statute. The secretary-treasurer of the board is required to act both as a board member and the administrator of the agency and also must maintain an active medical practice. These requirements result in the board having a part-time board member and part-time administrator. This structure should be modified to require that the board have a full-time administrator or executive director.

A second concern relates to the board's current funding structure. Nearly half (46.7%) of the board's fiscal 1980 operating budget is held outside the State Treasury. To ensure that the management of this agency adheres to general

standards established for efficient and accountable state operations, all funds utilized by the medical board should be placed in the State Treasury and be subject to the appropriations process.

A third concern relates to the range of activities for which board members claim per diem. Particular concern is raised by the fact that board members claim "preparation" for board and board committee meetings (135 days in fiscal year 1979). Per diem claims should only be allowed for actual attendance at board or board committee meetings or for association or medical school liaison meetings when the members are officially representing the board.

A fourth concern involves the statutory requirement that the president and secretary-treasurer of the board must sign all disbursements of the board. This is a cumbersome requirement and does not add to funds accountability. This requirement should be modified to require only the secretary-treasurer's or board designee's signature.

A fifth concern relates to cash (currency) control procedures. During the review, unattended currency was observed on the receptionist's desk with visitors in the reception area. Steps should be taken to avoid such occurrences in the future.

With regard to licensing, the board's procedures can be broken down into three general areas: examination, reciprocity, and registration (renewal). Although the licensing functions operate in a generally efficient manner, four areas do exist where improvements can be made.

First, the board's statute, the Medical Practice Act, presents general problems in organization. The fee structure is confusing, exam language is outdated, two sections duplicate other sections of the Act and the grounds for

applicant or licensee disqualification need revision. As the statute is modified during the next legislative session, these areas of confusion or duplication should be corrected.

Second, the requirement that the board verify applicant transcripts for specific "Basic Science" background areas is no longer necessary and presents unreasonable barriers to licensure for certain applicants. Only four states (other than Texas) still require some Basic Science review for applicants and seven have eliminated the requirement since 1970. Basic Science knowledge is tested through the national "FLEX" examination and the requirement should be eliminated.

Third, the board's renewal delinquency procedures are burdensome and costly. Current certified mail notice requirements should be eliminated and the following standard delinquency process should be put in place: 1) the renewal of licenses expired for more than ninety days would require payment of the examination fee, and 2) the renewal of licenses expired for more than two years would require reexamination or continuing education as determined by the board. The board's current reinstatement process would be required in either situation.

Fourth, rules relating to physician assistants (PAs) should be modified to increase public notice of their activities and make consistent for all PAs educational and competency testing requirements. These modifications would require: 1) that physicians utilizing physician assistants develop and maintain written descriptions of the types of services delivered by these individuals, with such descriptions available to the public and board investigators upon request; and 2) that any physician assistant utilized by a board licensee must have certain education or equivalent experience qualifications and have passed the national certification exam for physician assistants.

The review of agency enforcement activities indicates that the board has devoted considerable time and personnel in pursuit of illegal practitioners of medicine. The board receives approximately 1,000 complaints a year and the investigation division is active in pursuing and resolving complaints received. However, concerns have been encountered in the following general areas: complaint processing (2); intra-office and hearing procedures (3); and the scope of the board's enforcement authority (2).

Complaint Processing

First, the board does not notify parties of complaints on a regular basis. The agency should implement a notification procedure (at least every six months) for those involved in complaints handled by the board, unless such notification would jeopardize an on-going investigation.

Second, the complaint receipt and processing operations are conducted manually. Automation through data processing assistance could greatly enhance the accountability and general management of the investigation division.

Intra Office and Hearing Procedures

First, no written procedural guidelines have been developed for the execution of the division's general duties. These include: 1) complaint processing; 2) reinstatement applications; 3) physician assistant permits; and 4) malpractice and peer review report processing. Additionally, training materials for board investigators consist of general instructions on report writing, voucher processing, etc. Improvements in investigator training can be gained through the development of written training materials including: 1) a general synopsis of attorney general opinions and case law regarding the practice of medicine in Texas; 2) guidelines concerning acceptable interview procedures and techniques and cautionary

materials on general law enforcement problems (e.g., entrapment, rights violations, etc.); and 3) guidelines on the sufficiency of evidence for filing cases and procedures needed to secure drugs purchased through undercover work. Development of written guidelines for all of the above areas would improve new employee training and provide reference materials to ensure consistent treatment of all items and persons handled by the division.

Second, procedures used for the board's "Administrative Sanction Hearings" should be developed into board rules and regulations to comply with the Administrative Procedures Act. Written notice to those requested to attend such hearings should include the general areas of concern (complaints or allegations) for which the person is being summoned.

Third, board rules developed concerning the District Review Committees do not fully address the purpose, general activities, conduct of hearings, or the committees' scope of authority. The current rules should be modified to address the above areas.

Scope of Board's Enforcement Authority

First, the board has made recommendations on the need for additional enforcement powers. Two of these appear to have significant merit. First, the board should be able to discipline physicians:

1) who have been disciplined by regulatory boards in other states; and

2) through the imposition of fines for violations of the Act.

Second, the Medical Liability and Insurance Improvement Act (Article 4590i) established permissive reporting provisions for the board to receive reports from "peer review committees" (e.g., hospital staffs) and "professional societies" (e.g., county medical societies) concerning physician incompetence or disciplinary

actions against physicians. The board has been able to use the reports received under the permissive provisions (eighteen total) and such reporting should be mandatory to improve the board's ability to act in cases related to illegal activities of physicians.

IV. ALTERNATIVES AND CONSTRAINTS

The material presented in this section combines several sunset criteria for the purpose of evaluating the activities of the agency. The specific criteria covered are the extent of overlap and duplication with other agencies and the potential for consolidation with other agencies; an assessment of less restrictive or alternative methods of performing any regulation that could adequately protect the public; and the impact in terms of federal intervention or the loss of federal funds if the agency is abolished.

Consolidation Alternatives

The organization of regulatory activities in other states was reviewed in order to identify potential organizational alternatives for use in Texas. In twenty-nine of the fifty states which regulate physicians, regulation is carried out by an independent state agency not associated with another agency or department. In ten states, physicians are regulated by a board located within a department charged with the regulation of multiple professions and, in nine other states, physicians are regulated through a board of medical examiners placed within the state health department. Two states regulate physicians through boards associated with law enforcement agencies.

In Texas, it is not possible to consolidate the Texas Board of Medical Examiners within a department of occupational licensing because no such organization exists. To determine the feasibility of consolidating the functions of the board with those of the Department of Health or of a state law enforcement agency, the objectives and functions of the agencies were reviewed and the potential benefits to be derived from consolidation assessed.

Review of organizational alternatives in Texas indicates that the Department of Health possesses objectives most compatible with those of the Board of Medical Examiners. The Health Department currently licenses health facilities and provides direct health services to the public. While the department provides administrative support for other regulatory agencies, these regulatory activities are limited in scope and directed at a relatively small number of licensees. As presently structured, the Health Department is not capable of assuming the extensive regulatory functions for which the Board of Medical Examiners is responsible, and no savings could be anticipated to result from the consolidation of the agencies.

Regulatory Alternatives

The need to regulate the practice of medicine is well established and recognized throughout the world. The complexity of modern medical practice and the potential danger to the public resulting from incompetent practitioners establishes a continuing need for the regulation of physicians in Texas.

All states regulate the practice of medicine and do so through licensing of physicians. Although the certification or registration of physicians could provide a less restrictive form of regulation, neither of these alternatives would provide for the necessary enforcement activities characteristic of a licensing approach. The licensing requirements of the Texas Board of Medical Examiners are comparable to those of other state medical boards and do not appear to be excessively restrictive. In the area of enforcement, the board possesses broad investigative authority and may impose a wide range of sanctions in response to unethical or incompetent practice.

The requirement of continuing medical education prior to relicensure represents an alternative to current Texas licensing requirements. It was noted during the review that twenty-one states require continuing medical education prior to the renewal of a physician's license. Four additional state boards have been granted the authority to establish continuing education requirements for relicensure. The American Medical Association also encourages voluntary continuing education on the part of its members by requiring 150 hours over a three-year period for receipt of its Physicians Recognition Award. In general, continuing medical education requirements are intended to ensure that a physician possesses sufficient and current knowledge of his or her area of practice. While most physicians conscientiously seek to keep abreast of the rapid changes in medical knowledge, it is possible that a Texas physician could graduate from medical school and never update his medical knowledge through additional courses or readings. A survey of Texas physicians conducted by the Texas Medical Association indicates that the average physician currently spends 21.7 hours per month engaged in voluntary continuing education activities. For these physicians, mandatory continuing education requirements, similar to the A.M.A.'s voluntary program, would not pose significant restrictions on licensure. Continuing medical education requirements would only impose additional restrictions to licensure for the minority of physicians who do not seek to update their medical knowledge. The experiences of other states indicate that, for continuing education to be of most value, activities or courses should be related to a physician's area of practice and the physician's knowledge of the material presented should be assessed. Although the benefits of mandatory continuing medical education are difficult to document, the continuing education requirements adopted by other states provide a practical method of promoting physician competence while not significantly increasing the restrictiveness of state regulation.

Impact on Federally Funded Programs

Many federally funded health programs provide benefits to Texas citizens contingent on the identification, through state law, of those practitioners who may deliver health services. Should the state cease to regulate and identify those who may practice medicine, federal funding for Medicare, Medicaid, public health, medical research, and other programs could be lost.

Summary

A review of the consolidation alternatives in other states was conducted to determine the potential for combining the regulation of physicians with the functions of another agency. In Texas, the Department of Health offers the most reasonable consolidation alternative. The objectives of the Department of Health are compatible with those of the Board of Medical Examiners; however, as presently structured, the department does not appear capable of assuming the board's broad regulatory functions and no savings could be expected to result from the consolidation of agency activities.

The review indicated that a continuing need exists for the regulation of the practice of medicine and that this need can best be met through the licensing of physicians. The federal funding of numerous health and medical programs could be lost should the state choose to no longer regulate the practice of medicine.

With regard to regulatory alternatives, many states have adopted the requirement that physicians participate in continuing medical education programs. These requirements, which promote the continued competence of physicians, do not appear to significantly increase the restrictiveness of state regulation for the majority of physicians and could be considered as an alternative to current licensing requirements.

V. COMPLIANCE

The material presented in this section combines several sunset criteria for the purpose of evaluating the activities of the agency. The specific criteria covered are the extent to which the agency issues and enforces rules relating to potential conflict of interest of its employees; the extent to which the agency complies with the Open Records Act and the Open Meetings Act; and the extent to which the agency has complied with necessary requirements concerning equality of employment opportunities and the rights and privacy of individuals.

In its efforts to protect the public, the agency's operations should be structured in a manner that is fair and impartial to all interests. The degree to which this objective is met can be partially judged on the basis of potential conflicts of interest in agency organization and operation, as well as agency compliance with statutes relating to conflicts of interests, open meetings, and open records.

Conflict of Interest

Board members, as appointed state officers, are subject to statutory standards of conduct and of conflict-of-interest provisions (Article 6252-9a and 9b, V.A.C.S.). Review indicates that six board members have not complied with conflict-of-interest provisions which require the filing of an affidavit by every appointed board member who has a substantial interest in a business subject to regulatory agency action. The board has been informed concerning this discrepancy and has indicated corrective action will be taken.

The Sunset Commission has adopted a number of across-the-board approaches to help minimize possible conflicts of interest in agency operations. One of these approaches prohibits board members from being officers in a professional associa-

tion of the regulated profession. The review indicated that a number of such ties exist in the case of this agency. A second approach would prohibit a person registered as a lobbyist from acting as a general counsel to the board. The agency currently retains the services of a counsel who is registered with the Office of the Secretary of State as a lobbyist for several groups, four of which relate to the practice of medicine. As in the case of other agencies under review, the Sunset Commission's across-the-board provisions concerning conflicts of interest should be incorporated in the agency's statute.

Open Meetings - Open Records

As evidenced by publications in the Texas Register, board meetings have been preceded by adequate and timely notice to the public. However, the board has not fully complied with procedures for closed meetings as outlined in Article 6252-17, V.A.C.S. At the beginning of the period under review, the board regularly went into executive session to discuss disciplinary action and to take action on complaints, procedures which are not authorized under the Open Meetings Act. Later, the board properly began to vote and, starting in 1978, began to conduct hearings in open meetings. However, on at least three occasions since February 1979, executive sessions have been held without identifying the reason and the section of the Open Meetings Act authorizing such meetings as required by law. The agency has been informed of appropriate procedures for closed meetings and has indicated that future meetings will be in compliance.

Many records of the board are privileged information and are not available to the public. However, results of board action on disciplinary action are matters of public record and are made available to the public.

Employment Practices

The agency is operating under an Affirmative Action Plan which was updated June 1980. Grievance procedures are in place, but have not been used since the agency has received no formal complaint on employment practices.

Summary

The board has not fully complied with filing requirements related to conflict-of-interest provisions, although that discrepancy is being corrected. The Sunset Commission's across-the-board provisions concerning conflicts of interest should be incorporated in the agency's statute. Currently, several board members serve as officers in professional associations of the regulated industry and counsel to the board is a registered lobbyist for several groups -- actions which would be prohibited under the Sunset Commission's across-the-board approaches.

The board has improved its compliance with the Open Meetings Act. Although three executive sessions since February 1979 have been held without proper notification as to the purposes, the board has indicated corrective action is being taken to ensure full compliance. The board has complied with the provisions of its statute and of the Open Records Act relating to freedom of information. An Affirmative Action Plan and grievance procedures are in place.

VI. PUBLIC PARTICIPATION

The review under this section covers the sunset criteria which calls for an evaluation of the extent to which the agency has encouraged participation by the public in making its rules and decisions as opposed to participation solely by those it regulates and the extent to which the public participation has resulted in rules compatible with the objectives of the agency.

The degree to which the agency has involved the public in the rules and decisions of the agency can be judged on the basis of agency compliance with statutory provisions on public participation, the nature of rule changes adopted, the availability of information concerning rules and agency operations, and the existence of public members on the board.

Agency Activities

Review of pertinent records indicates that the board has adopted twenty-eight rule changes in the last four fiscal years. The content area of the rules adopted can be broken down into the following eight categories: physician assistants (2); district review committee (1); licensure by examination (6); licensure by endorsement/reciprocity (6); temporary licensure (1); institutional permits (5); foreign medical school graduates (2); and applications (5). The adoption of these rules has been in compliance with public participation requirements found in general state law. However, board minutes indicate that there were no members from the general public in attendance at the public hearings. Additionally, it is estimated that less than five percent of the correspondence received by the agency has been from the general public.

With respect to the agency's general efforts to inform the public and its licensees as to its operations, the review showed that the Medical Practice Act and

related legislation, an alphabetical directory of licensees, and licensee directory supplements are published bi-annually. These publications, in addition to a newsletter published quarterly, are distributed upon request to licensees, medical schools, insurance companies, medical societies, pharmacies, hospitals, and the general public. The board also publishes annually a brochure on duties and functions of the board which is distributed primarily at professional conventions but is available upon request. Board staff indicate that the general public seldom requests any board publications.

The utility of the various board publications could be increased through a consolidation of the materials for public distribution. This can be accomplished through the publication of a single source document which would include:

1) the board duties and functions brochure;

2) the Medical Practice Act pamphlet;

3) board rules and regulations; and

4) the directory of licensees listed alphabetically and by major geographical areas.

This document and the board newsletter should be sent to public libraries and be available upon request.

The board maintains a copy of board minutes for public inspection. In addition, seminars are conducted at professional conventions and for law enforcement personnel to explain the Medical Practice Act.

Board Membership

Review of the statutory composition of the board indicates the absence of any members from the general public. The lack of such members impedes the ability of any board to fairly and effectively represent the point of view of the

general public in the development of rules and the deliberation of other matters. In addition, the statute makes no provision for doctors of osteopathy or physician assistants to be represented on the board. However, the agency is directly involved in the licensure or establishment of standards for both of these groups. To provide representation for both the general public as well as the population regulated by the board, the composition of the board should be modified to consist of nine medical doctors, two osteopaths, one physician assistant, and three public members.

Summary

The board has complied with the general public notification requirements. Efforts to inform the public of its responsibilities and activities could be improved by consolidating the licensee directory, the Medical Practice Act, board rules and regulations, and the duties and functions of the board; listing licensees geographically as well as alphabetically; and distributing the directory and newsletter to public libraries. Additionally, the composition of the board should be modified to include nine medical doctors, two osteopaths, one physician assistant, and three public members.

VII. STATUTORY CHANGES

The material presented in this section combines several sunset criteria for the purpose of evaluating the activities of the agency. The specific criteria covered are whether statutory changes recommended by the agency or others were calculated to be of benefit to the public rather than to an occupation, business, or institution the agency regulates; and statutory changes recommended by the agency for the improvement of the regulatory function performed. In the period covering the last four legislative sessions, the review focused on both proposed and adopted changes in the law. Prior to that period, the staff review was limited to adopted changes only.

Past Legislative Action

Regulation of the medical profession has a long history in Texas, beginning in 1837 during the years of the Republic. The original licensing act was repealed in 1848 after Texas became a state. Although the Act was reinstituted in 1873, it was not until 1907 that the state initiated the approach still in use today with the establishment of a single Board of Medical Examiners. Since the establishment of the board in 1907, the Act has been amended twenty-eight times. These changes provided for modifications in the operations of the Texas State Board of Medical Examiners three basic activities: administration, licensing and enforcement.

The following general changes were made in the area of administration:

1) The district clerk was mandated to keep a register of all physicians practicing in the county.

2) The board was authorized to act through a secretary-treasurer and to employ other necessary staff to act for the board.

3) Board members were increased from eleven to twelve with the governor's appointees requiring senate confirmation.

4) Board procedures were established requiring two meetings a year, notice of meetings by publication, and the prescribing of rules and regulations.

5) The fee structure of the board was periodically modified.

6) Yearly renewal fees were to be deposited into the State Treasury in the Medical Registration Fund.

7) Funds from examination fees were not to be placed in the Medical Registration Fund and were to be used for board expenses and compensation.

8) Board compensation was periodically increased from $20 to the current $100 per day plus expenses.

9) The board was made subject to the provisions of the Texas Sunset Act.

Changes in the area of licensing include:

1) Grounds for refusing to license were expanded for reciprocity licensure.

2) Licensing requirements were expanded to include United States citizenship, passage of an examination, and sixty semester hours of college other than medical school.

3) The board was authorized to stagger annual renewals.

4) Reinstatement requirements were established.

5) The Basic Science Board was established and later eliminated, with the Medical Board being given the function of verifying college transcripts to determine whether necessary basic science course work had been met.

The board's enforcement authority was expanded to include:

1) The authority to convict and fine any person practicing medicine who solicits patients.

2) The authority to adopt standards regulating physician assistants; the right to revoke, cancel, and suspend licenses; issue subpoenas; issue private or public reprimands; restrict the license; require care, counseling, treatment, or education; require supervison of practice; and probation.

3) The definition of medical practice was expanded.

4) Optometrists, chiropractors, and podiatrists were added to the list of persons exempted from the Act's licensing requirements.

5) District Review Committees were established to provide local expertise in determining physician competence.

6) Significant additional disciplinary powers were added which include the authority to deny licensure or discipline a licensee for:

   a) failure to practice medicine in a manner consistent with public health and welfare;

   b) receiving disciplinary action from professional societies or health care facilities; and

   c) repeated or recurring meritorious health care liability claims indicating incompetence.

Proposed Legislative Action

Apart from the successful legislation mentioned above, review of legislation indicates that several bills affecting the board's operations were unsuccessfully introduced in the last four legislative sessions. The majority of these proposed bills relate to the licensing function of the board and are listed as follows: House Bill No. 573 and Senate Bill No. 368 (Sixty-third Legislature, 1973); House Bill No. 19, House Bill No. 2137, House Bill No. 1341, and Senate Bill No. 525 (Sixty-fourth Legislature, 1975); House Bill No. 981 and Senate Bill No. 1023 (Sixty-fifth Legislature, 1977); and House Bill No. 2069 (Sixty-sixth Legislature, 1979). The bills proposed would have made the following general changes:

1) Extended the list of grounds for the refusal of a license.

2) Required an applicant to practice in a rural area or an area not adequately served for two years before permanent licensure by the board.

3) Established a procedure for licensing students of foreign medical schools.

4) Prohibited the suspension or non-issuance of a license for conviction of a crime unless the crime was directly related to duties of the medical profession.

5) Provided for the certification of physician assistants.

Various other bills have been proposed relating to board composition and other board activities. These bills are House Bills No. 577 and 1393, and Senate Bill No. 647 (Sixty-third Legislature, 1973); House Bill No. 1906 (Sixty-fourth Legislature, 1975); House Bill No. 1948 and Senate Bill No. 1023 (Sixty-fifth Legislature, 1977); and House Bills No. 1932 and 201 and Senate Bill No. 1062 (Sixty-sixth Legislature, 1979). These bills would have made the following general changes:

1) Provided for public members on the Board of Medical Examiners.

2) Reduced the number of general practitioners on the board and revised the agency's complaint process.

3) Prohibited the board from contracting for or employing private attorneys.

4) Allowed the board to require continuing education as a prerequisite for yearly renewal.

5) Provided for the regulation of health maintenance organizations.

6) Exempted acupuncture from the practice of medicine.

7) Created a Joint Practice Committee.

Apart from these proposed changes, several variations of the Medical Liability and Insurance Improvement Act were introduced along with the successful legislation during the Sixty-fifth Legislature in 1977. In addition, a bill proposing to abolish the Board of Examiners in the Basic Sciences was also proposed in the Sixty-fifth Legislature. This legislation, which required the medical board to test for basic science competency in their examinations, was passed the following session.

In the agency's self-evaluation report, the agency has made thirty-six recommendations for modifications to its statutes. While many of these recommendations are general "housecleaning" changes, substantive amendments include

allowing the board to set fees, giving the board the ability to fine, adding grounds for non-issuance of a license, amending the reciprocity and delinquency procedures, deleting the basic sciences verification process and endorsement fee, and allowing the Executive Committee to temporarily suspend licenses.

Summary

The board's enabling legislation has been amended twenty-eight times since 1907 when the state adopted the single board regulatory approach still in use today. Major changes include establishing board procedures, modifying the fee structure and board compensation, increasing licensure requirements for reciprocity applicants as well as other applicants, and expanding the board's enforcement activities. In the last four legislative sessions, unsuccessful legislation was introduced to further modify licensure requirements, to change board composition and activities, to regulate health maintenance organizations, to exempt acupuncture from the practice of medicine, and to create a Joint Practice Committee.

The agency recommended thirty-six modifications to its statutes in its self-evaluation report. Substantive changes include allowing the board to set fees, giving the board the ability to fine, expanding the board's licensing and enforcement authority, and deleting the requirement that the board verify an applicant's completion of basic science coursework required for licensure.