TEXAS RIGHT TO KNOW COMMENTS AND RECOMMENDATIONS REGARDING TEXAS SUNSET COMMISSION REPORTS AND DECEMBER 9, 2016 HEARING ON THE TEXAS MEDICAL BOARD

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Preface:

This report is a compilation of opinions and recommendations from several physicians who have been subject to Texas Medical Board Informal Settlement Conferences (ISC) and State Office of Hearings (SOAH) for submission given that the Texas Medical Board is undergoing the Sunset Commission review, which typically only happens every ten to twelve years.

The Texas Right to Know coalition has been following the activities of the board closely for many years and has read the board's self-report and the Sunset Commission's findings. After consideration of these reports and activities, and after witnessing Sunset hearing and participating in testimony on December 9, 2016, the Texas Right to Know coalition has some recommendations for improving the transparency and fairness of the physician compliance process while lowering the costs for both government regulation, improving physician compliance and patient care outcomes.

Additionally, since identifying many egregious behaviors and prosecutorial overreaching by the Texas Medical Board and taking notice of its adversarial culture, we recommend Sunset review every two years until such time as the TMB culture becomes less abusive of its power. We believe that a more collegial environment would better serve public health, public safety, the taxpayers, the patients and the physicians.

We have also concluded that the Texas Medical Board has colluded to squelch the progress in medicine by investigating integrative practitioners at an alarming rate. This is anti-trust and must be corrected by transparency in the complaint and investigative process as well as by including at least six integrative practitioners on the medical board going forward. We conclude that the board in its current form must be Sunsetted and a new model must replace it. Toward that end we have some suggestions in this report but we welcome the opportunity for further discussions with the Sunset Commission Members, their staff, legislators and current medical board staff and attorneys. Absent an open dialogue, there can be no meaningful improvement. Governing and regulation is not a one way street.

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DEFINITIONS:

1.1 **Complementary and Alternative Medicine (CAM)** is defined to be those health care methods of diagnosis, treatment, or interventions that are not acknowledged to be conventional. These may include but are not limited to nutrition, immune support, supplement support, acupuncture, and detoxification, hyper oxygenation etc.

1.2 **Conventional Medicine (CM) -**
is defined to be those health care methods of diagnosis, treatment, or interventions that are offered by most licensed physicians as generally accepted methods of routine. These may include but are not limited to surgery, radiation and drug therapies.

1.3 **Integrative medicine -** is the use of all medical modalities to help restore health that includes complementary, alternative and conventional.

1.4 **Standard of Care (SOC) -** is the based upon Conventional Medicine practices established by professional societies such as the American Medical Association (AMA), Texas Medical Association (TMA), Infectious Disease Society of America (IDSA), Lyme and Associated Diseases Society (ILADS).

1.5 **ISC** – Informal Settlement Conference aka Informal Show Compliant.

1.6 **SOAH** – State Office of Administrative Hearings.

1.7 **Texas Medical Board (TMB) –** state agency tasked to regulate the practice of medicine.

Chapter 200 CAM Physicians – Physicians who practice under

TITLE 22	EXAMINING BOARDS
PART 9	TEXAS MEDICAL BOARD
CHAPTER 200	STANDARDS FOR PHYSICIANS PRACTICING COMPLEMENTARY AND ALTERNATIVE MEDICINE
RULE §200.1	Purpose

The purpose of this chapter is to recognize that physicians should be allowed a reasonable and responsible degree of latitude in the kinds of therapies they offer their patients. The Board also recognizes that patients have a right to seek complementary and alternative therapies.

Note: Unless indicated otherwise, all chapter references pertain to Title 22 Part 9 of the Texas Administrative Code.

2 OBJECTIONS:

2.1 "…the Medical Board provided a consistent level of enforcement over those years" –

TMB has been conducting frivolous litigation prejudiced against Chapter 200 CAM physicians and conventional physicians as demonstrated by the increased cases of litigation that is not substantiated by the resulting disciplinary actions.

	FY 2007	FY 2013	Change
Complaints	6923	6857	**0.1% lower**
Informal Settlement Conferences (ISC) Supposedly Informal litigation but since TMB's attorneys are involved, physician's "lawyer up" as well, may cost $12,000 in one ISC.	482	752	56% higher
State Office of Administrative Hearings (SOAH) cases (Formal hearing before administrative judge)	48	77	60% higher
Disciplinary Action	311	330	6% higher
Source: http://www.tmb.state.tx.us/showdoc/statistics			

ISC's and SOAH complaints filed are at least 50 percent higher since 2007, despite fewer complaints. Actual disciplinary actions stayed about even suggesting a substantial increase in frivolous proceedings against physicians. Frivolous litigation has been proven to increase healthcare costs while providing no societal benefit:
(Litigation) reform reduces health care expenditures (and) had no impact on mortality
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1522105/

In a report issued by the Wisconsin Medical Journal, the chart on page 62 shows that Texas ranked 23rd among the 50 states and the District of Columbia, but 49th in Medicare Quality of care. (The state of quality reports: comparing states by their rankings. Roberts RG1, Friedsam D, Beasley JW, Helstad C, Moberg DP. WMJ. 2006 Dec;105(8):60-6.)

http://r.search.yahoo.com/_ylt=AwrTcdddkVFY2IcA3hsnnIlQ;_ylu=X3oDMTE0OGk5dHQyBGNvbG8DZ3ExBHBvcwM1BHZ0aWQDRkZVSTNDMl8xBHNlYwNzcg--/RV=2/RE=1481769437/RO=10/RU=https%3a%2f%2fwww.wisconsinmedicalsociety.org%2f_WMS%2fpublications%2fwmj%2fpdf%2f105%2f8%2f60.pdf/RK=0/RS=9ZgsCH._0CBYhYiunH2PxL8WBKY-

"The TMB (works) from a presumption of guilt. TMB experts do not consult applicable medical guidelines or references at ISCs. These proceedings result in significant legal fees for physicians…the TMB knows this and tries to take advantage of it. Baylor University Medical Center Proceedings. 2010 Jan; 23(1): 83–85."
http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2804500/

TMB has aggressively waged far more ISCs since 2007, despite fewer complaints; "Now even the most (minor) picayune complaints result in an ISC. For example, one matter sent to ISC involved a complaint by a nurse that a physician yelled at her. The documented objective facts were contrary to the complaint made. Baylor University Medical Center Proceedings. 2010 Jan; 23(1): 83–85

PROPOSED SOLUTION: Replace the ISC with an Independent 3 Physician Panel similar to the Indiana Model. Establish an independent three physician review panels to replace Informal Settlement Conferences patterned after Indiana's time-tested model.

INCAP (Indiana medical review panel legislation), created as a balance of competing public policy agendas…has met the test of public need (since 1976). Indiana State Medical Association White Paper (2003)

1. Fair, inexpensive, successful in Indiana since 1975
2. Efficiently weeds out frivolous cases, encourages settlements in legitimate cases

RULES: the panel is composed of three health care professionals and one attorney who serves as chairman with no vote. Each side chooses one expert health care provider; these two providers choose a third. The panel's findings are:

1. admissible in disciplinary cases or court;
2. not legally binding; and
3. as a practical matter, rarely overturned by a judge.
   http://www.ismanet.org/pdf/legal/RolesMedicalReview.pdf

For more information see: http://www.ismanet.org/pdf/legal/RolesMedicalReview.pdf

2.2 "…Sunset staff did not detect any obvious indications of bias in favor or against any type of practitioner."

The Sunset Commission Report on Texas Medical Board (TMB) was evaluated by statistical analysis and did not evaluate individual cases. The statement that the Sunset Staff did not find a *"bias in favor or against any type of practitioner"* does not reflect the reports coming from the Chapter 200 CAM physician community based upon personal knowledge of the physicians who make up this community.

Background: From the Sunset Executive Summary, *"In addition, after conducting a more detailed analysis of various Medical Board datasets and multiple years of case files,* ***Sunset staff did not detect any obvious indications of bias in favor or against any type of practitioner****. In other words, the Medical Board has come a long way and generally is a solid model for licensure and enforcement of occupations. That does not mean that people do not have complaints about or disagree with decisions and actions of the board. However, Sunset cannot and does not re-evaluate individual decisions of a board."*

Problem: According to the Sunset Executive Summary, Texas has 78,575 physicians. It is estimated that the number of physicians who practice Chapter 200 CAM medicine is very small,

perhaps as few as 500 or less. **If there was 100% bias against all 500, Chapter 200 CAM physicians, this would reflect .006 or 0.6% bias and would not be deemed statically significant.** Chapter 200 CAM medicine is sought by patients who do not want conventional treatment, may not tolerate conventional treatment or have failed "Standard of Care" practices. These Chapter 200 CAM physicians are highly sought after but few are free to practice in the hostile environment created by the Texas Medical Board.

The reason that Sunset staff could not discern bias against integrative practitioners is that when any complaint is filed against an integrative physician, they are not cited for breaking chapter 200 rules, but rather for not practicing the standard of care, or in some instances for false and misleading advertising about their services or certifications. It appears that many times violations against Chapter 200 CAM physicians results from conflicting rules such as Rule § 190.8 *(A) failure to treat a patient according to the generally accepted standard of care and* Rule § 164.3 *Misleading or Deceptive Advertising - (8) contains a testimonial that includes false, deceptive, or misleading statements,...* When Chapter 200 CAM physicians provide treatment compliant to Chapter 200, they can be cited under Rule § 190.8 for not following "Standard of Care". When Chapter 200 CAM physicians describe the therapies they offer in flyers or websites, they can be cited under Rule § 164.3 for misleading and deceptive advertising since the information they are communicating is not the "Standard of Care."

More importantly, integrative physicians who have come under scrutiny report the following:

1. ISC panels are overtly hostile to CAM and Integrative practitioners
2. ISC panels assume complainant are guilty until proven innocent.
3. ISC panels appear to be ignorant of the details of the case. Often there are voluminous records sent by the respondents and it is highly likely that these records are not inspected by the ISC panel. Therefore what good does it do to have a panel who is not familiar with details of the case? The ISC is not efficient if the panelists do not read the case files. Therefore it must be abolished and replaced with a more efficient mechanism. We are recommending the Indiana Compensation Plan for Patients (INCAP) model as discussed below.

If TMB panels are depending on an expert panel report, this has additional problems. ISC physicians and expert panelists who review the medical records are supposed to be in the same specialty as the respondent, but this has not been the case in the ISCs we have seen. As a matter of fact, not only are there no integrative practitioners on the medical board, but at least one public member interviewed recently indicated he was unfamiliar with the term integrative practitioner. Yet Title 22, Part 9, chapter 200 which has been effective since November 22, 1998 (over 18 years) describes in great detail the conditions that must be met when a physician and patient agree to embark on a course of diagnosis and treatment that may vary from current conventional standards.

Solution: Instruct the Sunset Commission to investigate the number of investigations and the high level sanctions delivered by the Texas Medical Board against Chapter 200 CAM physicians. This inquiry will yield information to the effect that since 2006, almost every CAM doctor has been investigated and most were either fined or sanctioned with few, if any genuine findings of fact.

The types of investigations opened against integrative practitioners are typically not filed by patients but by insurance companies and competitors. If these complaints were transparent and physicians were allowed to know their accusers, there would be far fewer complaints and the ones that were filed would be deemed bogus. When one looks closely at this population of physicians, they usually have a stellar medical liability record. In many cases the only claims paid out by malpractice carriers are for these unfair attacks and administrative actions.

Conclusion: Physician who are required to defend themselves in an administrative action come up against a government agency with seemingly endless resources to pay for litigation expenses which drives up both the cost of government and the cost of healthcare.

Regarding standard of care, the legal history of this term actually dates back to 1932 and relates to a non-medical situation. http://escholarship.org/uc/item/14z5w33g. Suffice it to say that one of the conclusions drawn in the article is that, "if there is a practice that is reasonable but not universally "customary" it may still be used as a measure of the standard of care." If this is true, then conventional physicians should be including alternative CAM options in their consenting process just as integrative physicians are required to discuss the risks and complications of mainstream, conventional options.

2.3 "… the Medical Board has come a long way and generally is a solid model for licensure and enforcement of occupations."

Problem: In the October 13, 2015, ruling from the 24th District Court located in Victoria, Texas, in the State of Texas v. Courtney Ricardo Morgan case, the court issued a clear reprimand to the TMB for their *"bad faith actions."* The ruling stated, *"The Court finds that the TMB acted in bad faith partnering up with law enforcement to conduct the search of the defendant's business. The Court finds that the TMB's interest in serving the subpoenas upon the defendant was not a legitimate pursuit of the administrative authority but an exercise to circumvent both the Texas and US Constitutions' requirement for a warrant. Because the Court finds that the TMB was acting as agents of law enforcement, defendants Motion to Suppress is GRANTED."*

Problem: The TMB asserts that they are not subject to Health Insurance Privacy and Portability Act (HIPPA) and are exempt State Patient Privacy Laws.

Problem: A U.S. Judge "Easily" Determines *Patients Have No Reasonable Expectation of Privacy in Their Medical Records.* Recommendation Allows Law Enforcement to Perform Widespread Warrantless Searches of Medical Records for the Purpose of Investigating Patients.

> *In* U.S. v Zadeh*, the DEA obtained the records of 35 patient files without showing probable cause or obtaining a warrant issued by a judge. Citing New Deal-era case law, Judge Reed O'Connor noted that "[t]he Supreme Court has refused to require that [a federal] agency have probable cause to justify issuance of an administrative subpoena," and that they may be issued "merely on suspicion that the law is being violated,* or even just because it wants assurance that it is not.*"*

"Dr. Zadeh has filed an appeal. Conservative activist Andy Schlafly, the lawyer for the Association of American Physicians & Surgeons, has filed an amicus brief stating, "[w]ithout a warrant and without initially identifying themselves, federal agents searched patient medical records . . . based merely on a state administrative subpoena. A month later the [DEA] sought enforcement . . . [and n]one of the checks and balances against overreaching by one branch of government existed for this warrantless demand for medical records."... "Administrative subpoenas issued unilaterally by bureaucrats and without probable cause directly violate the Fourth Amendment."

A private conversation between a patient and a physician may be a thing of the past. A U.S. Magistrate Judge in Fort Worth, Texas ruled in favor of enforcing a Drug Enforcement Administration (DEA) administrative subpoena which forces a local physician to turn over the medical records of 67 patients. The judge "easily" decided that patients have no reasonable expectation of privacy in their medical records and therefore a warrant was not required for law enforcement to obtain them. (Administrative subpoenas, which are not reviewed by a judge and do not require probable cause, can only be used to obtain records which are not considered private.) If upheld on appeal, the decision will effectively strip medical records of any meaningful privacy protection.

The physician argued in court that the government has explicitly promised patients that their medical records are private ("Only you or your personal representative has the right to access your medical records" is noted prominently of the U.S. Department of Health and Human Services website.) The physician also pointed out that patients withhold important sensitive information when they have privacy concerns, leading to missed diagnoses and harm to the public's health, and offered to turn over the records if they could be used only to investigate himself, the physician, but not his patients. The DEA refused the offer, indicating that they intended to use the medical records for the criminal investigation of patients.

The judge brushed aside privacy concerns in favor of the DEA: Both (patients and physicians) have a reduced expectation of privacy in the medical records…The government has a compelling interest in identifying illegal activity and in deterring future misconduct.

http://www.americanthinker.com/articles/2015/07/feds_get_the_power_to_seize_medical_records_on_fishing_expedition_investigations_with_no_subpoena_from_a_judge.html and
http://www.leagle.com/decision/In%20FDCO%2020150203F05/U.S.%20v.%20ZADEH

Problem:

Upon interviewing numerous physicians who have been investigated by the TMB, there was a consistency that the abuses primarily started in 2006. There are numerous complaints by physicians who have been investigated who stated that the TMB investigators made false statements regarding the contents of patient medical records and there are no current means of recourse available to the physicians to file a complaint nor any measure of penalty for the TMB staffer.

3 OPPOSITIONS:

3.1 Issue 1 – Key Recommendation 2, to *"Direct the Medical Board to use Prescription Monitoring Program data, along with other factors, to establish a risk-based approach to scheduling pain management clinic inspections."*

Assessing the distribution of pain medications based upon numbers of distributed pills recorded in a database does not provide for proper patient assessment. When analyzing patients for pain medicine distribution, three types of patients are possible; acute physical pain patients, patients addicted to narcotics and bad actors who acquire prescriptions for illegal sale. Rather than investigating pain clinics purely on database numbers, several technologies exist that detect and measure the autonomic nervous system to detect patients experiencing acute pain. If it is detected that the patient is not experiencing acute physical pain, then evaluation can be made to determine if the patient is an addict or a bad actor. For patients who are discovered to be addicts, referrals can be made to the appropriate care for that patient. For patients who are discovered to be bad actors, those patients should be turned over to law enforcement to follow legal due process for investigating and prosecuting these cases. We do not believe that the Texas Medical Board should be used as a police law enforcement agency. There are already many other law enforcement agencies that have jurisdiction in this area of criminal prosecution.

The current methodology for PMP is profiling based on the prescription database and is grossly inappropriate. What safeguards are going to be put into place that this profiling is not being done on race, national creed, addresses, or age?

Another problem is the use of "drag net" approach to investigations. The inclusion of nonrelated patients is used as a means to safeguard the confidentiality of a patient complainant such that other patients are included in the investigation purely to conceal who issued the complaint against a given provider.

There is the issue of the TMB criminally investigating patients without proper due process afforded by sworn, law enforcement officers but rather by TMB investigators.

In an exchange with Representative Bill Zedler, Mari Robinson, former executive director of the TMB stated under oath, *"If you see five people all living at the same address, with the same last name, all getting hydrocodone, soma and xanax, that implies that those people are getting those drugs to sell them, not for their own personal use. And so, if we get complaints like that, where we believe that there is crime being committed, we will expand that investigation to include other patient records."* How can anyone state that Ms. Robinson is acting from a presumption of innocence until proven guilty? How can anyone say with a straight face that the TMB is not criminally investigating patients after a statement like that? This is overreaching by the TMB. This is not a power expressly granted to them.

The TMB can issue a subpoena for any patient's chart any time it wishes to. If a provider does not wish to provide that patient's chart, the TMB can go to a judge and attempt to enforce the subpoena. The current method ensures that the TMB follows state law and the Constitution and gets rid of this grossly inappropriate presumption of guilt.

RECOMMENDATION: Require pain clinics to utilize technology that measures the autonomic nerve response to record the level of acute pain and confirms the necessity and dosage of pain medicine. Genetic testing can also help the physician know whether the patient is an average, slow or fast metabolizer of any given drug, which the doctor can then use to justify and adjust dosages. This will help the physician to know if a patient is lying about being in pain. This type of technology also serves to tailor treatments to given to patients.

3.2 Issue 1 – Key Recommendation 3, to *"Authorize the Medical Board to seek court enforcement of its administrative subpoenas."*

As written, this recommendation in the Sunset Commission report is unconstitutional. A subpoena has to be an adequate substitute for a warrant, and this proposal would not meet that requirement. The TMB is in essence asking for the power to use administrative subpoenas, which often contain criminal accusations against providers, for searches without probable cause and without the signature of a neutral magistrate.

A subpoena is supposed be written by the person given the ability by law to write and sign it. That person has to sign a sworn affidavit that the facts in the subpoena are true. The subpoena is given to another party who serves it. The person to whom the subpoena is issued can agree to the terms of the subpoena and comply with the request or make the body issuing the subpoena go to court to compel enforcement. If the party receiving the subpoena elects to not comply with it, the issuing agency, in this case the TMB, could then choose to involve the Attorney General's office and go to court to enforce compliance with the subpoena.

The way the TMB issues subpoenas is an unconstitutional mess. Ridiculously, the TMB often serves its own subpoenas. Their subpoenas often are not accompanied by sworn affidavits. These subpoenas are often written instanter (which requires immediate compliance) and without affording providers the right for judicial review. TMB investigators have harassed and intimidated the office staffs of providers telling them that not immediately complying with a subpoena may result in the physician being fined or having his license suspended.

It is illegal for TMB subpoenas to be issued for the criminal investigation of patients, but there is zero oversight on this issue. In fact, the TMB frequently identifies patients engaging in criminal activity with their subpoenas. The TMB has then published said activities along with patient prescribing information which makes it easy for law enforcement to use the PDMP database to identify said patients.

And perhaps worst of all, TMB subpoenas have been signed with forged signatures. In a recent deposition, Mari Robinson, former executive director of the TMB, admitted that she delegated her signature on subpoenas to one of her subordinates. So the TMB technically believes that anyone in their agency, even someone who is illiterate, can affix the executive director's signature to a subpoena.

A federal judge has already ruled that the way the TMB is issuing subpoenas is illegal. This proposal would shockingly make the way the TMB issues subpoenas even more illegal and unconstitutional than they already are.

3.3 Issue 1 – Key Recommendation 4, to "Clarify statute to authorize the Medical Board to inspect an unregistered pain management clinic."

Before the Texas Medical Board expands its power to do profiling of pain clinics, it must establish what a pain clinic is. This exception to pain clinic registration is particularly problematic: a clinic owned or operated by a physician who treats patients with the physician's area of specialty who personally uses other forms of treatment, including surgery, with the issuance of a prescription for a majority of patients.

The board will not officially define what "other forms of treatment" are. What the definition of "other forms of treatment" SHOULD be is any form of treatment the government already pays for with regards to pain management or the use of controlled substances.

The Sunset Report states other forms of treatment have to be offered. At various other times, the board has stated that other forms of treatment have to be performed and then stated at a different time that other forms of treatment have to be performed on a majority of patients.
The board says that it cannot give out advice on whether a doctor should register as a pain clinic as that would constitute legal advice. This fact alone dictates that registering as a pain clinic is more about legal opinion than following the law.

At the current time, the board can currently generate its own complaint, issue its own subpoena and inspect as many charts in a doctor's office as it wishes. The board can also require a medical practice questionnaire be filled out. It does not need any new authority to do inspections of potentially unregistered pain clinics.

What Federal Judge Robert Pitman objected to and declared illegal was not that the board investigated whether Dr. Joseph Zadeh ran an unregistered pain clinic but how the board went about its inspection. It was the board's use of a subpoena instanter, intimidating office staff in a fashion that there was no opportunity to have the subpoena reviewed by a judge, the inclusion of unannounced DEA investigators as part of the inspection, the lack of any attempt showing Dr. Zadeh met an exemption to pain clinic registration, and the inappropriate requesting of billing records to be received instanter.

It should be pointed out that the DEA sets a quota on the number of controlled substances that are allowed to be prescribed per year, and the amount of opioids is going to be massively reduced by 25% to 33% in 2017. Given the current explosion in heroin and fentanyl deaths and grumblings from patients about inadequate treatment of pain, the most prudent and wisest course for the legislature would be to sit back and see what effect this reduction in pain medication is going to have before passing any new legislation.

3.4 Issue 3 – Key Recommendation 4, to "Remove the statutory limitations on the Medical Board's authority to set fees."

According to the Sunset Advisory Commission Staff Report, *"The board collected $43 million in revenue in fiscal year 2015, which is far in excess of what is needed to cover board expenditures. The majority of the revenue originated from licensing and renewal fees, totaling $22.8 million, including more than $16.3 million from the professional fee paid by physicians directly to the General Revenue Fund. Although the Legislature discontinued this professional fee in 2015, the board is still projected to bring in about $12.5 million more from its fees in fiscal year 2016 than budgeted to run the board and pay for employee benefits."*

The mission of the TMB is to protect the public by ensuring quality health care for the citizens of Texas. Given that the current fees resulting in a $12.15 million surplus above the cost needed to service the TMB, it is perplexing as to why there is a recommendation to remove the statutory limitations on the Medical Board's authority to set fees.

3.5 Key Recommendation 1, to *"Adopt the Interstate Medical Licensure Compact (IMLC)."*

An Analysis of the proposed IMLC language done by the American Academy of Physicians and Surgeons concludes that implementation of the IMLC would add an unnecessary layer of bureaucracy to an already overregulated industry, would make "Maintenance of Certification (MOC) a requirement for license renewal and would usurp state licensing laws. All of these actions would increase the cost of both government and medical care while decreasing the number of practitioners. The MOC process alone, will only make money from the certifying process while taking inordinate amounts of time away from practicing physicians with no logical way to increase quality of care. http://aapsonline.org/fsmb-insults-physicians-and-patients-with-attempt-to-defend-power-grab

Physician shortages and rising costs are a byproduct of various government interventions which include an overzealous overreaching medical board. The Interstate Medical Licensure Compact (IMLC) does nothing to address causes of job dissatisfaction found in a 2012 nationwide survey of more than 13,500 doctors. More than 26 percent of physicians have closed their practices to Medicaid patients. More than 52 percent of physicians have limited the access Medicare patients have to their practices, or are planning to do so. Another seven percent plan to switch to cash-only "concierge" practices in which patients pay doctors an annual retainer fee. These responses represent counter-reactions to the growing presence of government intervention in medicine. The Compact does not improve the lives of physicians, nor does it represent a long-term solution to projected shortfalls of 46,100 to 90,400 physicians by 2025. Growing the bureaucracy is never a mechanism for lowering costs, improving access to quality care, or facilitating physicians' ability to care for their patients. If state licensing boards are really serious about improving the quality of medical care, they will begin figuring out how to promote a free market in medical care that attracts more physicians rather than further its declining quality by picking their pockets. http://r.search.yahoo.com/_ylt=A0LEVvqkaFFY40wAJhcnnIlQ;_ylu=X3oDMTE0cmJsMmxtBGNvbG8DYmYxBHBvcwMxBHZ0aWQDRkZVSTNDMl8xBHNlYwNzcg--/RV=2/RE=1481759013/RO=10/RU=http%3a%2f%2fwww.physiciansfoundation.org%2fupload

s%2fdefault%2fPhysicians_Foundation_2012_Biennial_Survey.pdf/RK=0/RS=Ym629uElUvEopOASSn95CUz1slw-

Centralizing medical care options continue a problematic effect seen in a "one-size-fits-all" Standard of Care protocols. Further centralization of medicine protocols through the IMLC poses to present a unilateral control of standard of care.

3.6 Issue 5 – Key Recommendation 2, to "Authorize the Texas Physician Health Program to accept gifts, grants, and donations."

Background: From the Sunset Executive Summary, *"Structure and Few Funding Sources Limit the Texas Physician Health Program's Success. The Legislature established the Texas Physician Health Program in 2009 to provide monitored recovery services to physicians and other Medical Board licensees that have physical or mental health conditions, including substance use disorder. Sunset staff found that while the program is administratively attached to the board, the details of that attachment are unclear, contributing to the program's organizational instability. Staff also found that limited funding sources reduce the program's ability to reach more licensees that have potentially impairing conditions. Requiring the Medical Board and program to establish a memorandum of understanding and authorizing the program to accept gifts, grants, and donations would better position the program to help licensees safely return to practice."*

From the Texas PHP website:
*"**Mission:** The mission of the Texas Physician Health Program (TXPHP) is to protect the health of Texans and to promote medical excellence by serving physicians, physician assistants, acupuncturists, and surgical assistants affected by substance use disorders (SUD), physical illnesses and impairment, and/or psychiatric conditions. TXPHP fulfills this mission by providing education, recognition, and assistance in diagnosis and treatment for physicians, physicians in training, physician assistants, acupuncturists, and surgical assistants (hereafter termed "participants") through a recovery program adapted and monitored according to their specific needs.*
***Vision:** All Texas participants will realize that SUD and psychiatric illnesses, like many other diseases, are treatable conditions, and colleagues who have completed acute treatment, continue ongoing treatment, and are appropriately monitored may have excellent outcomes and possess the ability to practice medicine in their field of expertise safely and effectively. This program strives to provide 'Responsible Advocacy' to participants by fostering a relationship of trust with participants and accountability to the Regulatory Agency (Texas Medical Board) and to the public."*

Problem: The PHP is not required to coordinate with other organizations that may be involved in a particular physician's case and undue hardships may be placed on that physician to meet the requirements of more than one entity (i.e. in the case of a DWI the county has another set of requirements that may be in direct conflict with the PHP requirements). Allowing donations invites conflicts of interest which must be held in check. The TMA has a similar organization, Texas Medical Association Committee on Physician Health and Wellness. According to the

Federation of State Physicians Health Programs the TxPHP already accepts grants and donations as part of their funding. Currently physicians participating in the program are required to pay $1,200 per year for years to the PHP. This does not include the cost of mandated drug testing. Solution: An independent review board should be put in place allowing recourse for the physician should he/she feel conflicts of interest are interfering with the success of the program. This board will review the Texas PHP annually to determine its efficiency. The PHP will be required to provide statistics to the board including number of participants, recidivism, and surveys from physicians. The surveys will be voluntary and anonymous. All donations should be made public on the TMB website and updated monthly. The TMA and TMB will be allowed to donate to the PHP. Other states, such as Alabama and Colorado are funded from their state licensing agencies.

4 RECOMMENDATIONS:

1. The Executive Director and Board Chairman are to practicing physicians.
2. Sunset review every two years to provide for better oversight and serve as an avenue for patient and physician grievances against the TMB.
3. Release of patient's records shall require a court warrant or patient consent.
4. The identities of the expert panelist to be disclosed to defendant.
5. Only complaints from patients or cases of patient harm may be considered confidential.
6. TMB required to provide assistance to physicians when guidance is requested in an attempt to be complaint with rules. No more, "We don't provide legal advice" from the TMB.
7. TMB to provide clarity for compliance with rules. When asked what was specifically considered, *"false, misleading or deceptive"* in an ad, the TMB's response was, "We don't get that specific."
8. Require transparency regarding Freedom of Information Act. The TMB sued the Texas Attorney General's office and Representative Bill Zedler to prevent the release of information regarding communications between Zedler and the TMB that the AG had cleared for release.
9. Replace Informal Settlement Conference with proper peer review using Indiana Compensation Act for Patients (INCAP) model.
10. Six of the physician board seats to be filled by physicians practicing integrative medicine.
11. State Office of Administrative Hearing (SOAH) decision should not be eligible for over rule by TMB.
12. Removal of the restriction to serve on board purely based upon investigative review when no fault was determined.
13. Support the TMA recommendations except for statement "*Ensure that the board does not provide any information directly or indirectly identifying the expert physician reviewer to the physician who is the subject of the review. TMA says revealing a reviewer's identity could discourage physician participation, which the board relies upon heavily."*
14. Oppose Interstate Licensing Compact.

4.1 SAMPLES OF ABUSE –

See Attachments in Email

Example 1:

The only eligible complaints triggering investigations should come from patients or family members who have been harmed. Insurance companies should not have standing to file a complaint. Additionally, if a competitor files a complaint that is clearly malicious, the board should file a complaint against the competitor for unprofessional and anti-competitive behavior. The complainant should have to bear the cost of defense incurred by the subject of the investigation.
Quackwatch – Stephen Barrett and Robert Barratz – serial complaintives
Quackbusters Barrett and Barratz, who have been shown to have malicious intent against CAM practitioners and have lost numerous lawsuits in court, should ABSOLUTELY NOT have standing to file complaints or be expert panelists. (See Quackwatch link below.)
http://r.search.yahoo.com/_ylt=AwrTccaqfVFYu7MA.eQnnIlQ;_ylu=X3oDMTE0cXRuNzI2BGNvbG8DZ3ExBHBvcwM3BHZ0aWQDRkZVSTNDMl8xBHNlYwNzcg--/RV=2/RE=1481764395/RO=10/RU=http%3a%2f%2fquackwatch.org%2f/RK=0/RS=TSAsqIDcJOsxC3vtisk1vXKPVk8-
Nor should either of them EVER be used as an expert witness as Baratz was in the case outlined below. See highlights on page 4 in attachment titled:

HEARING CONDUCTED BY THE
TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS
SOAH DOCKET NO. 503-10-3509.MD
LICENSE NO. F-8432

These people have been using government resources to persecute CAM doctors while the Texas Medical Board (especially Mari Robinson) has knowingly cooperated in these sham investigations. A Perfect example is evident in the attached letter which was written to the medical board by Stephen Barrett, MD (who has no medical license). In this "complaint" dated 12-22-2008 (attached), he accuses Dr. Jesus Caquias of:

- Advertising of a nonaccredited degree
- Advertising of nonrecognized credentials
- False advertising
- Implied claims of superiority
- Inappropriate diagnosis of heavy metal toxicity
- Inappropriate use of chelation therapy to treat autism
- Insurance fraud

Example 2:

HEARING CONDUCTED BY THE
TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS
SOAH DOCKET NO. 503-10-3509.MD
LICENSE NO. F-8432

Dr. Caquias was medical director of Care Clinics in Austin, TX, a clinic that specialized in the biomedical treatment of autism. This complaint resulted in a several years-long investigation which pulled in the FBI and IRS and other agencies. The federal agencies involved confiscated all of Care Clinic's records to investigate them for insurance and tax fraud as Barrett had accused, and effectively the clinic had to be closed. Several years after the ordeal began, and over a million dollars in defense costs, Care Clinics were found guilty of nothing. The question remains, what did this malicious attack cost the taxpayers? In the attached document titled Dr. Caquias was found innocent on all these trumped up charges. (See highlights on pages 12-13.)

Complaints against physicians are often resolved at an Informal Settlement Conference (ISC). Unfortunately, these ISCs commonly do not give physicians a fair and transparent forum to defend themselves:

Sheila Hemphill

#1

TEXAS
RIGHT TO KNOW
MORE UNITES US THAN DIVIDES US

TEXAS MEDICAL FREEDOM

Reclaiming Patient and Physician Rights

RIGHT TO KNOW BRIEF

The *Right To Know Brief* is sample of opinions shared by patients, licensed and unlicensed health practitioners, conventional medicine physicians, and complementary and alternative physicians interviewed by Texas Right To Know in preparation for the December 9, 2016 Sunset Commission hearing regarding the Texas Medical Board. It is the intent of Texas Right To Know to provide the Sunset Commission a report from these interested parties after the public has a chance to submit testimony during the December 9, 2016 Sunset hearing. It is the hope of the interested parties that this effort will receive support and cooperation from the Sunset Commission and House and Senate Legislative Staff to provide the report prior to the Sunset Commissions final recommendations are submitted in January.

The following is a portion in the shared opinions of interested parties regarding OBJECTIONS to assertions and statements contained in the Sunset Staff Executive Summary and OPPOSITIONS to key recommendations put forth in the report. Also contained is a sample of RECOMMENDATIONS forthcoming.

1. OBJECTIONS
   to assertions and statement contained in the Sunset Staff Executive Summary:
   1.1 "*...the Medical Board provided a consistent level of enforcement over those years.*"
   1.2 "*...Sunset staff did not detect any obvious indications of bias in favor or against any type of practitioner.*"
   1.3 "*... the Medical Board has come a long way and generally is a solid model for licensure and enforcement of occupations.*"

2 OPPOSITIONS
   to the following Key Recommendations contained in the Executive Summary:
   2.1 Issue 1 – Key Recommendation 2, to *"Direct the Medical Board to use Prescription Monitoring Program data, along with other factors, to establish a risk-based approach to scheduling pain management clinic inspections."*
   2.2 Issue 1 – Key Recommendation 3, to *"Authorize the Medical Board to seek court enforcement of its administrative subpoenas."*
   2.3 Issue 1 – Key Recommendation 4, to *"Clarify statute to authorize the Medical Board to inspect an unregistered pain management clinic."*
   2.4 Issue 3 – Key Recommendation 3, to *"Clarify statute to authorize the board to conduct fingerprint-based criminal background checks of all applicants."*
   2.5 Issue 3 – Key Recommendation 4, to *"Remove the statutory limitations on the Medical Board's authority to set fees."*
   2.6 Issue 4 – Key Recommendation 1, to *"Adopt the Interstate Medical Licensure Compact."*

2.7 Issue 5 – Key Recommendation 2, to *"Authorize the Texas Physician Health Program to accept gifts, grants, and donations."*
2.8 Issue 6 – Key Recommendation 1 to "*Continue the Texas Medical Board for 12 years."*

3 RECOMMENDATIONS
3.1 Establish a Sub-board for CAM / Integrative Physicians
3.2 Insurance companies should be forbidden from filing complaints.
3.3 Establish an independent three physician review panel to replace Informal Settlement Conferences patterned after Indiana's time-tested model
INCAP (Indiana medical review panel legislation), created as a balance of competing public policy agendas...has met the test of public need (since 1976). Indiana State Medical Association White Paper (2003)
http://www.ismanet.org/pdf/INCAP_White_Paper.pdf

Indiana Review Panel: Explanation

The panel consists of one attorney and three healthcare providers. The attorney acts as chair and has no vote. Both parties (plaintiff and defendant) then agree on a third independent healthcare provider.

The panel renders an opinion as to whether the evidence supports the conclusion that the defendant acted or failed to act within the standard of care. The opinion is non-binding but may be admitted in court. (The panel's opinions are rarely overturned in practice).

The Indiana panel legislative language may be found on pg. 187 of the following pdf file:
http://iga.in.gov/static-documents/3/4/e/f/34efb8e4/TITLE34_title34.pdf