J. Gregory Myers, DDS, JD
Myers-Doyle Attorneys at Law

To: Members of the Sunset Commission of Texas

Texas Medical Liability Trust (TMLT) provides affordable, reliable coverage against medical liability claims for its members. TMLT is a not-for-profit self-insurance trust, established during the medical malpractice crisis of the late 1970's. TMLT is led by a Board of Governors who are elected by TMLT policyholders. Members of the Board of Governors are physicians who draw on their own experience in medical practice to help guide operations.

Today, TMLT has more than 19,000 insureds and covers more physicians in Texas than our next five largest competitors combined. We provide the best protection and benefits to our policyholders, including a strong claim defense, coverage for medical board and other regulatory defense costs, customized risk management, and enhanced policy features.

While we recognize that the Texas Medical Board (TMB) has an important mission of protecting patient safety, many physicians believe that its processes are too inflexible, and in many ways, inefficient. In addition, sometimes more minor issues take resources that should be reserved for areas where patient safety is more likely to be impacted. Some of our concerns include unrealistic deadlines that provide inadequate opportunity for both the TMB and physicians to clarify and respond to complaints, remedial plan restrictions that if modified could enhance their usefulness, some due process issues that need to be remedied, informal settlement conference scheduling issues, and others.

1. **DEADLINES:** The deadlines within which the Board, physicians, and their attorneys must operate are often unrealistic. The Board has only 45 days from the time it receives a complaint to determine if it should be investigated. It is not unusual for the original complaint letter to be very non-specific and since the Board is itself on a short time fuse, they do not have any opportunity to try to get more information before sending a complaint letter to the physician. The physician then receives that often very non-specific complaint, making it at times impossible (or guesswork) for him/her to respond meaningfully. The physician must review the complaint and perhaps voluminous medical records, and respond within 28 days. There is no flexibility in this deadline. (This 28 day deadline is not in the law or rules, but is related to the Board's 45 day deadline to investigate the case.) If the physician was ill or out of the country, or for any other reason was not able to respond timely, the case is automatically sent to a full investigation. In addition, if *the Board* is unable to finish *their* preliminary investigation within 45 days, then the case also goes automatically to a full investigation, requiring the physician to report, if asked, that he/she is or has been under TMB investigation.

Example: one attorney was representing two physicians in the same group for the same patient complaint. The responses were timely filed with the TMB on electronic media. One response was opened and the physician dismissed. The other could not be opened for some technical reason.

The attorney was not advised of this until the 28th day. Within hours, a new CD was delivered to the board. However, that was after the deadline because of the late notice back to the attorney, so that physician was unnecessarily put through a full investigation, which is not only costly and time consuming for the doctor AND the board, but is reportable to credentialing bodies as well. The case was then dismissed. This creates inefficiency and speaks to the need for some level of flexibility.

We would suggest that the Board's deadline be extended and that they have some reasonable amount of flexibility to determine just what the grievance is before sending a complaint letter to the physician, with the stated purpose being to clearly define the complaint and have time to preliminarily investigate it if needed. As it is, and with current deadlines, the doctor, lawyer, and staff often must drop what they are doing to study the medical records, try to figure out what the complaint is about, and attempt to provide a meaningful response. While we agree that we do not want these dragged out for an inordinate amount of time, the Board's current 45 day window is in many cases inadequate, and the result is both unfairly detrimental to the doctors and expensive and time consuming for all. The Board should increase its efforts to provide enough information for the doctor to understand what he/she is being accused of so that a meaningful response can be provided back to the Board. If that information is not available in the complaint received by the Board, rules should require them to follow up with the complainant before sending it to the physician. If a complainant cannot articulate a specific legitimate grievance, then why should the doctor be investigated? Vague complaints can also adversely impact due process (see bullet point 'e' below).

The physician should then have a reasonable amount of time to respond – we would suggest 60 days. With a reasonable amount of time to respond, extensions would rarely be needed, but the opportunity should exist for a showing of good cause. The rule might read: An extension of time shall be requested in writing and be submitted to and received by the TMB at least five business days in advance of the original deadline for which the extension is requested. If requested in writing by the practitioner with written documentation of a previously scheduled engagement, work conflict, court date, agency hearing, or other good cause, and for reasonable cause shown, the TMB shall extend the deadline for 30 days. Notwithstanding the above, nothing shall prevent the TMB and the practitioner from obtaining mutually agreeable deadlines and/or extensions.

2. REMEDIAL PLAN: this plan had its roots in providing a good option for physicians willing to voluntarily accept a plan to resolve issues in qualifying complaints. However, although they are supposed to be non-disciplinary encouraging physicians' acceptance in appropriate cases, the remedial actions are placed on the TMB web site (and are therefore public) for the duration of the physicians' licenses. (Although I did not find it in the Remedial Plan rule 187.9, HB 680 passed in 2011 modifies Section 164.002(c) of the Occupations Code by adding the italics: "An agreed disposition *or a remedial plan under Section 164.0015* is public information.") In view of the current environment where everyone has ready access to the internet and networks are restricting their approved physician lists, this makes the process indeed punitive. They have been, to the Board's chagrin, used against physicians by credentialing bodies. We propose that publication should occur only if the physician fails to satisfactorily complete the remedial plan.

In addition, only one of these plans can be entered into in the physician's entire career. (Rule 187.9 says "(3) A remedial plan may not be issued to resolve a complaint against a licensee if the licensee previously entered into a remedial plan with the board for the resolution of a different complaint relating to a violation of the Act or board rules"). Since a remedial plan can only be entered into with TMB approval, this restriction seems unnecessary and a detriment to efficient resolution of issues where such a plan would otherwise be appropriate.

Another thing about Remedial Plans that often makes them not workable is that they are presented as take it or leave it offers, and they specifically say that they are nonnegotiable in their terms. (Rule 187.9 (f) says "the board may issue and establish the terms of a non-disciplinary remedial plan to resolve an investigation of a complaint.") This arbitrary restriction often results in rejection of the plan, for reasons unrelated to the ultimate goal of encouraging voluntary remedial action. It seems completely unreasonable to refuse to consider modifications that could be agreeable simply because "no modification is allowed" and for no other reason. (I did not find this restriction in the rules.)

We propose that the recommended changes would improve efficiency without sacrificing results. We would also suggest that the attorneys be able to approach the Board early in the process with a remedial plan proposal. This would help avoid the expense of performing an investigation of a situation which clearly qualifies for a remedial plan, such as a physician who has failed to timely provide a patient with a copy of their records. Again, since the Board has the final say, there seems to be no reason not to allow or even encourage this.

3. **DUE PROCESS ISSUES:**

a. Cutting and pasting reports together so that the critical aspects are saved and the exculpatory portions deleted.

b. Withholding exculpatory material from the doctor. TMB ought to conduct itself in a manner of seeking the truth rather than simply seeking to prosecute a doctor. In matters that go to ISC hearings, there are 3 expert reviewers involved when the first 2 reviewers disagree with one another. TMB will produce only the critical reviews and they will not even give the supportive review to the Board's panelists. Much as in a criminal case, and because the physician's career is at stake, the TMB should turn over any exculpatory material in their file so that ultimately the truth can be discerned.

c. The TMB should not suppress evidence or secrete witnesses capable of refuting the complaint. Further, while the practitioner is provided materials obtained by the Board, it could be useful to know what materials were requested, but not obtained. For instance, there may situations where the practitioner is unaware that the patient sought care from an undisclosed treating physician.

d. ISC panel having the discretion to sanction or find violations of Medical Practices Act outside the scope of what has been set forth by the TMB expert reviewers. It is enormously frustrating and more importantly lacks due process when attorneys have spent hours addressing the comments of the TMB's expert reviewers and rebutting them through narrative responses,

applicable literature, and through their own expert, only to have the ISC Panel decide to focus on a point never previously raised or which has been abandoned by the Board's experts and Staff Attorney. There is really nothing the attorney for the doctor can do about it other than either wing it or refuse to discuss it, in which case the panelists can then refuse to recommend a dismissal. There have been times when the doctor was threatened with a separate complaint if he refused to discuss that newly raised issue.

e. While due process is more critical in the context of an ISC, it's also relevant to the initial complaint. If the complaint lacks specificity, the practitioner and his/her attorney may spend a significant amount of time rebutting a tangential issue. Often the initial letters are so vague that it is utterly impossible to respond meaningfully. This is inefficient for the physician and the Board. An effort should be made to define the complaint before notifying the physician. We propose that the rules be amended to allow time and to require it.

f. The identity of the panel is concealed until the moment of the hearing. As in general society, Board panelists are not consistent in their views, their expectations, or how they process information. For example, some prefer a physician to acknowledge any ways that they could have done better, and some will hold the slightest concession against the doctor. Each panel member has his/her own style, disposition and typical areas of questioning, which can differ significantly. Better communication would be facilitated if the physician and his/her attorney were advised who will be on the panel. It is of great importance that the physician knows whether the Board's panelist will be of the same specialty (and subspecialty) as the Respondent physician. This information is critical in order to allow the Respondent physician to tailor their presentation to either a true expert or to a physician who really has no expertise in the specific medical science involved in the case. Therefore, we request physicians be allowed to discover the identity of the panel 2-3 days before the ISC. The physician needs at least 2-3 business days to determine how best to make the presentation meaningful to the specific ISC panel members who will consider the issues.

g. While a large number of cases go away before being even preliminarily investigated, many feel that once the case does go to investigation, investigators and reviewers are geared heavily towards finding the doctor "guilty" of some board rule violation. Some of the more frequently and heavily penalized violations don't even involve patient safety, such as the violation of the death certificate rules or failure to timely notify patients of a change of address. In a recent *Annals of Internal Medicine study* that had its genesis with the Harris County Medical Society and TMA, it was found that during the outpatient care office day, physicians spent 27% of their total time on direct clinical face time with patients and 49.2% of their time on EHR and desk work. The TMB should be heavily weighted towards patient safety issues. On issues that are important but not patient safety related, the most expeditious handling possible should be sought. Examples could include things like billing complaints such as copays and deductibles below a certain threshold.

h. Failing to provide Rebuttal Expert Reports to the physician's attorney until at or shortly before the hearing, giving the attorney no opportunity to analyze and rebut the report.

i. Failing to have panel members of the physicians own specialty on the panel. If the Respondent doctor is a cardiologist, there should be a cardiologist on the panel. Otherwise, the panel members do not have a firm grasp of the presented medical issues and must almost blindly

rely upon the Board's expert report. Some of those experts are not necessarily totally up to date on newest medicine technologies, which can particularly impact physicians practicing the most state of the art medicine or in some cases, alternative medicine. There are certain situations where a sub-specialty is needed. For example, consider a Board action involving retinal care. A general ophthalmologist is ill-suited for the case. The panel member needs expertise in the particular issue.

j. In section 3 of HB 680 passed in 2011 {referring to Section 154.057 (b)}, it says that "The board shall complete a preliminary investigation of the complaint not later than the 45th day after the date of receiving the complaint" (changed from 30th day). Later in the paragraph it says "If the board fails to complete the *preliminary* investigation in the time required by this subsection, the board's *official* investigation of the complaint is considered to commence on that date." (emphasis added) So if they don't finish their preliminary investigation it goes to official investigation...that seems unfair in the sense that if the doctor is late he/she faces consequences but if the board is late, then the physician also faces the consequences. This is proven by the many "investigation" letters some physicians have received over the years that state "if you haven't sent your narrative response, please do so at this time"– proving they have yet to even see if the doctor sent one or not. The fallback position by the TMB has always been to open an investigation when they have failed to review a case. If the Board needs additional time, then the rules should be changed to allow it, but the allowance should not be unilateral.

4. SCHEDULING ISSUES/CONFLICTS: ISCs are unilaterally scheduled by the Board without any input from the doctor or his/her lawyer. It is very difficult to reschedule an ISC due to conflicts of either the physician or the attorney. It is the Board's position that attorney conflicts are rarely a sufficient reason to reschedule an ISC, typically claiming that another lawyer from the same firm can handle the proceedings. It is unfair to force physicians to turn their cases over to attorneys they may not know or trust, on a matter that potentially impacts their license to practice medicine. In addition, any attorney who is a solo practitioner would have difficulty doing Board work. On the other hand, the Board can reschedule the hearing at will. While it is understandable that the Board needs some certainty with its schedule, cooperation in scheduling would be more fair and efficient.

5. CHART MONITORING: The frequently recommended sanction of Chart Monitoring, while in theory a good idea, has many problems. It is exceptionally and expensive and lengthy process which we believe could be improved and streamline for more efficient and effective outcomes. The process itself can also be self-perpetuating in that the chart monitors often find and report other issues that are then used as a basis for a new complaint. The chart monitoring program should have as its goal better patient care and not be utilized as a conduit for further punitive action. The difficulties and issues with chart monitoring are frequently an obstacle in having the respondent doctor voluntarily agree to any order which contains such a provision. This is a frequently encountered problem, which, if corrected, could encourage physicians to accept this remediation voluntarily and early in the process. We are not trying to suggest that the issue is not important-only that we should look for a way to make the improvement process more effective and less punitive.

One suggestion is that the time period be based on how the doctor responds, with the possibility of one more session perhaps at a later date (perhaps one year later) to be sure he/she is still complying. As an example, some physicians are being monitored for pain medicine prescriptions, long after they have decided to quit prescribing those drugs, so they have months and months (or longer) of monitoring for something they are no longer doing. Some feel that the monitoring net is cast too wide and would be more effective if done with more precise focus. In many cases, the chart monitoring could be first assigned to a nurse, PA, or nurse practitioner for review. The charts should be reviewed specifically for the items at issue and only expanded on significant issues found that could impact patient health and safety. After their review, the nurse/physician extender could send the physician monitor the culled down files/entries and their recommendations. The physician monitor would give the final recommendation to the Board.

We understand that many reviews these days are related to pain medication prescribing, and suggested that the Board could administratively review the PDM web site where prescription data is entered. Then they could order the specific charts where pain meds were prescribed. Additionally, where physicians no longer prescribe these meds, they could see that administratively and avoid a long and expensive, yet unnecessary process. With regard to EMRs, one of the main charting issues arises out of cutting and pasting. This is certainly something that a nurse, physician extender, or even risk manager could potentially work on at least initially.

6. TEMPORARY INACTIVE LICENSE STATUS FOR MEDICAL REASONS: A provision is needed which would allow for a medical license to be placed in an inactive status, for non-substance abuse medical problems, which does not require a physician to take a full retirement of a license. Currently, a physician who participates in a long term rehabilitation program must take a medical retirement or an agreed order of suspension. The proposed inactive status would be a non-disciplinary, self-explanatory process that avoids the stigma and hassle of a suspension or full medical retirement because the physician is temporarily physically unable to practice. An example would be a physician injured in an automobile accident who has to go through extensive rehabilitation to regain the ability to practice. Perhaps a surgeon may not be able to return to the OR, but could still have a non-surgical practice. One highly credentialed physician with a medical problem requiring rehab voluntarily relinquished his license as required. Afterwards, he wanted to return to do pro bono work at a charity clinic but could not because of the difficulty of getting licensed again. The Board would retain control but have the ability to restore that valuable resource to society once a physician has been sufficiently rehabilitated.

7. ALTERNATIVE AND CUTTING EDGE MEDICINE: The Board is not fully accepting of or prepared to assess new or alternate forms of therapy. Some have commented that board experts can be 10-15 years behind in current medical advances. The panel expert reports typically cite to old literature or textbooks, which preach traditional concepts taught in medical school. There is little latitude given to more unconventional or alternate therapies, even though there is a specific rule which now addresses this. Specifically, Rule 200 of the Texas Administrative Code has, pursuant to §200.1, the following as its stated 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 therapy they offer their

patients. The Board also recognizes that patients have a right to seek complementary and alternative therapies.

Notwithstanding the above, the Board, in the view of some, gives little latitude to physicians providing therapy which it does not consider to be main stream. Whether it is prescribing bio-identical hormones or alternate cancer therapy, the Board seems to have little tolerance for these types of treatments, even when the evidence shows that they have provided patient benefit, and there are no other effective therapies available. The Board should more proactively recognize that medicine evolves and that doctors should be allowed to provide alternate or unconventional therapy, *particularly when a patient has fully consented thereto.*

Allowing the practitioner some discretion as to therapy is critical. For instance, one attorney told of a case in which the complaint proceeded to the investigative phase partly because the Board was unfamiliar with off-label use of a particular medication. While a dismissal was ultimately obtained, it appeared that the Board panel expert was not aware of newly published studies that established the efficacy of the prescribed drug.

8. **Limitation on the time period that Agreed Orders stay on the Board's website.** With possibly some exceptions related to serious misconduct, physician board rule violations, once corrected, should not be punishable for the duration of the physician's license. Once the physician has complied will all corrective measures, perhaps there should be a showing that the physician is still complying for a specified period of time before the matter goes off the site. Lifetime punishment seems excessive for all but the truly serious infractions.

9. **Require that everything the Board wants to use at SOAH be provided to the physician in the ISC packet**, so the physician ("client") can weigh if they want to go to SOAH, based on all the evidence the Board has at the time. While the Board may discover more evidence after the ISC and prior to SOAH, it's unfair for the Board to withhold such evidence at the ISC stage, but then bring it forward at SOAH.

10. **Delay in ability to appeal a Temporary Suspension -** Once physicians get temporary license suspensions, they must wait for the SOAH case on the underlying allegations to conclude, plus getting a final order from the Board, they can appeal the TS to Travis County District Court. This can take 15-18 months. Thus, TS puts a physician out of work, even if the Board loses at SOAH and the TS goes away. Other agencies are required to take the allegations forming the TS case to SOAH within 15-30 days. But the Board waits months sometimes. We recommend that temporary and emergency License restrictions go immediately and promptly to SOAH.