Texas State Board of Medical Examiners
Texas State Board of Physician Assistant Examiners
Texas State Board of Acupuncture Examiners

Agency at a Glance

To ensure that Texans receive safe and quality medical care, the Texas State Board of Medical Examiners, Texas State Board of Physician Assistant Examiners, and Texas State Board of Acupuncture Examiners regulate medical practitioners in Texas. The State first began regulating the practice of medicine in 1837, when the Legislature created the Board of Medical Censors. In 1907, the Legislature passed the Texas Medical Practice Act and established the Medical Board to regulate physicians. In 1993, the Legislature passed the Physician Assistant Licensing Act and established the Physician Assistant Board. Also in 1993, the Legislature created the Acupuncture Board and began regulating the practice of acupuncture in Texas. The boards' main functions include:

For additional information, please contact Meredith Whitten at 512-936-2692.

- licensing qualified physicians, physician assistants, acupuncturists, and surgical assistants;
- issuing permits to and certifying other providers of medical care, such as physicians-in-training, acudetox specialists, and nonprofit health-care entities;
- investigating and resolving complaints, and taking disciplinary action when necessary to enforce the boards' statutes and rules; and
- monitoring compliance with disciplinary orders.

Key Facts

- **Funding.** In fiscal year 2004, the agency operated with a budget of $8,324,346, about a 50 percent increase over the fiscal year 2003 budget. This increase is due to additional funding the agency received for its enforcement efforts. These additional funds come from an $80 surcharge paid by each licensed physician. In addition, the agency collected about $25 million in professional and licensing fees and fines in fiscal year 2004. All agency costs are covered by licensing fees collected from the professions.
- **Staffing.** The agency has a staff of 133 employees, with 105 based in Austin and 28 based in field offices throughout the state.
- **Licensing.** The boards regulated 55,993 physicians, 6,544 physicians-in-training, 3,453 physician assistants, 693 acupuncturists, and 259 surgical assistants in fiscal year 2004. These numbers include 2,338 new physician licenses, 2,492 new physician-in-training licenses, 380 new physician assistant licenses, 80 new acupuncturist licenses, and 96 new surgical assistant licenses issued that year.

- **Enforcement.** The boards received 6,090 complaints in fiscal year 2004. Of these, 1,900 were jurisdictional. That year, the boards resolved 1,755 complaints, with 287 resulting in sanctions against a licensee.

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Agency Head

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Recommendations

1. Require the Board to Provide Stakeholders With Meaningful Opportunities for Input Into the Rulemaking Process.
2. Update the Boards' Licensing Process to Ensure Fair, Consistent Decisions.
3. Provide Further Improvements to the Medical Board's Investigations Process to Better Protect the Public.
4. Define Clear Roles, Responsibilities, and Authority for the Boards' Informal Hearings Process.
5. Clarify the Language Regarding the Use of Peer Review Documents in Formal Hearings by the Board and the State Office of Administrative Hearings.

6. Ensure That Private, Nondisciplinary Rehabilitation Orders Provide Adequate Public Protection.

7. Require Physicians Who Use Moderate Sedation in Outpatient Settings to Comply With the Board's Safety Requirements.

8. Strengthen the Acupuncture Board's Licensing and Enforcement Authority, and Clarify That the Board Does Not Approve Acupuncture Schools.

9. Provide the Medical Board With a Streamlined, Flexible Process for Regulating Prescriptive Delegation Authority.

10. Conform Key Elements of the Boards' Licensing and Regulatory Functions to Commonly Applied Licensing Practices.

11. Prohibit Medical Board Members From Using Information Obtained Through Their Duties for Personal Gain.

12. Require the Medical Board to Publish Updated or Corrected Disciplinary Actions.

13. Clarify the Medical Board's Authority to Modify a Proposal for Decision Received From the State Office of Administrative Hearings.

14. Continue the Medical Board for 12 Years and Eliminate the Separate Sunset Dates for the Physician Assistant and Acupuncture Boards.

Issue 1

Limited Stakeholder Involvement Affects the Boards' Rulemaking and Policymaking Processes.

Key Findings

- The Medical Board's rules define how it regulates the practice of medicine in Texas and enforces statutes regarding physicians, physician assistants, and acupuncturists.
- The Board's limited use of stakeholders in rule development, or in efforts to publicize adopted rules, hampers its ability to make sound regulatory decisions.
- The Board's public hearings process does not provide meaningful opportunities for public comment or an adequate record of deliberations.
- Other state agencies have developed more effective processes for soliciting stakeholder input during rule and policy development.

The rules adopted by the Texas State Board of Medical Examiners have an impact on a variety of stakeholders. These stakeholders – including licensees, educators, other health-care practitioners, hospitals, and other state agencies – have a vested interest in providing input and feedback to the Medical Board as it develops its rules. As such, the Board could be more active in reaching out to stakeholders when developing rules. While some responsibility lies with stakeholders to participate in the rulemaking process, the Board could also provide more opportunities for stakeholders to address the Board with their concerns. The Medical Board also has oversight over the Physician Assistant and Acupuncture boards' rulemaking process, but has not clarified the process for the public to provide comments regarding issues related to these two boards. As a result, the public does not have meaningful opportunities for input and interaction with the boards, and the boards

have a limited ability to make well-informed decisions, address stakeholder concerns, and efficiently establish rules and policies.

Recommendations

Change in Statute

1.1 Require the boards to develop guidelines for the early involvement of stakeholders in its rulemaking process.

The boards would develop a process for providing stakeholders with the opportunity for a stronger role in the development of rules, before formal proposal in the *Texas Register.* Allowing stakeholders who would be most affected by a proposed rule to provide advice and opinions earlier in the process would result in better rules that take the perspectives of all license groups into consideration. Because the Physician Assistant and Acupuncture boards do not have independent rulemaking authority, the Medical Board would approve the boards' proposed rules. However, because the debate and detailed discussion related to physician assistants and acupuncturists occurs at these boards' meetings, the Physician Assistant and Acupuncture boards should seek stakeholder input when developing rules to propose to the Medical Board. In addition, the Board would accept comments regarding rules recommended by the Physician Assistant and Acupuncture boards when those rules are being considered by the Medical Board. Once the Medical Board receives input, it would still publish the proposed rules according to the Administrative Procedure Act, and allow the public an opportunity to oppose the rules or suggest alternatives during the comment period. Each board should use its judgment in determining which issues would benefit from early stakeholder involvement, as the boards would not need to seek input on every proposed rule.

Management Action

1.2 The Board should withdraw or repeal rules it does not intend to enforce.

The Board should withdraw proposed rules or repeal adopted rules that it does not intend to enforce while negotiating with stakeholders. The Board should withdraw or repeal these rules in a timely manner so that licensees and other stakeholders would have a clear understanding of the Board's regulatory requirements and so that the Board effectively enforces its statutes and Board rules.

1.3 The Board should ensure that the public has an opportunity to testify or appear before the Board.

This recommendation would provide the public with a reasonable opportunity to address the Physician Assistant and Acupuncture boards at a public meeting. The boards would set deadlines for interested parties to provide notification of their intent to appear *after* the meeting agendas have been made public and would allow individuals to testify if good cause exists for why they did not notify the boards. This change would allow individuals to make an informed decision about whether they want to appear, and would enable the boards to adequately plan for the amount of public testimony they will receive at meetings.

1.4 The Board should consider recording Board subcommittee and full Board meetings.

Although by publishing meeting minutes the Board complies with record-keeping provisions in the Administrative Procedure Act, the Board should consider recording meetings of full Board and subcommittee meetings for the Medical, Physician Assistant, and Acupuncture boards. Because of

the complex nature of many issues discussed by the boards, audio recordings of the debates and activities at these meetings would provide each board with a more complete record of the board's decisions.

1.5 The Board should notify stakeholders of adopted rules.

The Board would develop a better process for notifying identified stakeholders or individuals who have expressed interest in certain issues addressed by any of the boards when rules that relate to their areas of interest have been adopted. While some onus is on stakeholders to stay abreast of the Board's policies and rules, taking steps to inform stakeholders about new rules would improve the likelihood that stakeholders are aware of new and updated rules.

Issue 2

Some of the Boards' Licensing Processes Lack Structure Needed to Ensure Consistent Decisions.

Key Findings

- The Medical, Physician Assistant, and Acupuncture boards assess all candidates for licensure to ensure that the public will receive quality medical services.
- Lack of guidelines for evaluating applicants' mental and physical health disorders may cause inconsistent decisions, place undue burden on applicants, and result in less public protection.
- Provisions in the Medical Practice Act regarding exam attempts treat applicants inconsistently.
- The Medical Board has no options for licensing physicians who want to practice medicine strictly in an administrative setting.

Through their licensing decisions, the Medical, Physician Assistant, and Acupuncture boards ensure that only qualified medical professionals practice in Texas. However, because the boards have not established standards to guide their licensing decisions, some of the boards' licensing policies may place an undue burden on applicants and could result in inconsistent licensing decisions. Additionally, provisions regarding exam attempts in the Medical Practice Act treat applicants inconsistently, and may allow less qualified applicants to get licensed. Finally, the Medical Board lacks options for licensing physicians who want to practice medicine only in an administrative setting and an institutional medical license for foreign medical graduates.

Recommendations

Change in Statute

2.1 Require the boards to develop guidelines, by rule, for evaluating applicants' mental and physical health disorders.

The Medical, Physician Assistant, and Acupuncture boards would eliminate the practice that self-reported or other diagnosis of a psychiatric or medical disorder alone serve as a stimulus for an independent medical or psychiatric examination. Instead, the circumstances for evaluations would also be based upon mutually agreed-upon guidelines for evaluating mental and physical health, alcohol and substance abuse, and professional behavior problems, developed by each board with its

associated stakeholders. When developing the rules, the boards should avoid requiring applicants to meet with a specific type of physician to conduct an evaluation, unless medically indicated, or to undergo evaluations outside the city in which they work or live. Exceptions could be established for applicants who live in an area with a limited number of physicians to ensure that an applicant would receive an evaluation from someone other than a treating physician.

2.2 Eliminate the medical licensing exam attempt exceptions from the Medical Practice Act and clarify the number of exam attempts for doctor of osteopathy applicants.

This recommendation would remove from the Medical Practice Act the current exceptions to the number of allowed licensing examination attempts. All applicants would be required to complete each of the three licensing exam sections within three attempts, within seven years of passing the first examination section. For doctor of osteopathy applicants, the number of exam attempts would not apply separately to the Comprehensive Osteopathic Medical Licensing Examination and the U.S. Medical Licensing Examination. The Board would establish by rule the combination of examination section attempts for both of the exams that would satisfy licensure eligibility requirements, thus ensuring that a doctor of osteopathy applicant has the same number of exam attempts as a doctor of medicine.

2.3 Authorize the Medical Board to award a limited license for the practice of administrative medicine.

The Board would be able to award a medical license limited in scope to the practice of administrative medicine, obviating the need to use a nondisciplinary order as part of the license. Physicians would still need to meet licensing requirements, such as education and examination qualifications, fee payment, and continuing medical education, to receive a limited practice license, as specified in Board rule. Any physician wishing to practice clinical medicine after being on a limited license would need to prove clinical competence to practice, including the passage of any examinations the Board deems necessary to test fitness to practice.

2.4 Authorize the Medical Board to issue an institutional medical license to foreign medical graduates.

The Board would issue and renew an institutional medical license to any foreign medical graduate who has extensive and verifiable specific academic or clinical qualifications and achievements, as long as the individual has been recommended, endorsed, and specifically requested by the president or dean of an accredited Texas medical school. The license would remain valid as long as employment as a physician at the requesting medical school continues.

Management Action

2.5 The Medical Board should work with residency programs and other stakeholders when developing guidelines for evaluating applicants' risk for behavior likely to result in poor practice.

This recommendation establishes a working group comprising representatives from the Medical Board and Texas Graduate Medical Education programs to develop guidelines for evaluating applicants' risk for behaviors likely to result in poor medical practice and problems requiring action by the Board. The Physician Assistant and Acupuncture boards would also consult with stakeholders when developing guidelines to identify behaviors that would result in applicants' poor professional practice and problems requiring board action.

Issue 3

The Medical Board's Investigations Process Needs Further Improvement to Better Protect the Public.

Key Findings

- The Board's investigation process has changed as a result of recent legislative directives.
- Limitations in the way the Board uses its experts and protects them from legal challenge threaten the quality of standard-of-care reviews.
- The Board lacks clear direction with regard to meeting its investigation time frames.

With statutory directives and additional resources provided by the Legislature in 2003, the Medical Board's investigation process has significantly improved. The Board has implemented all of the required provisions, including a 180-day deadline for complaint investigations, the development of a pool of nearly 400 expert panelists to assist the Board with complaints regarding medical competency, and a system for prioritizing quality of care, impaired physician, and sexual misconduct cases. Further improvements to the Board's investigation process would help maintain the quality of standard-of-care reviews by Board experts, and ensure timely completion of investigations in accordance with the Legislature's directives.

Recommendations

Change in Statute

3.1 Require the Board to use at least two expert panelists for each standard-of-care investigation.

The Board would be required to get a review from at least two expert panelists before recommending a case be dismissed, as it currently does for cases in which the first reviewer finds that a standard-of-care violation has occurred. Doing so would prevent cases from being dismissed on the basis of one expert panelist's opinion. Using two expert panelists would require cases currently reviewed by just one panelist to be sent to a second, and possibly a third, panelist in instances when the first and second panelist disagree as to whether a standard-of-care violation occurred.

3.2 Direct the Board to develop additional qualifications and service restrictions for its experts.

The Board would adopt rules to address the length of time that a physician may serve as an expert panelist, develop grounds for removal from service, establish how experts should handle conflicts of interest related to standard-of-care cases, and establish the random selection of expert panelists for quality-of-care cases. To serve, experts also must have necessary expertise and clear a conflict-of-interest review. Grounds for removal from service would include being repeatedly delinquent in reviewing complaints and submitting reports to the Board.

3.3 Clarify the legal protections of Board expert panelists and consultants.

Providing expert panelists and consultants immunity from suit and judgment would help ensure that the Board is able to secure physicians to assist it in the evaluation of medical competency cases, as required by the Medical Practice Act. Protections should not apply in situations where services provided to the Board were fraudulent or with malice. Additionally, statute would clarify that expert

panelists and consultants are represented by the Office of the Attorney General in the event of a lawsuit related to good-faith services provided to the Board.

3.4 Authorize the Board to use up to 30 days to evaluate incoming complaints.

Authorizing the Board to use up to 30 days to evaluate complaints, before complaints are officially filed, would allow the Board to dismiss nonjurisdictional and frivolous complaints. If the Board takes more than 30 days to conduct this initial review, the 180-day deadline to complete investigations would start. Dismissing nonsubstantive complaints would ensure that agency resources get directed to cases more likely to result in a violation of the Medical Practice Act.

3.5 Clarify the consequences of not meeting the 180-day investigation requirement.

The Board would be required to notify all parties to a complaint if, for any reason, an investigation extends beyond the 180-day deadline. Investigations going beyond 180 days should also be reported, along with reasons, in the Board's annual report to the Legislature, in addition to listing cases more than one year old. Additionally, statute should clarify that complaints may not be dismissed solely because they have not been set for a hearing within 180 days.

3.6 Require the Board to develop additional definitions of good cause for extending an investigation.

Requiring the Board to further define good cause in rule would lead to a better understanding among staff, licensees, and the public of the reasons a Board investigation may go beyond 180 days. The Board should include internal circumstances that may affect an investigation's time line, such as the extended illness of a staff investigator or an expert panelist's delinquency in reviewing and submitting a report to the Board.

Management Action

3.7 The Board should make an effort to use more expert panelists who reside outside the Austin area.

The Board would avoid repeated preferential selection of expert physician panel members by developing, by rule, the method for which it would rotate through the expert physician panelists, taking into account issues such as a lack of experts in a particular specialty or a high number of complaints. In all instances, the Board would still match the respondent's specialty to that of an expert panelist.

Issue 4

The Boards Have Not Established Clear Guidelines to Govern the Informal Hearings Process.

Key Findings

- The boards resolve many disciplinary cases through informal hearings.
- The roles of staff and panel members in hearings has not been defined.
- The role and responsibilities of the District Review Committees are not clear.

- The composition of the boards' informal hearing panels does not ensure balanced representation.
- The boards are limited in their ability to quickly resolve nonmedical complaints.
- The boards inappropriately consider complaints that have not resulted in sanctions.

The informal hearings process is a key part of the Medical, Physician Assistant, and Acupuncture boards' enforcement process, as the majority of the boards' disciplinary actions result from informal hearings. Board members, staff, and other designated participants play significant roles in these hearings. However, the roles and responsibilities of these participants, as well as the makeup of the panels that hear complaints at the informal hearing level, have not been clearly defined. In addition, staff does not have authority to handle administrative, nonmedical complaints, resulting in some complaints unnecessarily going through the informal hearings process.

Recommendations

Change in Statute

4.1 Clarify the roles and responsibilities of participants in informal hearings.

The roles and responsibilities of informal hearings participants – including board members, District Review Committee (DRC) members, and all appropriate staff – would be defined in statute to ensure fairness and consistency in the process. The Medical, Physician Assistant, and Acupuncture boards would ensure that all participants are aware of their required tasks, as well as their limitations during informal hearings.

4.2 Clarify the District Review Committees' role in statute.

This recommendation would clarify that DRC members assist the Medical Board in the informal settlement conference process. The Medical Board would retain authority to adopt rules assigning additional duties to the District Review Committees, as long as the rules do not conflict with other statutory provisions.

4.3 Clarify eligibility requirements and establish conflict of interest, grounds for removal, and training requirements for District Review Committee members.

Statutory provisions for conflict of interest, grounds for removal, and training that apply to Medical Board members would be reflected for DRC members as well. In addition, physician members who serve on the District Review Committees and are involved in standard-of-care cases would be required to meet the same qualifications, as defined by the Medical Board, as physicians who serve on the Board's expert physician panel.

4.4 Require at least two panelists in all informal hearings.

A minimum of two panelists – including at least one physician – would serve on all informal settlement conference panels that deliberate on disciplinary cases to determine if a violation occurred. However, if a respondent waives this requirement, the boards may conduct the informal hearing with one panel member. Physician panelists must have qualifications comparable to physicians serving on the Medical Board's expert physician panel. This recommendation would also apply to informal hearings requesting a modification or termination of an order, but does not apply to hearings for showing compliance with a Board order.

4.5 Require the boards to include one public member in the informal settlement process.

The boards would include at least one public member in their informal settlement conferences. These conferences help the boards determine whether a violation occurred and what action to take, and therefore should always include public membership to ensure consumer interests are properly represented in the enforcement process. For the Medical Board, the public member could be a Board member or a member of one of the District Review Committees.

4.6 Increase the number of public members on the District Review Committees.

This recommendation would add two additional public members to each District Review Committee, bringing each committee's composition to seven Governor-appointed members – three doctors of medicine, one doctor of osteopathic medicine, and three public members. Because DRC members' primary role is to serve on informal settlement conference (ISC) panels for the Medical Board, increasing the number of public members on the District Review Committees would provide the Board with a larger pool to draw from for informal hearings without increasing the size of the Medical Board.

4.7 Authorize staff to settle nonmedical complaints.

Staff would have authority to resolve cases involving nonmedical and administrative violations, subject to delegation by the boards. Staff would dismiss these complaints, subject to review by the boards at their public meeting, or refer the matter directly to a settlement conference. Staff would recommend enforcement action, which the licensee could accept or reject. The boards would retain final decisionmaking authority over the staff's recommendations, and the licensee would always retain the right to request that the case be heard at an informal settlement conference.

4.8 Require the Board to provide licensees scheduled for an informal hearing with information regarding the grounds for the hearing.

The Medical Board would provide licensees with the information used by the Board as the basis of a complaint for which an informal hearing has been scheduled. The Board must provide this information at least 30 days before the informal hearing, unless the Board shows cause for the delay. If the Board does not provide the information to the physician at least 30 days before the hearing, the licensee may use the delay as grounds for rescheduling the hearing.

Management Action

4.9 The boards generally should not consider previously dismissed complaints when deliberating on disciplinary actions.

Although previously dismissed complaints are maintained in a licensee's record, the boards should not consider them when deliberating on a current complaint, except when the nature of previous dismissals involves a similar type of complaint that is relevant to the current complaint. However, informal hearing panel members would continue to be able to consider a licensee's previous history of all *violations* when determining sanctions for a current violation.

4.10 The Medical Board should improve its communication with District Review Committee members.

The Medical Board should develop a more formal, consistent process for communicating with District Review Committee members. Because DRC members play a significant role in the Medical Board's

informal hearings process, they could benefit from receiving timely updates regarding the ISCs in which they participated. Providing information such as the Board's final decision on a case, the results of a SOAH hearing, and the reasons for any modifications to an ISC panel's recommendation would allow DRC members to have a better understanding of the Board's priorities, the level of evidence needed to indicate a violation of statute or Board rules occurred, and the appropriate sanction level for types of violations.

4.11 The Medical Board should require at least one member from each informal settlement conference panel to attend Board meetings.

The Medical Board should require at least one member from an ISC panel to attend the full Board meeting when a case the panel heard is on the agenda. This would ensure that the Board members who did not serve on the ISC panel are able to get a complete picture about the case, including how the panel arrived at its decision. In the event that only DRC members sat on the ISC panel, the Board should require the panelists to either attend the full Board meeting or be available via teleconference. This recommendation does not require that a Board member attend each ISC.

4.12 The Medical Board should adopt rules to prohibit communication between Board members and staff regarding open enforcement cases.

Under this recommendation, the Medical Board would establish rules prohibiting ex parte communication between Board members and agency staff regarding enforcement cases actively under consideration by Board members, including while the case is at the State Office of Administrative Hearings.

4.13 The Medical Board should attempt to resolve enforcement cases informally.

The Medical Board should make a good-faith effort to resolve complaints through the informal hearings process before proceeding with a contested case at the State Office of Administrative Hearings.

Issue 5

The Board Cannot Enforce Provisions of the Medical Practice Act Relating to Medical Peer Review.

Key Findings

- Peer review actions against a physician are grounds for disciplinary action by the Medical Board.
- Statute is not clear on the Board's authority to use peer review information in disciplinary hearings, causing the Board to miss an opportunity to discipline physicians for violations of the Medical Practice Act.

Medical peer review provides a valuable process for physicians and other health-care practitioners to monitor and evaluate physicians' qualifications, professional conduct, and patient care. As the professionals who work most closely with a physician, other licensed physicians and medical staff have the best opportunity to identify known or suspected problems and to make recommendations to improve the quality of medical care.

The Medical Practice Act requires a health-care facility or medical peer review committee to report to the Medical Board certain adverse actions taken against a physician's privileges to practice because

of unprofessional conduct or professional incompetence that was likely to harm the public. Such actions are to be considered violations of the Medical Practice Act, subject to discipline by the Medical Board, upon finding that the actions were appropriate and reasonable. However, the Board has difficulty enforcing these provisions because statute does not clearly allow the Board to disclose peer review documents in a contested case hearing.

Recommendations

Change in Statute

5.1 Clarify the Board's ability to disclose peer review documents in disciplinary hearings, subject to confidentiality at the Board and at the State Office of Administrative Hearings.

This recommendation would clarify that the Board's current authority to disclose peer review documents in disciplinary hearings extends to formal contested case hearings before the State Office of Administrative Hearings (SOAH). It would also clarify that peer review documents shall remain confidential at the Board and at SOAH. Although the Board would be able to disclose peer review documents at SOAH, peer review documents would not be available for discovery or court subpoena and may not be introduced into evidence in any action for damages, including a medical professional liability action.

5.2 Clarify that medical records otherwise available are not confidential.

This recommendation would clarify that records, such as a patients' medical records, that are available to the Board through means other than a peer review committee's records are not privileged and confidential, even if the medical records are used in peer review proceedings.

5.3 Clarify the scope of the hearing, standard of review, and burden of proof for formal disciplinary proceedings in which peer review action is the sole ground alleged for disciplinary action.

This recommendation would provide guidance to administrative law judges at the State Office of Administrative Hearings in determining whether an action taken by a peer review committee was appropriate in contested cases where peer review action is the sole ground alleged for disciplinary action. Guidance would also include how SOAH should evaluate peer review documents that support the committee's action.

5.4 Clarify that the appropriate use of peer review information in contested case hearings at SOAH is the basis for the opinion of an expert witness called by the Board.

Peer review action would be one element of proof in a contested case, as it would not serve as a substitute for required evidentiary proof of the facts supporting the alleged violation. Members of the peer review committee would not be subject to subpoena or discovery in the contested case hearing at SOAH.

5.5 Direct the Medical Board to investigate complaints regarding misuse of the peer review process.

The Medical Board would have clear authority to review complaints regarding misuse of the peer review process, including fraud and malicious conduct. The Board would investigate these complaints the same way it handles other complaints.

Issue 6

The Medical Board's Private Rehabilitation Order Does Not Adequately Provide Public Protection.

Key Findings

- The Board issues rehabilitation orders to applicants and licensees with impairment issues.
- The use of private rehabilitation orders does not protect the public when it shields standard-of-care violations.
- The role of county medical societies and other professional organizations in the Board's compliance program is unclear.
- Other health licensing agencies' rehabilitation orders provide better public protection.

Both the Legislature and the Board have established addressing impaired physicians as a priority. To encourage practitioners to report their impairment, the Board offers private, nondisciplinary rehabilitation orders to applicants and licensees who meet certain requirements. However, the Board may issue a private order to a physician, even if that physician also violated the standard of care. As a result, the public's knowledge of the violation is limited. While private rehabilitation orders serve as a valuable incentive to seek treatment for impairment, the Board should limit use to those physicians who have not harmed the public by violating a standard of care. Also, while professional organizations can serve as a significant resource in the Board's efforts to monitor a physician's rehabilitation, the Board does not provide clear direction to these entities. As a result, these organizations may be unsure of the Board's expectations, thus affecting the Board's ability to ensure that impaired physicians get needed treatment and to accurately monitor licensees under rehabilitation orders.

Recommendations

Change in Statute

6.1 Restrict nondisciplinary rehabilitation orders to impaired physicians who have not also violated the standard of care.

Applicants and licensees with a current condition or history of substance or alcohol abuse would be eligible for a private, nondisciplinary order only if the licensee has not violated the standard of care as a result of the impairment. If the Board receives a valid complaint related to the physician's impairment before the physician signs an agreed private rehabilitation order, the physician is not eligible for the private order. In addition to physicians, this recommendation would also apply to physicians-in-training, physician assistants, acupuncturists, and surgical assistants.

6.2 Require the Board to define the roles and responsibilities for professional associations in rehabilitation orders.

The Board would clarify its expectations of county medical societies and other professional associations in a physician's rehabilitation. Among other things, the Board should clearly state the type of information to be reported, the frequency of the reports, and the format the association should use to submit the reports to the Board, and any other relevant requests. This recommendation would

also apply to surgical assistants licensed by the Medical Board, and licensees of the Physician Assistant and Acupuncture boards.

Issue 7

Exemptions From Office-Based Anesthesia Regulation Potentially Place the Public at Risk.

Key Findings

- The Medical Board regulates physicians' use of anesthesia to ensure the quality and safety of office-based surgery.
- Lack of regulation of moderate anesthesia places the public at risk of bodily injury or death.
- Exempting physicians from regulation of moderate sedation is inconsistent with other Texas health-care practices and other states' medical practice laws.

Because the volume and complexity of surgical procedures performed in outpatient settings has increased, the Medical Board regulates physicians who provide office-based anesthesia to ensure public safety. Physicians who administer office-based anesthesia must register with the Board and follow strict safety guidelines regarding anesthesia administration, including the maintenance of emergency supplies and equipment and transportation agreements with local emergency services. Several exemptions to regulation requirements exist, most of which relate to facilities licensed by another entity. However, exempting physicians who use moderate sedation potentially reduces the Board's ability to protect the public. Patients who receive moderate sedation from exempt physicians for surgery and other invasive procedures in an outpatient setting are at risk because such physicians do not have to follow the Board's safety guidelines and may be unprepared to handle unforeseen emergencies.

Recommendation

Change in Statute

7.1 Remove the statutory exemption for physicians who use moderate sedation in outpatient settings.

Physicians who use certain drugs for moderate sedation in an outpatient setting would no longer be exempt from the Medical Board's regulations and would be required to register with the Board and comply with Board rules regarding minimum standards for providing anesthesia services. The Board would have authority to discipline those physicians who violate office-based anesthesia rules. All other exemptions, such as outpatient settings where local anesthesia is used, and licensed and accredited facilities, would not be affected by this recommendation and would remain in place. Requiring physicians who use moderate sedation to register with the Board would ensure that surgery and invasive procedures performed by a physician in an outpatient setting are subject to similar safety standards as those performed in a hospital or ambulatory surgical center, or even a dental office, which would ultimately make the Board better able to protect the public.

Issue 8

The Diffusion of Authority for Regulating Acupuncture Causes Inefficiency and May Affect the State's Ability to Protect the Public.

Key Findings

- The Acupuncture and Medical boards share responsibility for the regulation of acupuncture in Texas.
- Medical Board oversight of acupuncture licensing and enforcement actions does not provide added public protection and creates an unnecessary layer of regulation.
- The Acupuncture Board lacks authority to protect the public from immediate danger.
- The Acupuncture Board's process for approving continuing education is inconsistent and time-consuming.
- The authority to approve degree programs at Texas acupuncture schools is unclear.

The Texas State Board of Acupuncture Examiners has the responsibility for protecting public safety by ensuring that acupuncturists are qualified and competent practitioners. However, the Acupuncture Board does not have final approval authority for licensing and enforcement activities, as this rests with the Medical Board. This delays licensing and enforcement actions and wastes resources. The Acupuncture Board also approves all continuing education courses and, until recently, acupuncture degree programs in the state.

Recommendations

Change in Statute

8.1 Authorize the Acupuncture Board to approve licensing and enforcement actions.

The Acupuncture Board would approve applications for licensure and finalize enforcement actions without needing the Medical Board's approval. The Medical Board would maintain oversight of the Acupuncture Board's rulemaking process.

8.2 Strengthen the Acupuncture Board's enforcement authority to include summary suspension and cease-and-desist orders.

The Acupuncture Board would have authority to temporarily suspend a license without holding an initial hearing or Medical Board approval. Doing so would allow the Acupuncture Board to immediately stop activity that could harm the public. Also, the Acupuncture Board, without Medical Board approval, would be allowed to issue cease-and-desist orders. Cease-and-desist authority would enable the Board to move more quickly to stop unlicensed activity that threatens the health and safety of the public.

8.3 Streamline the Acupuncture Board's process for approving continuing education.

The Acupuncture Board would establish guidelines for preferred providers and course content using other state agencies and other acupuncture licensing boards' methods as a model. Once guidelines

for approval are established, agency staff would approve course applications, and would refer any questionable applications to the Board for review and final approval.

8.4 Clarify that the Texas Higher Education Coordinating Board has the authority to approve degree programs for acupuncture schools in Texas.

The Texas Higher Education Coordinating Board would have the authority to approve Texas acupuncture schools and their degree programs. The Acupuncture Board would maintain the authority to establish education requirements for licensure.

8.5 Require the presiding officer of the Acupuncture Board to be a licensed acupuncturist.

When selecting the presiding officer of the Acupuncture Board, the Governor would choose from the four licensed acupuncturists required on the Board.

Issue 9

The Medical Board Needs Flexibility in How It Regulates the Delegation of Prescription Authority by Physicians.

Key Findings

- Physicians can delegate prescriptive authority to physician assistants and advanced nurse practitioners.
- The Board's authority to waive prescriptive delegation requirements is scheduled to expire.
- Registering prescriptive delegation authority with the Medical Board provides no useful information.

By delegating prescriptive authority to physician assistants and advanced nurse practitioners, physicians can provide increased access to care. The Medical Practice Act establishes requirements for prescriptive delegation, and allows the Board to waive some of the supervision requirements. The Prescriptive Delegation Waiver Committee, an advisory committee to the Medical Board, currently reviews requests for waivers and makes recommendations to the Board. However, both the Board's authority to waive and the committee expire in 2005. In addition, requiring practitioners to register prescriptive authority with the Board is not necessary to protect the public.

Recommendations

Change in Statute

9.1 Continue the Board's authority to waive prescriptive delegation requirements.

This recommendation would remove the expiration date for Board waiver of delegation requirements. The Board would continue to be able to waive site and supervision requirements for physicians who delegate prescriptive authority to physician assistants and advanced nurse practitioners. However, the Prescriptive Delegation Waiver Committee would expire and the Medical Board would assume this responsibility through its committee structure.

9.2 Eliminate the prescriptive delegation registration requirement and authorize the Board to establish rules that require physicians to record delegation.

Physicians, physician assistants, and advanced nurse practitioners would no longer be required to register their intent to practice or to supervise delegated prescriptive authority with the Board. Physicians who delegate prescriptive authority would be required to document in their own records when prescriptive authority is delegated, and the Board would have access to this information if needed for an investigation.

Issue 10

Key Elements of the Boards' Licensing and Regulatory Functions Do Not Conform to Commonly Applied Licensing Practices.

Key Findings

- Licensing provisions of the boards' statutes do not follow model practices and could potentially affect the fair treatment of licensees and the agency's ability to protect consumers.
- Nonstandard enforcement provisions of the boards' statute could reduce the agency's effectiveness in protecting consumers.
- Certain policy body and administrative requirements of the boards' statute could reduce the boards' efficiency and flexibility to adapt to changing circumstances.

Various licensing, enforcement, and administrative processes in the Medical, Physician Assistant, and Acupuncture boards' statutes do not match model licensing standards developed by the Sunset Commission from experience gained through more than 80 occupational licensing reviews over the last 25 years. For example, prohibiting medical faculty members from serving on the Medical Board prevents qualified members of the medical profession from serving on the policy body. A comparison of the Board's statute, rules, and practices with model licensing standards identified variations from these standards and the needed changes to bring the Board in line with other agencies.

Recommendations

Licensing

Change in Statute

10.1 Require physician assistant and acupuncture applicants to pass a jurisprudence exam as a condition for licensure.

This recommendation builds upon existing licensure requirements by requiring physician assistant and acupuncture applicants to pass a jurisprudence exam to be eligible for licensure. The Physician Assistant and Acupuncture boards would each need to develop an examination based on their licensing act and rules, and other applicable state laws and regulations affecting professional practice. The boards would also establish rules regarding examination development, fees, administration, re-examination, grading, and notice of results. The requirement to pass the jurisprudence exam would only apply to individuals who apply for licensure on or after September 1, 2006; individuals licensed before then would be exempt from passing the jurisprudence exam.

10.2 Clarify that the Medical, Physician Assistant, and Acupuncture boards must address felony and misdemeanor convictions in the standard manner defined in the Occupations Code.

This recommendation would clarify the Medical, Physician Assistant, and Acupuncture boards' authority to adopt rules that follow the general guidelines in Chapter 53 of the Occupations Code by specifically requiring the boards to develop rules, under the provisions in Chapter 53, defining which crimes affect licensees' ability to practice. This recommendation would not affect the changes made last session authorizing the Medical Board to refuse to license or to take disciplinary action against physicians placed on deferred adjudication for felonies or certain misdemeanors. Because the Physician Assistant and Acupuncture boards do not have final rulemaking authority, these boards would recommend rules to the Medical Board for approval.

10.3 Authorize staff to issue licenses to qualified physician, physician assistant, and acupuncture applicants.

Staff would have authority to issue permanent physician, physician assistant, and acupuncture licenses to individuals who meet all licensing requirements without needing formal board approval. However, staff would forward applications that do not clearly meet licensing requirements to the appropriate board for further consideration. Because surgical assistant licenses fall under the Medical Board's jurisdiction, staff would have authority to issue these licenses as well. The Board would adjust license fees to compensate for any lost revenue caused by eliminating temporary licenses.

10.4 Clarify the Physician Assistant Board's responsibility to establish a system of continuing medical education.

The Physician Assistant Board would have clearer statutory authority to adopt, monitor, and enforce a reporting program for the continuing medical education of license holders. Specifically, the Board would adopt and administer rules that:

- establish the number of hours of continuing medical education the Board determines appropriate as a prerequisite to the renewal of a license;
- require at least one-half of the hours to be Board approved; and
- adopt a process to assess a license holder's participation in continuing medical education courses.

10.5 Change the basis for the Physician Assistant Board's late-renewal penalties.

The renewal fee for physician assistants who are delinquent in renewing their license would be based on the normal renewal rate set by the Board, not the examination fee. To renew a license that has been expired for 90 days or less, the renewal fee would equal 1-1/2 times the standard renewal fee. If the license has been expired for more than 90 days, but less than one year, the renewal fee would equal two times the standard renewal fee. This would bring the Physician Assistant Board in line with statutory requirements for the Medical and Acupuncture boards.

10.6 Authorize the Medical and Physician Assistant boards to adopt a system under which physician and physician assistant licenses expire on various dates during the year.

The Medical and Physician Assistant boards would establish, by rule, a license renewal system under which licenses expire on various dates during the year. This change would replace the requirement for the Medical Board to renew physicians' licenses at the end of their birth month, and it would

provide new authority to the Physician Assistant Board to stagger its renewals. Because the Medical Board oversees the Physician Assistant Board's rulemaking process, the Physician Assistant Board would recommend its rules to the Medical Board.

Management Action

10.7 The Medical Board should discontinue its practice of requiring applicants to appear before the Board for a personal interview.

The Medical Board should no longer require physician applicants to travel to Austin to prove their identity and the authenticity of their original medical school diploma, particularly if staff can verify the information through primary sources. The Board already receives primary source verification of applicants' medical school education from transcripts sent directly to the Board from medical schools. The Board would not be prohibited from requiring applicants to make a personal appearance, but should only do so when staff cannot verify vital information through an independent source.

Enforcement

Change in Statute

10.8 Authorize the Acupuncture Board to refuse to renew a license and allow the Physician Assistant and Acupuncture boards to accept the voluntary surrender of a license.

The Acupuncture Board would have the full range of penalties available for disciplinary actions against an acupuncturist who violates state law or Board rules. In developing its standard penalty matrix, the Acupuncture Board would incorporate refusal to renew a license into its disciplinary options. Doing so would allow the Board to better apply the appropriate sanction for offenses, such as failure to pay an administrative fine. This recommendation also would clarify that the Physician Assistant and Acupuncture boards have authority to accept the voluntary surrender of a license. The boards would recommend rules to the Medical Board that outline how the boards determine whether a practitioner is competent to return to practice.

10.9 Authorize the boards to require refunds as part of the agreed settlement process.

The Medical, Physician Assistant, and Acupuncture boards would be allowed to include refunds as part of an agreed order reached in an informal settlement conference on a complaint. This authority would be limited to ordering a refund not to exceed the amount the complainant paid for services. Any refund order would not include an estimation of other damages or harm and must be agreed to by the licensee. The refund may be in lieu of or in addition to other sanctions against a licensee.

10.10 Authorize the Medical and Physician Assistant boards to issue cease-and-desist orders.

Cease-and-desist authority would enable the boards to move more quickly to stop unlicensed activity that threatens the health and safety of the public. The boards would also have authority to assess administrative penalties against individuals who violate cease-and-desist orders. The Acupuncture Board's ability to issue cease-and desist orders is addressed in Issue 8.

Policy Body & Administration

Change in Statute

10.11 Allow medical faculty members to be eligible to serve on the Medical Board.

The statutory prohibition against salaried faculty members at a college of medicine serving on the Medical Board would be removed. To be eligible for appointment to the Board, a faculty member would have to satisfy the qualifications outlined in the Medical Practice Act, including conflict-of-interest provisions.

10.12 Clarify that the Senate must confirm appointments to the Physician Assistant and Acupuncture boards.

This recommendation would establish current practice in statute and ensure that future appoints to the Physician Assistant and Acupuncture boards are approved by the Senate in the same process as other Governor appointees.

10.13 Authorize the Physician Assistant Board to establish a fee for individuals who hold an inactive license.

The Physician Assistant Board would set a renewal fee for its inactive licenses. In addition, the Board would establish a time limit for physician assistants to hold an inactive license. Because the Medical Board oversees the Physician Assistant Board's rulemaking process, the Medical Board would have final approval of any fees and time limitations for the license.

10.14 Require the Acupuncture Board to recommend licensing and other fees to the Medical Board.

The Acupuncture Board would propose rules establishing licensing and other fees to regulate acupuncturists. All rules regarding fee levels proposed by the Acupuncture Board would be approved by the Medical Board, which has rulemaking oversight for the Acupuncture Board. However, the Acupuncture Board would play a more significant role in determining what fees are appropriate to regulate acupuncturists in Texas.

Issue 11

Medical Board Members Have Access to Information That Could Potentially Be Used for Personal Advancement or Gain.

Physician members of the Medical Board and physicians acting as Board agents have access to confidential information, such as the number or nature of complaints against another physician, that could potentially be used by the Board member or agent for personal benefit or to harm the career or medical practice of a competitor. Although the Texas Penal Code makes it an offense for public servants to misuse official information to obtain personal benefit or for intent to harm or defraud another, the Medical Practice Act does not prohibit Board members or agents from using or disclosing confidential information to obtain benefit or to harm another.

Recommendation

Change in Statute

11.1 Prohibit physicians from using information acquired from Medical Board duties for personal advancement or gain.

This recommendation would prohibit physicians on the Medical Board or physicians acting as agents of the Board from using information acquired through their Board duties for the advancement of their personal medical practice, or for assisting in the advancement or gain of any other physician or affiliate.

Issue 12

The Medical Board Does Not Publish Reversals of or Errors Related to Its Disciplinary Actions.

The Medical Board currently publishes its disciplinary actions on its Web site and in its newsletters. However, if the Board reverses a disciplinary action because of a decision made by the State Office of Administrative Hearings or by district court, or if the Board finds any errors in its disciplinary decisions, the Board does not subsequently post corrections or acknowledge errors on its Web site or in its newsletters.

Recommendation

Change in Statute

12.1 Require the Medical Board to publish any corrections or reversals of Board disciplinary decisions.

The Board would publish acknowledgments of any errors or reversals related to its disciplinary actions with equal presentation and prominence as the originally published action, and in a form approved by the physician and the physician's lawyer or arbitrator.

Issue 13

The Medical Practice Act Does Not Provide Clear Direction on the Medical Board's Ability to Modify Findings or Rulings Made by the State Office of Administrative Hearings.

For enforcement cases that the Medical Board cannot resolve through informal hearings, the Board files the case at the State Office of Administrative Hearings, where an administrative law judge hears the case in a formal hearing. The administrative law judge then reports the findings of fact and conclusions of law, including recommendations for sanctions, to the Board. While the Administrative Procedure Act outlines the requirements an agency must meet before the agency can change a judge's findings or conclusions, the Medical Practice Act does not prohibit such guidance for the Board in considering proposals for decision submitted by a SOAH judge in a contested case.

Recommendation

Change in Statute

13.1 Clarify that the Medical Board must adhere to the provisions of the Administrative Procedure Act when acting on rulings by the State Office of Administrative Hearings.

This recommendation clarifies that the Medical Board may only change a finding of fact or conclusion of law, or modify or vacate an order made by an administrative law judge at the State Office of Administrative Hearings under certain provisions outlined in the Administrative Procedure Act. Specifically, the Board must determine that the administrative law judge did not properly apply or interpret applicable law, agency rules, written policies provided by the agency, or prior administrative decisions; that a prior administrative decision on which the administrative law judge relied is incorrect or should be changed; or that a technical error in a finding of fact should be changed. The Board would be required to state in writing the specific reason and legal basis for any changes made.

Issue 14

Texas Has a Continuing Need for the Boards That Regulate Physicians, Physician Assistants, and Acupuncturists.

Key Findings

- The Texas State Board of Medical Examiners, Texas State Board of Physician Assistant Examiners, and Texas State Board of Acupuncture Examiners seek to protect the public by ensuring that only qualified physicians, physician assistants, and acupuncturists practice in Texas.
- Texas has a continuing need for regulating physicians, physician assistants, and acupuncturists.
- The existing name of the Board of Medical Examiners does not accurately reflect the Board's current responsibilities and operations.

The State of Texas recognized the need to protect the health, safety and welfare of Texans more than a century ago, when the State began regulating physicians. As the practice of medicine has evolved, the State strengthened its regulation of physicians, who play a pivotal role in diagnosing and treating disease and injury and establishing preventative health care for Texans. Likewise, as the physician assistant profession grew, the State began regulating these key health-care practitioners. And, as the practice of acupuncture became more common in the United States as well as Texas, the State saw the need to ensure that acupuncturists are qualified to practice. Because Texans should have confidence that their health-care practitioners are competent, meet established standards, and are held accountable for their actions, the State has a continuing need in regulating physicians, physician assistants, and acupuncturists. In addition, the current name of the Board of Medical Examiners creates confusion for consumers and other stakeholders, as the name reflects the agency's historic function of administering licensing examinations for physicians, and also implies that the Board solely regulates medical examiners, or coroners.

Recommendations

Change in Statute

14.1 Continue the Texas State Board of Medical Examiners for 12 years, but change its name to the Texas Medical Board.

Under this recommendation, the Medical Board would be continued for 12 years, although to better reflect and communicate the Board's responsibilities, the name would change from the Texas State Board of Medical Examiners to the Texas Medical Board.

14.2 Continue the Texas State Board of Physician Assistant Examiners and Texas State Board of Acupuncture Examiners for 12 years, but remove their separate Sunset dates.

The Texas State Board of Physician Assistants and Texas State Board of Acupuncture Examiners would continue with their existing names as advisory boards under the Medical Board, but their separate Sunset dates would be eliminated. As a result, future Sunset reviews of these two boards would be conducted in conjunction with reviews of the Medical Board.

Fiscal Implication Summary

Several recommendations regarding the boards would have a fiscal impact to the State. The fiscal impact of the recommendations is summarized below:

- **Issue 3** – Requiring the Board to use at least two expert panelists for each standard-of-care investigation would cost $218,000 per year for the additional panelist's review as well as mailing and copying costs.
- **Issue 4** – Increasing the number of District Review Committee members by eight and requiring committee members to receive training would have a minimal cost, depending on the type of training the Medical Board requires, but these costs would not be significant.
- **Issue 10** – Creating a statutory basis for the Physician Assistant Board's late-renewal penalty would result in a gain of $3,745 annually. Establishing a renewal fee for the physician inactive license would result in a small, positive fiscal impact as well. Authorizing staff to issue licenses, and thus eliminating the need for temporary licenses, would result in a one-time gain in revenue of $400,000 in fiscal year 2006 by speeding up the payment of the permanent license fee in the first year of implementation. The agency would experience a loss of $120,000 that same year and each subsequent year, resulting from the elimination of the temporary fee. The agency also would experience an annual savings of about $8,000 each year because of reduced administrative effort in processing these temporary licenses.

Fiscal Year	*Cost to the General Revenue Fund*	*Loss to the General Revenue Fund*	*Savings to the General Revenue Fund*	*Gain to the General Revenue Fund*	*Net Effect on the General Revenue Fund*
2006	$218,000	$120,000	$8,000	$403,745	$73,745
2007	$218,000	$120,000	$8,000	$3,745	($326,255)
2008	$218,000	$120,000	$8,000	$3,745	($326,255)
2009	$218,000	$120,000	$8,000	$3,745	($326,255)
2010	$218,000	$120,000	$8,000	$3,745	($326,255)