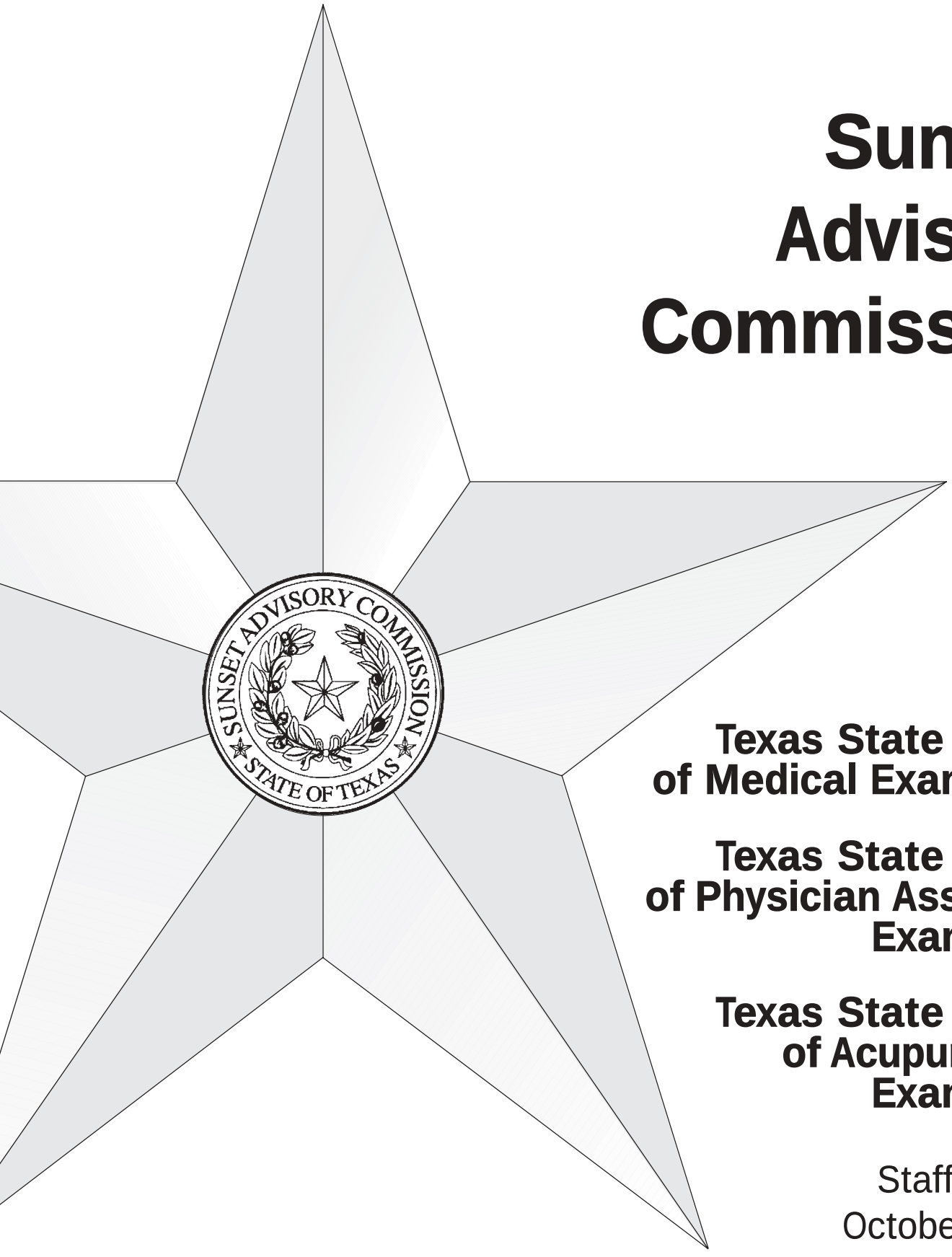

Sunset Advisory Commission

Texas State Board of Medical Examiners

Texas State Board of Physician Assistant Examiners

Texas State Board of Acupuncture Examiners

Staff Report
October 2004

Texas State Board of Medical Examiners

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SUMMARY

Summary

Texas State Board of Medical Examiners
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The Sunset review of the Texas State Board of Medical Examiners occurred during a period of transition for the Board. During the 2003 legislative session, in the wake of news stories highlighting significant enforcement deficiencies at the Board and the push to limit noneconomic damages in tort claims against physicians, the Legislature recognized the need to strengthen the regulation of physicians. In a tight budgetary session, the Legislature appropriated almost $3.5 million in additional funds to the Medical Board to overhaul its enforcement process. The Board received clear direction and the fortified tools and resources to prosecute complaints against physicians more quickly and forcefully than it ever had in the past.

Despite strengthened authority and a more assertive attitude, the Medical Board needs further statutory directive to better regulate physicians.

The Sunset review found that Medical Board members and agency staff have taken their enhanced responsibilities seriously, and in addressing the Legislature's directives, have instilled a more assertive attitude across all agency operations. Still, as with any wholesale change, the Board has experienced growing pains and, in some areas, needs further statutory directive. For example, the requirement for the Board to complete complaint investigations within 180 days needs clarification of what happens if the Board does not meet this time frame. The Sunset review also found that, in this new regulatory environment, the Board cannot conduct its business in a vacuum, but should reach out to stakeholders in developing its rules and policies. Doing so would allow the Board to make more-informed decisions.

The Texas State Board of Physician Assistant Examiners and the Texas State Board of Acupuncture Examiners fall under the Medical Board's umbrella and share the Medical Board's staff. The Sunset review of these two boards identified ways to reduce burdens of these regulatory programs on the day-to-day operations of the Medical Board.

This report addresses issues relating to the operations of the Medical, Physician Assistant, and Acupuncture boards. Recommendations relating to the organizational structure of the boards are addressed in the Licensing Reorganization Project report.

Ultimately, Sunset staff intends for the recommendations in this report to build upon the Legislature's recent directives and assist the Medical, Physician Assistant, and Acupuncture boards in providing fair, objective processes for licensees while continuing to meet high standards in protecting the safety, health, and welfare of Texans.

A summary of the Sunset staff recommendations in this report is provided in the following material.

Issues/Recommendations

Issue 1

Limited Stakeholder Involvement Affects the Board's Rulemaking and Policymaking Processes.

Key Recommendations

- Require the Board to develop guidelines for the early involvement of stakeholders in its rulemaking process.
- The Board should withdraw or repeal rules it does not intend to enforce.
- The Board should ensure that the public has an opportunity to testify or appear before the Board.
- The Board should consider recording Board subcommittee and full Board meetings.
- The Board should notify stakeholders of adopted rules.

Issue 2

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

Key Recommendations

- Require the boards to develop guidelines, by rule, for evaluating applicants' mental and physical health disorders.
- Eliminate the medical licensing exam attempt exceptions from the Medical Practice Act and clarify the number of exam attempts for doctor of osteopathy applicants.
- Authorize the Medical Board to award a limited license for the practice of administrative medicine.

Issue 3

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

Key Recommendations

- Require the Board to use at least two expert panelists for each standard-of-care investigation.
- Direct the Board to develop additional qualifications and service restrictions for its experts.
- Clarify the legal protections of expert panelists and consultants.
- Authorize the Board to use up to 30 days to evaluate incoming complaints.
- Clarify the consequences of not meeting the 180-day investigation requirement.
- Require the Board to develop additional definitions of good cause for extending an investigation.
- The Board should make an effort to use more expert panelists who reside outside the Austin area.

Issue 4

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

Key Recommendations

- Require the boards to define the roles and responsibilities of participants in informal hearings.
- Clarify the District Review Committees' role in statute and establish eligibility, training, conflict of interest, and grounds for removal requirements for DRC members.
- Require at least two panelists and one public member in the informal settlement process.
- Increase the number of public members on the District Review Committees.
- Authorize staff to settle nonmedical complaints.

Issue 5

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

Key Recommendations

- Clarify the Board's ability to disclose peer review documents in disciplinary hearings.
- Clarify that medical records otherwise available are not confidential.

Issue 6

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

Key Recommendations

- Restrict nondisciplinary rehabilitation orders to impaired physicians who have not also violated the standard of care.
- Require the Board to define the roles and responsibilities for professional associations in rehabilitation orders.

Issue 7

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

Key Recommendation

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

Issue 8

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

Key Recommendations

- Authorize the Acupuncture Board to approve licensing and enforcement actions.
- Strengthen the Acupuncture Board's enforcement authority to include summary suspension and cease-and-desist orders.
- Streamline the Acupuncture Board's process for approving continuing education.
- Clarify the Texas Higher Education Coordinating Board's authority to approve degree programs for acupuncture schools in Texas.

Issue 9

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

Key Recommendations

- Continue the Board's authority to waive prescriptive delegation requirements.
- Eliminate the prescriptive delegation registration requirement and authorize the Board to establish rules that require physicians to record delegation.

Issue 10

Licensing Surgical Assistants Does Not Provide Added Public Protection That Warrants State Oversight.

Key Recommendation

- Abolish the surgical assistant license.

Issue 11

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

Key Recommendations

- Standardize the boards' licensing functions by requiring physician assistant and acupuncture applicants to pass a jurisprudence exam, authorizing staff to issue licenses, clarifying continuing education requirements, and allowing staggered license renewals.
- Improve the boards' ability to protect the public by granting them use of cease-and-desist orders, authorizing refunds as part of the agreed settlement process, and establishing a full range of penalties available as disciplinary sanctions.
- Update elements related to the policy body and agency administration, such as allowing medical faculty members to serve on the Medical Board, clarifying the requirement that the Senate confirms appointees to the boards, and authorizing a fee for the physician assistant inactive license.

Issue 12

Texas Has a Continuing Need to Regulate Physicians, Physician Assistants, and Acupuncturists.

Key Recommendation

- Continue regulating physicians, physician assistants, and acupuncturists in Texas.

Fiscal Implication Summary

This report contains recommendations that 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 size of the District Review Committees and requiring committee members to receive training would have a minimal cost, depending on the type of training the Medical Board requires.
- *Issue 11* – Creating a statutory basis for the Physician Assistant Board's late-renewal penalty would result in a positive fiscal impact 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 loss of revenue of about $165,000 each year. The Board would adjust license fees to compensate for this loss.

Fiscal Year	*Cost to the General Revenue Fund*
2006	$218,000
2007	$218,000
2008	$218,000
2009	$218,000
2010	$218,000

ISSUES

Issue 1

Limited Stakeholder Involvement Affects the Board's Rulemaking and Policymaking Processes.

Summary

Key Recommendations

- Require the Board to develop guidelines for the early involvement of stakeholders in its rulemaking process.
- The Board should withdraw or repeal rules it does not intend to enforce.
- The Board should ensure that the public has an opportunity to testify or appear before the Board.
- The Board should consider recording Board subcommittee and full Board meetings.
- The Board should notify stakeholders of adopted rules.

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.

Conclusion

The rules adopted by the Texas State Board of Medical Examiners have an impact on a variety of stakeholders. As such, these stakeholders – including licensees, professional associations, 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. The Sunset review found that 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. Also, because the Medical Board has oversight over the Physician Assistant and Acupuncture boards' rulemaking processes, the Board could clarify the process for the public to provide comments regarding issues related to these two boards. Doing so would allow the Board – as well as the Physician Assistant and Acupuncture boards – to make better informed decisions, identify stakeholder concerns, and more efficiently establish rules and policies while allowing stakeholders more input into developing the regulations that govern their professions.

Support

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 Medical Practice Act authorizes the Board to adopt rules and bylaws as necessary to perform its duties, regulate the practice of medicine in Texas, and enforce state laws.[1] Under this authority, the Board has adopted rules concerning licensing, enforcement, scope of practice, unlicensed practice, and agency operations to govern regulation of physicians, physician assistants, and acupuncturists in the state. The Board regularly proposes and adopts new rules, modifies existing rules, and deletes obsolete rules.

- As advisory boards to the Medical Board, the Texas State Board of Physician Assistant Examiners and Texas State Board of Acupuncture Examiners discuss policy issues and develop rules to regulate their respective licensees. Because neither the Physician Assistant Board nor Acupuncture Board has independent rulemaking authority, the two boards submit their rules to the Medical Board for final approval.

- The Board's rulemaking process is governed by the Administrative Procedure Act (APA).[2] The APA requires the Board to give all interested parties a reasonable opportunity to submit data, views, or arguments – either orally or in writing – concerning proposed rules, and the Board must fully consider all submissions about a proposed rule.[3] Members of the public who want to comment on a Board rule may appear before the Board during a public comment period. In addition, the APA authorizes the Board to appoint committees of experts or interested members of the public to obtain advice and information about contemplated rulemaking.[4]

By not pursuing input from stakeholders, the Board sometimes experiences difficulty regarding the feasibility of its rules.

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.

- Because the Board has received minimal input during the rule-development process, its ability to efficiently and effectively make decisions is limited. By not actively pursuing input from stakeholders and affected parties – such as licensees, professional associations, and medical schools – when developing rules, the Board sometimes experiences difficulties regarding the feasibility of rules late in the process, and even after the rules have been adopted. The textbox, *Recent Rules*, provides examples of these difficulties.

  In the first example, the Board adopted a rule, in October 2003, modifying requirements for physician preceptors. After medical schools, physicians who serve as preceptors, and students expressed concern about the effects the rule would have on medical schools and students, the Board decided not to enforce the rule until agency staff and Board members discuss a workable solution with medical school representatives. In the second example, stakeholders noted concern that some of the Board's proposed rules regarding office-based

anesthesia restricted the scope of practice for some registered nurses. Shortly after proposing these rules in July 2004, the Board withdrew them so that it could include the Board of Nurse Examiners in the development of the rules.

- While the Board could never expect to receive complete buy-in from all stakeholders, by not actively seeking input when developing rules, the Board affects stakeholders' confidence and investment in Board activities. In fact, stakeholders have expressed frustration at their limited participation in the rule-development process. By not seeking early input from the stakeholders who will be directly affected by a rule, the Board gives the appearance of not being concerned with the effect of the Board's policies and regulation on its stakeholders, and to have already determined a course of action.

- By not considering stakeholder input until proposed rules have been drafted and posted in the *Texas Register*, the Board may not become aware of problems with implementation of its rules or the consequences of the rules until staff and Board members have devoted a substantial amount of time to drafting the rules, resulting in delayed adoption of some of the Board's rules. Once stakeholders have voiced concerns with a proposed rule, the Board may withdraw the rule or postpone its adoption while staff modifies the rule. As a result, adoption of the rule is delayed for several months, as the rule must be redrafted and published again in the *Texas Register.* For example, the Board recently delayed adoption of rules regarding prescription medical devices because the Board did not consult with the Board of Physical Therapy Examiners. For more information on this rule, see the third example in the textbox, *Recent Rules.*

Recent Rules

Examples of proposed or adopted rules that could have better involved stakeholders include the following.

- **Preceptors:** The Board recently adopted a rule requiring professors who serve as preceptors to hold a clinical faculty appointment at a Texas medical school. Not having a faculty appointment would result in a rules violation for the physician, and students studying under preceptors who did not have a clinical appointment would not receive academic credit. After medical schools, physicians who serve as preceptors, and students strongly expressed their concerns, the Board decided at its June 2004 meeting that it would not enforce the rule, but also would not repeal it. As a result, both medical schools and students expressed concern that because the rule is still legally in effect, the Board could choose to enforce it at any time. Stakeholders also have concerns about knowingly violating a Board rule, even if Board members and agency staff have indicated they will not enforce the rule.

- **Office-based anesthesia:** Because of potential conflicts between rules adopted by the Medical Board and the Board of Nurse Examiners relating to office-based anesthesia, the Legislature statutorily directed the Medical Board to cooperate with the Nurse Board in the adoption of rules related to this issue. However, the Medical Board developed and proposed rules in July 2004 without contacting the Nurse Board. As a result, the Nurse Board submitted a letter to the Medical Board requesting that the Medical Board adhere to its statute and consult with Nurse Board staff to address their concerns about the rule's effects on the Nurse Board's licensees as well as conflicts with the Nurse Board's rules.

- **Prescription medical devices:** The Board did not consult with the Physician Assistant Board on the proposed rule for prescription medical devices, even though Medical Board members stated publicly that a primary reason for the rule was to clarify that physicians could not delegate the needle electromyography (EMG) procedure to midlevels, such as physician assistants. The Physician Assistant Board had recently informed its licensees that they could perform the procedure as long as they did not make a diagnosis. The Medical Board also did not inform the Board of Physical Therapy Examiners when it proposed rules concerning delegation of prescription medical devices, including the use of needle EMG, even though the Attorney General has ruled that the development of rules regulating EMG would require the cooperation of both the Medical Board and the Physical Therapy Board, as the procedure falls within the scope of practice of both agencies' licensees.

Stakeholders are unclear about which board to address for rules relating to physician assistants and acupuncturists.

- The Physician Assistant and Acupuncture boards do not have final rulemaking authority, but the debate and detailed discussion involved in developing rules occurs at the boards' meetings. However, interested stakeholders are not clear if they should address the Physician Assistant Board or Acupuncture Board when these boards deliberate on recommending a rule to the Medical Board, or if they should address the Medical Board, which officially adopts the rules.

  For example, at the July 2004 Acupuncture Board meeting, Board members discussed the definition of acupuncture as part of the agency's regularly scheduled rule review. Staff noted that public comment regarding the rule would be heard by the Medical Board; however, stakeholders typically contact the Acupuncture Board regarding their concerns with rules related to the practice of acupuncture.

- The Board makes little effort to publicize adopted rules to directly affected parties. Stakeholders claim that the Board does not take needed steps to educate them when rules that affect them have been proposed or adopted. The Board posts proposed rules on its Web site and rule changes in its semiannual newsletter, which is available on the Board's Web site. The Board also adheres to the Administrative Procedure Act by posting rule changes in the *Texas Register*. Although the Board complies with statutory requirements regarding rulemaking, making an extra effort to ensure that affected parties are aware of rule changes could benefit stakeholders as well as the Board, as the Board frequently deals with wide-reaching, complex issues.

The Board's public hearings process does not provide meaningful opportunities for public comment or an adequate record of deliberations.

- The process used by the Board for allowing the public to address the Board limits public input and interaction. The Board requires interested persons who want to address the Board on an issue under the Board's authority to submit a written request at least 10 business days before the Board meeting.[5] Staff notifies the requestor of the date and time when the individual can address the Board's Public Information Committee. This committee then makes recommendations to the Board regarding matters brought to the committee's attention by the public.[6] Members of the public can only comment on items on the agenda, so they cannot address the full Board. Because the committee serves as a filter, the full Board is insulated from hearing the public's comments directly.

- Stakeholders have also expressed concern that, to address any of the boards, they must identify which agenda item they want to speak about. However, the Board typically posts meeting agendas seven days before a meeting, as required by the Open Meetings Act.[7] Because requests to appear before a board must be made 10 business days in advance, stakeholders cannot identify which agenda item they want to discuss until after the deadline for requesting to address the board has passed.

- When the Board does hear from stakeholders or the public regarding rule or policy development at Board and committee meetings, the Board

does not record the meetings. Although the Board publishes minutes from Board subcommittee and full Board meetings, the Board does not have an adequate record of comments to refer to when deliberating on issues. Given the complex, technical issues heard by the Board, making an audio recording of Board and committee meetings could give Board members and agency staff, as well as stakeholders, a precise account of Board discussions and decisions to refer back to.

The Board does not have an adequate record of its meetings to refer to when deliberating on issues.

Other state agencies have developed more effective processes for soliciting stakeholder input during rule and policy development.

- When developing rules to regulate the nursing profession, the Board of Nurse Examiners seeks stakeholder input up front. Through a negotiated rulemaking process, the Nurse Board solicits advice, information, and opinions from stakeholders before a rule is proposed. As a result, the Nurse Board's rules rarely are disputed or challenged by stakeholders.
- To assist in developing standards, the Pharmacy Board forms task forces to provide additional expertise and advice on rule development. For example, task forces have advised the Pharmacy Board on pharmacists' working conditions, remote pharmacy services, peer review guidelines, and generic substitutions.

Recommendations

Change in Statute

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

This recommendation would require the Board to 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.* This process would apply to the Physician Assistant and Acupuncture boards as well. 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. One option for early involvement would be to post topics for rule development on the Board's Web site to solicit input. Once the 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. 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. The Board should use its judgment in determining which issues would benefit from early stakeholder involvement, as the Board 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.

Under this recommendation, the Board would withdraw proposed rules or repeal adopted rules that it does not intend to enforce while negotiating with stakeholders. The Board would 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 Board at a public Board meeting. The Board would set deadlines for interested parties to provide notification of their intent to address the Board *after* the meeting agenda has been made public. This change would allow individuals to make an informed decision about whether they want to appear before the Board, and would enable the Board to adequately plan for the amount of public testimony it will receive at its meetings. If, however, an individual does not notify the Board of a desire to appear before the Board by the deadline, the Board would still allow the individual to testify if good cause exists for why the individual did not previously notify the Board. This recommendation would apply to the Physician Assistant and Acupuncture boards, as well.

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.

Under this recommendation, 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.

Impact

These recommendations would provide the Board with a more efficient, productive process for developing rules. Stakeholders, including licensees, would have greater opportunity to provide their advice, expertise, and opinions on rules in the early stages of development. The Board would be better able to craft rules that take stakeholders' concerns into consideration before they are published in the *Texas Register.* As a result, the Board would have to withdraw rules or postpone rule adoption less frequently, allowing for more timely adoption of rules.

Fiscal Implication

These recommendations would not have a fiscal impact to the State.

[1] Texas Occupations Code, sec. 153.001.

[2] Texas Government Code, ch. 2001, subch. B.

[3] Texas Government Code, sec. 2001.029.

[4] Texas Government Code, sec. 2001.031.

[5] Texas Administrative Code, Title 22, part 9, rule 199.2(a).

[6] Texas Administrative Code, Title 22, part 9, rule 199.2(b).

[7] Texas Government Code, sec. 551.044(a) and Texas Administrative Code, Title 1, part 4, rule 91.21(a)(1).

Issue 2

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

Summary

Key Recommendations

- Require the boards to develop guidelines, by rule, for evaluating applicants' mental and physical health disorders.
- Eliminate the medical licensing exam attempt exceptions from the Medical Practice Act and clarify the number of exam attempts for doctor of osteopathy applicants.
- Authorize the Medical Board to award a limited license for the practice of administrative medicine.

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.

Conclusion

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. For example, Sunset staff found that the boards' use of independent psychiatric evaluations places financial and time burdens on applicants, and that a lack of guidelines for evaluating applicants with mental and physical health disorders 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 become licensed. Finally, the Medical Board lacks options for licensing physicians who want to practice medicine only in an administrative setting, and instead must offer them a license with a nondisciplinary Board order. Directing the boards to develop guidelines for the assessment of mental and physical health, eliminating exam attempt exceptions, and authorizing an administrative medicine license would result in a more consistent and unbiased licensing process.

Support

The Medical, Physician Assistant, and Acupuncture boards assess all candidates for licensure to ensure that the public will receive quality medical services.

- Staff processes all license and permit applications to ensure that individuals meet required licensing qualifications. Applications go through multiple levels of review. Initially, staff evaluates applications to ensure that candidates for licensure have submitted all required documents, then follows up with individuals whose applications are incomplete. Staff then analyzes applications to determine whether all licensing qualifications have been met, including education and testing requirements and clinical experience. The Executive Director may deem applicants who do not meet statutory licensing requirements, such as passing an examination within the number of attempts allowed by statute, ineligible for licensure. In fiscal year 2003, the boards reviewed 4,902 applications, as noted in the chart, *Applications Processed*. About 8 percent of applications did not result in a license.

Applications Processed FY 2003

Application Type	Number
Physician	2,430
Physician-in-training permit	1,868
Physician assistant	370
Acupuncturist	76
Surgical assistant	158
Total	**4,902**

- In addition to verifying general licensing requirements, staff further evaluates candidates who indicate on their applications that they have experienced certain mental health conditions, alcohol or substance abuse, or physical or neurological disorders within the past five years.[1] These individuals must submit all related treatment records to agency staff, who reviews the information and presents summaries about applicants to the Executive Director at weekly application review meetings. The Executive Director may recommend that no further evaluation is necessary or, if concerns remain about an individual's fitness for practice, request that an applicant undergo an independent psychiatric or medical evaluation.

  The chart, *Independent Psychiatric Evaluations*, lists potential reasons for an evaluation, and provides the number of recent evaluations required by the boards with licensure outcomes. Unless recommended for an unrestricted license at an application review meeting, staff forwards all applicant files requiring further evaluation to the appropriate board's licensing committee for further consideration.

Staff evaluates candidates who indicate mental health or physical disorders, or alcohol or substance abuse.

- Staff may grant temporary licenses to applicants who meet all licensure requirements, so individuals can practice in their profession until the full boards can approve licenses at their regularly scheduled meetings. Applicants about whom eligibility concerns remain, or those who wish to appeal staff decisions, must meet with the appropriate board's licensing committee, which evaluates applicants and recommends full or restricted licensure, further evaluation, or ineligibility for licensure to the full board. A restricted license could include additional conditions placed on a licensee to practice medicine, such as submitting quarterly progress reports to the board, or it could include limitations on the type of medicine practiced, such as administrative medicine. The full board may approve, reject, or modify its licensing committee's recommendations.

Independent Psychiatric Evaluations (IPEs)

The Medical, Physician Assistant, and Acupuncture boards' licensing committees and the Executive Director (E.D.) may request an independent psychiatric evaluation for conditions such as major depression, bipolar disorder, schizophrenia, and alcohol or substance dependency or addiction.

	FY 03	FY 04
Physician applicants		
Number of applicants	2,430	2,426
Number of applicants reviewed by E.D. for psychological impairment	47	51
Number of IPEs requested by E.D. and/or licensure committee	12	25
Outcome		
Licensed	9	14
Licensed with a rehab order	0	1
Licensed with a public order	0	0
Withdrew application	3	1
Pending	0	9
Physician-in-training applicants		
Number of applicants	1,868	1,817
Number of applicants reviewed by E.D. for psychological impairment	45	89
Number of IPEs requested by E.D. and/or licensure committee	3	27
Outcome		
Licensed	2	17
Licensed with a rehab order	1	2
Licensed with a public order	0	0
Pending	0	8
Physician assistant applicants		
Number of applicants	370	425
Number of IPEs requested by E.D. and/or licensure committee	1	3
Outcome		
Licensed with a rehab order	1	0
Temporary license	0	1
Pending	0	2
Acupuncture applicants: No IPEs requested	0	0

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.

- The Medical, Physician Assistant, and Acupuncture boards do not have standards to guide licensing decisions regarding applicants with mental health and impairment issues. The boards must consider a variety of factors when evaluating such disorders, including the presence of active symptoms, events that precipitated diagnosis, the frequency and intensity of mental health episodes, response to treatment, and reports from independent psychiatrists, treating physicians, and residency program directors. However, with no specific guidelines for evaluating how these factors affect applicants' fitness for practice, staff and board members risk treating applicants inconsistently.

- Applicants, medical schools, and active license holders have expressed concern that the Medical Board's decisions regarding licensure eligibility are inconsistent. For example, concern exists that the Board focuses on diagnoses of major depression, without taking applicants' clinical performance or positive evaluations into account. While Sunset staff does not intend to question the Medical Board's decisions in individual cases, establishing written standards for making licensure decisions could reduce applicant and practitioner concerns about the appearance of inconsistency in the Board's licensing decisions.

- The Medical Board's specifications for independent psychiatric evaluations place an undue burden on applicants. Although an evaluation conducted by a professional other than the applicant's treating psychiatrist is needed, the Board often requires applicants to see a forensic psychiatrist, defined in the accompanying textbox. Out of about 79 forensic psychiatrists in Texas, the Board uses only 11 to conduct psychiatric evaluations of licensure applicants. These 11 evaluators practice in the cities noted in the chart, *Forensic Psychiatric Evaluators' Practice Locations*. In contrast, more than 2,000 nonforensic psychiatrists practice throughout Texas.[3] Applicants must pay the evaluation fee, which typically ranges from $750 to $3,000, and the appointment can take up to 10 hours to complete. The Board also frequently requires that applicants get evaluated outside their city of residence and pay all related travel costs. For example, an applicant in Houston may be required to travel to Temple for an evaluation, although the Board uses two forensic psychiatrists from Houston and more than 480 nonforensic psychiatrists work in Houston.

What Is a Forensic Psychiatrist?[2]

Forensic psychiatrists are medical doctors who have an understanding of, ability to diagnosis, and capability to treat mental disorders, plus additional training in the law. They typically work in the court system, performing work that includes making determinations about competency to stand trial and fitness for child custody. Their work differs from nonforensic psychiatrists, who typically prescribe and monitor medication and provide psychotherapy for clients with mental health disorders.

Forensic Psychiatric Evaluators' Practice Locations

City	Number of Evaluators
Austin	1
Dallas	3
Horseshoe Bay	1
Houston	2
Lubbock	1
San Antonio	2
Temple	1
Total	**11**

- Although the Medical Board's emphasis on evaluating physicians with mental health disorders is designed to protect the public from impaired physicians, the continued practice of judging applicants on the basis of such diagnoses may result in less public protection. Individuals may be less likely to seek treatment for mental health disorders if they believe their professional future will be negatively affected by the stigma of having to undergo a psychiatric evaluation or the imposition of a potentially unwarranted restricted license. According to psychiatric experts, untreated practitioners are more likely to place the public at risk than those who have actively sought help when needed.

- The Medical Board lacks specific guidelines for making licensing decisions regarding applicants' self-reported physical impairments as well, and considers such applicants on a case-by-case basis. Although, in fiscal years 2003 and 2004, the Medical Board referred only three physician applicants for an independent medical review because of

physical conditions, such as epilepsy, the lack of guidelines for physical disorders could cause the Board to make inconsistent licensing decisions, just as it may for mental health disorders. The chart, *Medical Evaluations*, provides information on the Board's evaluation of applicants with physical conditions.

Medical Evaluations

The Medical, Physician Assistant, and Acupuncture boards' Executive Director and licensing committees may request an independent medical review (IMR) for conditions that could impair professional practice, such as epilepsy and neurological disorders. In fiscal years 2003 and 2004, no physician assistant or acupuncture applicants were evaluated for medical conditions.

	FY 03		FY 04	
	Physician-in-Training	Physician	Physician-in-Training	Physician
Number of applicants with medical conditions approved by the E.D. for a license without an IMR	6	6	23	12
Number of applicants referred for an IMR	0	0	1	2
Number of applicants with a medical condition approved for a license with restrictions	0	1	0	1
Total number of applicants reviewed by E.D. for medical conditions	6	7	24	15

Provisions in the Medical Practice Act regarding exam attempts treat applicants inconsistently.

- Statutory exceptions regarding exam attempts, noted in the textbox, *Physician Licensing Examinations,* on the following page, allow some physician license applicants extra opportunities to pass a national medical licensing exam, potentially allowing less qualified applicants to become licensed. As illustrated in the chart below, *Medical Licensing Examination Passage Rates*, first-time test takers pass exam sections at a higher rate than repeat exam takers. Additionally, the statutory exceptions serve no valuable purpose because few individuals are eligible for them.

Exceptions allow some applicants extra opportunities to pass a national exam.

Medical Licensing Examination Passage Rates 2003

	Part One		Part Two		Part Three	
	First-Time taker	Retaker	First-time taker	Retaker	First-time taker	Retaker
USMLE - M.D.	93%	62%	96%	64%	95%	65%
- D.O.	74%	44%	88%	50%	92%	67%
- Foreign graduate	65%	42%	79%	47%	68%	47%
COMLEX	91%	63%	93%	66%	90%	66%

Physician Licensing Examinations

All physician applicants must pass a medical licensing exam, made up of three sections taken during the medical school and post-graduate training, within specific time frames. Two national exams exist – the United States Medical Licensing Examination (USMLE) and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX). Physicians with a medical degree take the USMLE, while physicians with an osteopathy degree may take either exam. The exam passage time frames and number of allowed attempts are as follows.

Exam attempts allowed

- All physicians applicants must pass all parts of a licensing examination within seven years of passage of the first exam section.
- Within the seven-year time frame, each exam section must be passed within three attempts.
- M.D.-Ph.D. and D.O.-Ph.D. applicants must pass an exam no later than two years after their medical degree was awarded, or within the seven-year time frame.

Exam exceptions

- Physicians may pass two exam sections within three attempts, and one within four attempts.
- Physicians may pass two exam sections within three attempts, and one within five attempts, as long as the applicant is specialty-board certified and completed an additional two years of training in Texas.

Because an individual with a doctor of osteopathy degree can take either the U.S. Medical Licensing Examination or the Comprehensive Osteopathic Medical Licensing Examination to satisfy licensing requirements, those applicants receive more opportunities to pass an examination than applicants with a medical degree. For example, statute does not prevent a doctor of osteopathy applicant from using the allowed exam attempts for each of the licensing exams, essentially allowing these physicians to double the length of time and number of exam attempts allowed to pass the licensing exam.

The Medical Board has no options for licensing physicians who want to practice medicine strictly in an administrative setting.

- The Board has no authority to grant licenses that limit a physician's scope of practice to nonclinical medicine. As a result, the Board is forced to offer a license restricted with a public, nondisciplinary order. Currently, the Board has eight physicians practicing administrative medicine, described in the accompanying textbox, under such an administrative medicine order. However, with more physicians working in nonclinical settings – such as a medical director for a health plan – the Board expects this number to grow.

Administrative Medicine

Administrative medicine describes the kind of work a physician may do as a medical director of a health plan or other corporation. Such work may involve making medical judgments at times, but the physician has no clinical interaction with patients. The Board offers administrative medicine orders to physicians who may only need a limited license for their professional practice, or to those who have not had enough recent clinical experience to qualify for a full physician license.

- Licensing physicians with a restrictive order has unintended negative consequences. Although an administrative medicine order is nondisciplinary, employers and other health-care professionals may believe that, because the physician is under an order, the physician has violated the Medical Practice Act and has been sanctioned by the Board. Because of this misconception, the Board finds that physicians would rather withdraw their licensing application than accept an administrative medicine order. As a result, these physicians may not be able to practice in their chosen occupation.

  Additionally, granting licenses for administrative medicine through nondisciplinary orders wastes staff time and resources. Even though they are on nondisciplinary Board orders, the physicians must participate in the Board's compliance program, which requires staff compliance officers to track the licensee's compliance with the terms and conditions of the order, just as they do with physicians under disciplinary orders.

Recommendations

Change in Statute

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

This recommendation would require the Medical, Physician Assistant, and Acupuncture boards to establish guidelines for evaluating mental health, physical conditions, and alcohol and substance abuse, as well as the circumstances under which independent psychiatric and medical evaluations would be required. The circumstances for evaluations should not be tied simply to a self-reported diagnosis and treatment of a disorder, but should be based on an indication of poor performance or incompetent practice that warrants further evaluation of an applicant. 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. The boards would consider applicants' needs on a case-by-case basis and would not, for example, automatically use a forensic psychiatrist to conduct mental health evaluations or require an applicant to travel for an evaluation if a competent psychiatric evaluator lives near the applicant. 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. The boards should refer applicants with physical conditions to the most appropriate medical specialist for evaluation. Finally, the boards should develop guidelines to assist in making licensing determinations that are based on the results of the requested independent psychiatric or medical evaluation. The guidelines would help board members make more consistent licensing decisions, but would not remove their ability to make independent decisions.

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.

This recommendation would allow the Board to award a medical license limited in scope to the practice of administrative medicine. The Board would not 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.

Management Action

2.4 The Medical Board should work with residency programs and other stakeholders when developing guidelines for use of independent psychiatric evaluations.

When developing guidelines for the evaluation of candidates with a history of mental health disorders, the Board should consult with residency programs and other stakeholders to ensure that their concerns and needs are taken into consideration. The Physician Assistant and Acupuncture boards should also consult with stakeholders when developing guidelines for the use of independent psychiatric evaluations for their licensees.

Impact

Directing the Medical, Physician Assistant, and Acupuncture boards to develop guidelines for the use of independent psychiatric and medical evaluations would create a more consistent licensing process and ensure the fair treatment of all applicants and licensees. The recommendation is not intended as a cookbook, but a way for the boards to make sound, consistent licensing decisions. Eliminating the extra exam attempts that have been added to the Medical Practice Act over the years ensures that only qualified applicants may become physicians. Authorizing the Medical Board to offer an administrative medicine license would allow the Board to focus its resources on physicians under disciplinary orders and convey that an administrative medical license is simply a limited license rather than a restricted license.

Fiscal Implication

These recommendations would not have a significant fiscal impact to the State. The Medical Board would realize a savings from eliminating the need to have staff compliance officers follow up on physicians practicing administrative medicine under a nondisciplinary Board order. The time saved would be redirected to other staff efforts.

[1] The licensure application asks the following question. "Within the past five years, have you been diagnosed, treated, or admitted to a hospital or other facility for any of the following: (i) major depressive disorder, bipolar disorder, schizophrenia, schizoaffective disorder, or any severe personality disorder? (ii) alcohol or substance dependency or addiction? (iii) a physical or neurological impairment (iv) a sexual disorder, including, but not limited to pedophilia, exhibitionism, voyeurism, frotteurism, or sexual sadism?" If an applicant answers yes to any of the above, the person must submit another application form with five years' worth of records and information related to the self-reported condition, including diagnosis, lists of medications taken, medical records, and counseling records.

[2] Psychiatry and Law Updates, "Frequently Asked Questions About Forensic Psychiatry." Online. Available: www.reidpsychiatry.com/reidfaq.html. Accessed: August 20, 2004.

[3] Texas State Board of Medical Examiners, "Physicians by Specialty, May 2004" (Austin, Texas, 2004). Online. Available: www.tsbme.state.tx.us/demo/docs/d2004/0504/spec.htm. Accessed: August 31, 2004. The document shows that 2,267 licensed physicians declare their primary medical specialty as Psychiatry; American Board of Medical Specialties, "Geographic Distribution of Diplomates by General Certificate," (2004). Online. Available: www.abms.org/Downloads/Statistics/Table7.PDF. Accessed: August 18, 2004. The document shows that 2,233 physicians in Texas are specialty-board-certified psychiatrists.

Issue 3

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

Summary

Key Recommendations

- Require the Board to use at least two expert panelists for each standard-of-care investigation.
- Direct the Board to develop additional qualifications and service restrictions for its experts.
- Clarify the legal protections of expert panelists and consultants.
- Authorize the Board to use up to 30 days to evaluate incoming complaints.
- Clarify the consequences of not meeting the 180-day investigation requirement.
- Require the Board to develop additional definitions of good cause for extending an investigation.
- The Board should make an effort to use more expert panelists who reside outside the Austin area.

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.

Conclusion

With statutory directives and additional resources provided by the 78th Legislature, 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 300 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. Sunset staff evaluated the changes made last session to determine if further improvements are needed in these areas. The changes identified 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.

Support

The Board's investigation process has changed as a result of recent legislative directives.

- In 2003, the Legislature provided additional statutory direction and increased resources to the Medical Board's enforcement program, significantly changing the Board's investigation process. The new investigation provisions, as noted in the textbox, *Investigation Program Changes*, apply to all complaints received after November 2003.[1]

Investigation Program Changes

Senate Bill 104, passed by the Legislature in 2003, resulted in the following changes to the Medical Board's investigation process.

- A new expert panel to assist the Board in reviewing standard-of-care cases;
- 180-day deadline to complete an investigation and schedule an informal hearing;
- Requirement to report investigations extending beyond one year to the Legislature;
- Priority given to complaints involving quality of care, impairment, and sexual misconduct; and
- Requirement to review the medical competency of a physician against whom three or more malpractice suits have been filed within five years.

- Staff investigates complaints filed against physicians, physician assistants, and acupuncturists. Complaints fall into two groups – standard-of-care cases, which allege substandard medical treatment; and cases relating to nonmedical violations, such as unprofessional conduct, failure to timely release medical records, and impairment. Because the same staff serves the Medical, Physician Assistant, and Acupuncture boards, the investigation process for complaints involving physicians, physician assistants, and acupuncturists is similar.

Staff has up to 180 days to complete a complaint investigation.

- Staff has up to 30 days after receiving a complaint to evaluate whether a case is jurisdictional. If a complaint is jurisdictional, staff opens a case and forwards it to a field investigator, who has up to 180 days to complete the investigation, unless the Board has good cause to extend the investigation. Staff nurse investigators handle cases that allege standard-of-care violations, but do not make determinations regarding medical competency. Instead, nurse investigators use the standard-of-care determinations by experts to report whether the case involves a violation of the Medical Practice Act and should be heard at an informal settlement conference, or that no violation occurred and the case should be dismissed. Complaints not involving standard of care get assigned to a staff investigator who completes an investigation, provides a determination as to whether allegations have been substantiated, and suggests the need for an informal hearing or dismissal.

- The Medical Board uses expert panel members to evaluate standard-of-care allegations. In 2003, the Legislature directed the Board to create, by rule, an expert panelist system to ensure that a complaint is reviewed by a physician who practices within the same specialty as the physician

being investigated. The Board has developed a pool of nearly 300 physicians in about 75 medical specialties to make standard-of-care determinations, according to the guidelines detailed in the textbox, *Expert Panelist Duties*. Expert panelists do not actually recommend that a case be dismissed or set for an informal hearing, and do not suggest disciplinary action; their sole task is to determine whether the standard of care was violated. However, their opinions may provide the basis for Board action. Each panelist generally reviews three to four cases a year and is paid $100 per hour.

Expert Panelist Duties[2]

The expert physician panel assists the Medical Board with complaints and investigations regarding medical competency. Cases concerning possible standard-of-care violations get assigned to an expert panelist who practices in the same specialty or a similar area of practice as the licensee under investigation. The panelist must review all records and documents collected by a staff investigator and make a determination as to whether a patient received substandard care. The panelist must prepare a report for the Board that includes:

- findings of medical competency;
- the applicable standard of care; and
- the clinical basis for the determinations, including the use of peer-reviewed journals, studies, or reports.

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 relies on the opinion of only one panelist to determine complaint dismissals, potentially depriving the Board of a thorough, balanced assessment of standard-of-care complaints. Currently, to refer the case to an informal hearing, the Board requires two expert panelists to agree that a physician violated the standard of care. However, the Board does not apply that same policy to dismissals. Instead, the Board generally dismisses complaints if the lead panelist does not find evidence of substandard care, without the benefit of a second panelist's review of the case. Ultimately, this policy gives too much authority to one person to influence the outcome of a complaint.

  Despite having almost 300 physicians on its expert panel, the Board regularly uses only a small subset to review standard-of-care cases. The 46 physicians, known as lead panelists, act as first reviewers for all medical competency cases. Of these lead panelists, 38 work in or near Austin, as shown in the chart, *Lead Panelists' City of Residence*. By relying primarily on Austin-area physicians, the Board reduces its ability to ensure that its lead panelists represent statewide standard-of-care practices.

Lead Panelists' City of Residence

City	Number of Lead Panelists
Austin	35
Round Rock	3
Houston	2
Temple	2
Dallas	1
San Antonio	2
Cleburne	1
Total	**46**

- Expert panelists must meet specific qualifications to be eligible to review standard-of-care cases, as detailed in the textbox, *Expert Panelist Qualifications*. In October 2004, the Board adopted additional rules requiring experts to be actively practicing medicine. However, the Board has not addressed other issues that affect the quality of standard-of-care

Expert Panelist Qualifications

To qualify as a reviewer for the Medical Board's standard-of-care cases, a physician must meet the following criteria:

- have a Texas medical license;
- be certified by a national specialty board recognized by the Medical Board;
- have a clean disciplinary record; and
- have an acceptable malpractice complaint history.

reviews. For example, rules do not address the length of time a physician may act as an expert, grounds for removal, or potential conflicts of interest, such as if an expert knows a physician under investigation.

- Expert panelists do not have clear legal protection, which may make some physicians reluctant to serve as reviewers for medical competency complaints. The Medical Practice Act provides immunity from civil liability for individuals acting with regard to medical peer review, but does not clearly extend that immunity to experts or consultants acting as agents for the Board.[3] As a result, expert panelists and consultants do not have clear immunity from judgment like regular agency employees, who have protection from having to pay a settlement in the event of a lawsuit.[4] Expert panelists also do not have clear immunity from suit, which would protect them from being sued for their good-faith service to the Board. Finally, although the Office of the Attorney General represents the Medical Board in court proceedings, Board agents, such as expert panel members, have no such representation and would be responsible for obtaining their own legal representation if they were sued for service provided to the Board.

The Board lacks clear direction with regard to meeting its investigation time frames.

- The Board's 30-day complaint review period is not clearly authorized in statute.[5] Although the Board has a time limit to complete an investigation, the Board has implemented a 30-day evaluation period that does not count toward that 180-day deadline. Staff uses the 30 days to clarify complainant allegations and give licensees an opportunity to respond to allegations before opening a complaint. This initial review period allows the Board to eliminate frivolous and nonjurisdictional complaints and focus resources on cases with a greater chance of resulting in a violation of the Medical Practice Act. For example, the Board may receive a complaint alleging that a physician failed to perform a medical test, but during the 30-day review period, staff receives medical records that show the physician actually did perform the test. Such a complaint would be recommended for dismissal without being filed, saving agency resources for more substantive cases.

An initial 30-day review period allows the Board to eliminate frivolous and nonjurisdictional complaints.

- Although the Board must complete investigations and schedule an informal hearing within 180 days, the Act does not address the consequences of failing to meet this deadline. Since this provision became effective for complaints received after November 2003, the Board has completed more than 99 percent of its investigations within 180 days, with less than 1 percent going beyond the time requirement for good cause.[6] However, the Board does not know what would happen if it failed to meet the 180-day deadline in situations other than for good cause. A physician under investigation could argue that such a case should be dismissed, potentially harming the public if an incompetent physician is allowed to continue to practice because the Board could not complete a complex investigation within the prescribed time frame.

- Board rules do not adequately address reasons for good cause to extend an evaluation. As required by the Medical Practice Act, the Board has established reasons for good cause, including the unavailability of critical documents despite staff's reasonable efforts to obtain them, and a respondent's refusal to cooperate with an investigation.[7] However, rules also state that good cause may include other events beyond the Board's control. Although the Board has not demonstrated such a propensity, the lack of specificity of good cause potentially could allow the Board to claim any event that affects timeliness of an investigation as good cause. Clarifying additional reasons for good cause, such as an expert panelist taking an unusually long time to review a case or a staff investigator suffering an extended illness, could allow the Board to account for viable reasons to extend a deadline while ensuring that the Board cannot cite every delay in an investigation as good cause.

Recommendations

Change in Statute

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

Under this recommendation, 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 be sent to a second, and possibly a third, panelist. If the first panelist believes that the standard of care was not violated, the case would go to a second panelist, who would conduct an abbreviated review of the case, primarily based on the first panelist's written report. If the second panelist agrees that no standard of care was violated, the second panelist would not write a report, but would simply indicate agreement with the first panelist. Cases in which the second panelist disagrees with the first panelist's recommendation to dismiss would go to a third panelist. Again, this third review would be abbreviated, requiring less time and resources than the initial expert's review. The majority opinion of the expert panel would be reflected in the final report written by the first panelist.

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

Although the Board has recently adopted a rule to clarify that members of the expert physician panel must be actively practicing physicians, this recommendation would require the Board to adopt additional rules to address the length of time that a physician may serve as an expert panelist, develop grounds for removal from service, and establish how experts should handle conflicts of interest related to standard-of-care cases. Grounds for removal from service should 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 case, 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 should 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 officially are filed, would allow the Board to dismiss nonjurisdictional and frivolous complaints. The Board could conduct this initial review in less than 30 days, but cannot go more than 30 days, or the clock starts running on the 180-day deadline. 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.

Under this recommendation, the Board would be required to notify all parties to a complaint if, for any reason, an investigation extends beyond the 180-day deadline. The reasons for the extension should be noted in the notifications, whether the reasons are for good cause or not. 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.

Under this recommendation, the Board would use its entire panel of experts, instead of relying on a subset of panelists to make all first determinations on medical competency. The Board would develop, by rule, the method for which it will rotate through its 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 an expert panelist's.

Impact

The recommended changes would strengthen the Medical Board's investigation process and increase protection of the public. The recommendations build on recent legislative directives by ensuring fair, balanced investigation of standard-of-care complaints by qualified expert panelists, providing legal protection to experts and clarifying investigation deadlines.

Fiscal Implication

These recommendations would result in an annual cost of $218,000. According to agency staff, approximately 800 standard-of-care complaints currently reviewed by one panelist would be reviewed by at least two panelists each year under the recommendations in this issue. The agency also estimates that the first and second panelists would agree to dismiss a case 92.6 percent of the time, meaning that 740 cases would be dismissed after two reviews and that 60 cases would need review by a third panelist.

The agency also estimates that the first panelist's review requires four hours, on average, at a cost of $100 per hour. Because the review conducted by the second panelist would be abbreviated and would require no report if the panelist agrees that the case should be dismissed, the cost for the second review is estimated at one-half the cost of the first review. In the 740 cases in which the two panelists agree, the Board would incur an annual cost of $148,000.

For the 60 cases in which the first two panelists do not agree, the second panelist would write a report, spending an average of three hours on the case, at a cost of $18,000. The reports of both panelists would be reviewed by a third panelist, who also would conduct a shorter review of the case, at a total additional cost of $18,000. In addition, the agency estimates that additional mailing and copying costs would equal about $34,000 per year. In summary, the Board would incur a cost of $218,000 per year.

Fiscal Year	*Cost to the General Revenue Fund*
2006	$218,000
2007	$218,000
2008	$218,000
2009	$218,000
2010	$218,000

[1] Complaints filed before November 2003 fall under the Board's old investigation process. As of September 10, 2004, the Board had 13 open cases that were filed before November 2003.

[2] Texas Administrative Code, Title 22, part 9, rule 182.5 (2).

[3] Texas Occupation Code, sec. 160.010.

[4] United States Constitution, Amendment XI.

[5] Texas Administrative Code, Title 22, part 9, rule 178.5.

[6] Texas State Board of Medical Examiners, testimony to the Senate Health and Human Services Committee (Austin, Texas, June 8, 2004).

[7] Texas Administrative Code, Title 22, part 9, rule 179.6 (a).

Issue 4

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

Summary

Key Recommendations

- Require the boards to define the roles and responsibilities of participants in informal hearings.
- Clarify the District Review Committees' role in statute and establish eligibility, training, conflict of interest, and grounds for removal requirements for DRC members.
- Require at least two panelists and one public member in the informal settlement process.
- Increase the number of public members on the District Review Committees.
- Authorize staff to settle nonmedical complaints.

Key Findings

- The boards resolve many disciplinary cases through informal hearings.
- The Medical Board has not defined the roles of staff and panel members in hearings.
- 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.

Conclusion

The informal hearings process is a key part of the Medical, Physician Assistant, and Acupuncture boards' enforcement activities, 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 Sunset review found that 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. Clarifying the responsibilities of all parties involved in the boards' informal hearings and allowing staff to handle administrative, nontechnical complaints would enable the boards to have a fairer, better defined, and more efficient process.

Support

The boards resolve many disciplinary cases through informal hearings.

- The Medical Board holds informal hearings – also called informal settlement conferences – to resolve disciplinary issues against licensees. If, after staff investigates and medical experts evaluate a complaint, evidence suggests a violation of the statute or Board rules occurred, staff schedules an informal settlement conference (ISC) between the licensee and a panel of Board members. Because ISCs are informal, they do not follow procedures established for formal contested case proceedings. With the exception of evaluation by a medical expert, the Physician Assistant and Acupuncture boards use the same informal hearings process.

- Typically, ISC panels consist of two members, although Board rules specify that only one panelist is required.[1] For ISCs concerning physician assistants and acupuncturists, panels consist of members from the licensee's board. For physicians, panels consist of a combination of Medical Board members and members of the District Review Committees (DRCs). For more information on the makeup of the DRCs, see the accompanying textbox.

Because ISCs are informal, they do not follow procedures established for formal contested case hearings.

District Review Committees

In 1981, the Legislature established District Review Committees (DRCs) and required the Medical Board to determine the number of districts and the counties in each district. The Governor appoints five members to each committee – three medical doctors, one doctor of osteopathy, and one public member – who serve six-year terms. Currently, the Board has established four districts, bringing the total number of DRC members to 20. DRC members' sole responsibility is to serve on ISC panels. DRC members only serve on ISCs related to physicians; they do not participate in cases related to physician assistants or acupuncturists.

- At an informal settlement conference, staff attorneys present a synopsis of the allegations and the facts that staff believes support the finding that a violation occurred. Staff may introduce evidence, including medical and office records, X-rays, audio and video recordings, charts, or other explanatory materials. Licensees reply to the staff's presentation and present evidence that they believe proves that a violation of the Act or Board rules did not occur, or that circumstances may mitigate their culpability or the seriousness of the violation.

  At the conclusion, the ISC panel makes recommendations for disposition of the complaint. Outcomes of an ISC include dismissal of the complaint; resolution through an agreed order, in which the licensee agrees with the panel's recommended terms and conditions; referral to staff for more investigation; or referral to the State Office of Administrative Hearings (SOAH) for a contested case hearing before an administrative law judge. All recommendations by an ISC panel must receive final approval from the appropriate full board.

- In fiscal year 2004, the boards held 420 informal settlement conferences. Of these, 295 resulted in agreed orders with a physician and nine with a physician assistant; no agreed orders involved an acupuncturist. In addition, ISC panels referred 45 cases to SOAH.

The Medical Board has not defined the roles of staff and panel members in hearings.

Without guidelines for the informal hearing process, the Board cannot ensure consistency.

- The Board has not established guidelines for panel members who participate in informal hearings. With panels for physician cases consisting of two members drawn from the Board's 19 members and the District Review Committees' 20 members, the makeup, expertise, and style of each ISC panel varies. Because the Board has such a large number of hearings involving so many players, written guidelines could help panel members understand their roles and responsibilities at the hearing, follow applicable laws and procedures governing ISCs, determine whether a violation occurred, and recommend the appropriate sanction. Without such procedures, the Board cannot ensure consistency from hearing to hearing.

- The roles of staff who have significant responsibilities at ISCs are not outlined, either. In an effort to bring consistency to ISCs, the Board created the position of staff hearings counsel, who attends all ISCs for the Medical, Physician Assistant, and Acupuncture boards. While the hearings counsel position provides needed constancy across all ISC panels, the Board has not adequately clarified the position's role and responsibilities.

  Having a consistent participant in ISCs provides an opportunity to give panel members a historical perspective on comparable cases, keep panel members focused and on task, and ensure that both agency representatives and licensees have a chance to present their case. However, without defining the hearing counsel's responsibilities to such tasks, the Board cannot ensure that this staff position will not overstep its bounds, possibly infringing on the role of the panelists.

Defining the roles and responsibilities of ISC participants could reduce the potential for the appearance of conflict of interest.

  For example, although the hearings counsel serves as a neutral party, the position can interact with staff attorneys as well as licensees and their attorneys by asking questions about the case. The counsel may also interact with panel members by suggesting sanctions. Because a fine line exists between providing consistency and becoming an active participant, establishing clear guidelines for this valuable position, as well as other staff involved in ISCs, could reduce the potential for the appearance of conflict of interest. Similar concerns about licensing agencies' staffs being able to provide objective, independent judgment in contested case proceedings had given rise to the creation of the State Office of Administrative Hearings to assume this function.

The role and responsibilities of the District Review Committees are not clear.

- The Medical Practice Act does not specify a purpose for the District Review Committees. Instead, the Board is authorized to define the committees' authority.[2] Without statutory guidance, the Board has

defined the DRC's role to include a broad variety of tasks, including serving as a resource to staff investigators; serving as a public information representative of the Board; reviewing investigative files for evaluation of medical practice or competency; and participating on informal settlement conference panels.[3] Despite outlining all of these activities, however, the Board only uses DRC members to serve on ISC panels. In fact, DRC members served on more than one-third of the Medical Board's ISC panels in fiscal year 2003.

District Review Committee members served on more than one-third of the Medical Board's informal hearing panels.

Some of the activities authorized for the DRC may no longer be appropriate. For example, in 2003, the Legislature established an expert physician panel that the Board must use to review standard-of-care complaints for evaluation of medical practice or competency. As a result, use of DRC members to serve this function is no longer needed.

- Although the Board has scheduled annual meetings for DRC members, no mandatory training requirements exist. Given that DRC members play a crucial role in the Board's disciplinary process, DRC members could benefit from receiving an initial orientation as well as regular training updates on such subjects as the roles and responsibilities of a DRC member, the informal hearings process, and Board statute and rules – particularly those that relate to disciplinary and investigatory authority.

- Despite assisting the Medical Board in determining disciplinary actions, District Review Committee members experience a disconnect from the Board and its final enforcement actions. Although the Board may inform individual DRC members about outcomes of disciplinary cases, no formal process exists to inform all DRC members of the final outcomes. As a result, DRC members generally do not learn what action the Board took on a case they heard at an informal settlement conference. In addition, DRC members may miss out on information that could help them better understand the Board's priorities and bring more consistency to the ISC process. Because the full Board may change or reverse an ISC panel's decision, DRC members could benefit from learning what the final disposition of a case was and receiving an explanation if the Board modified the ISC panel's decision in any way.

Eligibility qualifications for District Review Committee members do not mirror those for Board members.

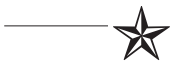
- The Act outlines minimal requirements for membership on the DRCs, which do not reflect comparable provisions for Board members, even though DRC members have a significant role in determining disciplinary action during the informal hearings process. For example, nothing in statute requires a DRC physician member to be actively practicing medicine; or prohibits a public member from being a health-care provider, although these provisions apply to Board members.

  In addition, no provisions outline conflicts of interest for DRC members or specify grounds for removal of DRC members. For example, the Medical Practice Act does not specify that a physician appointed to the DRC can be removed if the physician does not maintain an active Texas license to practice medicine, yet this requirement applies to Board members to ensure that they are abreast of current medical issues.

The composition of the boards' informal hearing panels does not ensure balanced representation.

- Minimal requirements exist regarding the makeup of ISC panels. Although the boards typically use two-member panels at ISCs, rules state that only one panelist is needed.[4] All actions by an ISC panel are ultimately reviewed by the full board, but the time spent on and details discussed about a complaint are much more significant at the ISC level, particularly for standard-of-care cases. Therefore, allowing one person to serve as the ISC panel delegates considerable authority to a single person. Requiring at least two panel members to hear a standard-of-care case provides an opportunity for having additional perspectives and expertise in deciding whether a licensee violated statute or rules.

- By not requiring at least one public member on each ISC panel, the boards cannot ensure a balance between occupational and public interests. In fiscal year 2003, the Medical Board used public members – either from the Board or the DRC – on 37 percent of its ISC panels. The Physician Assistant Board used public members on 33 percent of its ISC panels, while the Acupuncture Board used public members 10 percent of the time. Although the licensed professional members of the board are required to make decisions to protect the public, they remain members of the regulated profession. Public members of the boards, however, are appointed solely as representatives of the health-care consumer. Requiring a public member to sit on all ISC panels would help ensure that the public's perspective is represented at all informal disciplinary hearings, as well as help alleviate any concerns that could arise about the professions regulating themselves.



Requiring a public member on all ISCs could help alleviate concerns about the professions regulating themselves.

- In addition, the Medical Board does not require that at least one Board member serve on each ISC panel. Although it rarely happens, an ISC panel could consist of just DRC members, resulting in no Board presence at the ISC. Because the Board does not require at least one ISC panel member to attend Board meetings when a case heard by the panel is discussed, a representative from the panel may not be available to discuss details of the hearing and answer any questions other Board members may have as they deliberate on the final action.

The boards are limited in their ability to quickly resolve nonmedical complaints.

- The boards schedule informal hearings for all cases, including administrative violations. As a result, ISC panels spend time on cases that could be handled efficiently by staff, and complaints regarding administrative violations or cases that do not involve standard-of-care issues may take longer to resolve than needed.

  For example, complaints regarding a licensee not completing the required hours of continuing medical education or not releasing medical records in a timely manner currently must be scheduled for an informal settlement conference. When informed of the ISC date, many licensees waive their right to the informal hearing and sign an agreed order proposed by staff. In fact, 71 licensees waived their right to an ISC in fiscal year 2003. While these cases still required approval by the full

board, they point to the larger role staff could play in resolving cases that do not require professional expertise.

- Other boards allow staff to handle nontechnical complaints. For example, the Pharmacy Board has directed its staff on what type of cases staff is authorized to handle. All dispositions are ultimately approved by the Pharmacy Board and the licensee always has the right to an informal hearing.

Previously dismissed complaints have no bearing on a current investigation and may have a prejudicial effect on deliberations.

The boards inappropriately consider complaints that have not resulted in sanctions.

- During an ISC, staff informs the panel members about previous complaints filed against the licensee, even if those complaints were dismissed. As a result, panel members may consider this information when deliberating on a complaint case, including determining the type of sanction or amount of penalty to impose. However, previously dismissed complaints have no bearing on a current investigation and may have a prejudicial effect on the deliberations. While the Medical Practice Act specifies that a licensee may receive harsher punishment for a violation if the licensee has previously been found to have violated the Act, statute does not refer to dismissed complaints.

- While the public may benefit from knowing the types of complaints dismissed, staff could provide this information in aggregate form or in a manner that does not identify individuals who have not been found guilty of violating state laws or rules. In addition, staff can and should continue to use previously dismissed complaints to help guide current investigations. Information from past cases may be useful in helping staff prove current allegations.

- Other state boards do not look at dismissed complaints when determining sanctions. For example, the Texas Board of Professional Engineers reviews complaints for trends, but does not include previously dismissed complaints against a licensee when deliberating on a current complaint.

Recommendations

Change in Statute

4.1 Require the boards to define the roles and responsibilities of participants in informal hearings.

Under this recommendation, the boards would adopt rules or procedures clarifying the roles and responsibilities of ISC participants, including board members, DRC members, and all appropriate staff. The 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 training, conflict of interest, and grounds for removal requirements for DRC members.

Under this recommendation, statutory provisions that apply to Medical Board members would be reflected for DRC members as well. These provisions include conflict of interest, training, and grounds for removal.

4.4 Require at least two panelists in all informal hearings.

This recommendation would require that a minimum of two panelists 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. This recommendation would not apply to informal hearings for showing compliance with a Board order or requesting a modification to an order or termination of an order.

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

This recommendation would ensure that the boards 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 – four physicians and three public members. Because DRC members' primary role is to serve on ISC panels, increasing the number of public members on the DRCs would provide the Board with a larger to pool to draw from for ISC panels without increasing the size of the Board.

4.7 Authorize staff to settle nonmedical complaints.

This recommendation would authorize staff to resolve cases involving nonmedical and administrative violations, subject to delegation by the boards. Staff would have the ability to dismiss these complaints, subject to review by the boards at their public meeting, or to refer the matter directly to a settlement conference. A committee of 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.

Management Action

4.8 The boards 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 such dismissed complaints when deliberating on a current complaint. However, ISC panel members would continue to be able to consider a licensee's previous history of *violations* when determining sanctions for a current violation.

4.9 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.

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

The Medical Board should establish a policy requiring that at least one member from an ISC panel 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, by asking questions and hearing comments, 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.

Impact

These recommendations would clarify the roles and responsibilities of the participants in the boards' informal hearings process, as well as formalize some of the boards' existing processes. Establishing qualifications for District Review Committee members reduces the potential for a conflict of interest and ensures that panelists determining disciplinary actions meet certain standards. Requiring the boards to include a public member on their informal settlement conference panels ensures that consumer interests are represented at a critical stage in the disciplinary process. Adding two additional public members to each District Review Committee gives the Medical Board a larger pool of public members to draw from for its informal settlement conferences. Authorizing staff to handle nonmedical complaints, subject to final Board approval, streamlines the enforcement process and would likely result in having fewer complaints go to informal settlement conferences. Ultimately, these recommendations would provide a fairer, streamlined, and more defined informal hearings process.

Fiscal Implication

These recommendations would have a minimal fiscal impact to the State. Because the boards currently use two panel members for most informal settlement conferences, requiring one of those panel members to be a public member would not increase the size of the panels. Increasing the size of the District Review Committees would have a minimal cost, depending on the type of training the Medical Board requires for new members.

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1 Texas Administrative Code, Title 22, part 9, rule 187.21.

2 Texas Occupations Code, ch. 163.

3 Texas Administrative Code, Title 22, part 9, rule 191.4.

4 Texas Administration Code, Title 22, part 9, rule 187.21.

Issue 5

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

Summary

Key Recommendations

- Clarify the Board's ability to disclose peer review documents in disciplinary hearings.
- Clarify that medical records otherwise available are not confidential.

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.

Conclusion

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. In fact, both the medical community and policymakers have widely accepted peer review of physicians as essential to helping ensure high quality medical practice, have granted immunity to peer review participants from legal action, and have made the deliberations and records of medical peer review privileged from judicial disclosure to encourage full, honest participation.

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.

Clarifying that the Board's authority to disclose peer review documents extends to formal hearings would enable the Board to better enforce the Medical Practice Act and take action against physicians for conduct found likely to harm the public. Strengthening confidentiality and immunity provisions would encourage participation in medical peer review by assuring participants that they are protected from civil liability, which both state and federal law deem necessary.

Support

Peer review actions against a physician are grounds for disciplinary action by the Medical Board.

- The Medical Practice Act authorizes the Board to take enforcement action against or refuse to issue a license to a physician who is removed, suspended, or otherwise disciplined by a medical peer review committee or other organization of the physician's peers.[1] For more information on what peer review is, see the textbox, *Medical Peer Review*. In fiscal years 2003 and 2004, the Board opened 88 complaints relating to peer review action. In those years, the Board took disciplinary action against 29 physicians as the result of peer review actions.

In the last two years, the Board took action against 29 physicians based on peer review actions.

- Medical peer review committees and health-care entities must report to the Board the results and circumstances of certain peer review actions, including:
  - actions that adversely affect the clinical privileges of a physician for a period longer than 30 days;
  - instances when a physician surrenders clinical privileges for possible incompetence or improper professional conduct – either while under investigation by the medical peer review committee for possible improper professional conduct or in return for a peer review committee not conducting an investigation or proceeding; or
  - actions that adversely affect a physician's membership in a professional society or association, if the medical peer review is conducted by that organization.[2]

Medical Peer Review

Peer review is the evaluation of medical and health-care services, including evaluation of the qualifications of professional health-care practitioners and of patient care provided by those practitioners. In Texas, hospitals, medical organizations, university medical schools and health science centers, health maintenance organizations, extended-care facilities, hospital districts, and hospital authorities may form medical peer review committees.

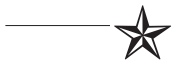
Peer review includes evaluation of the:

- merits of a complaint relating to a health-care practitioner and the determination or recommendation regarding the complaint;
- accuracy of a diagnosis;
- quality of the care provided by the health-care practitioner;
- report made to the medical peer review committee concerning activities under the committee's authority;
- report made by a medical peer review committee to another committee or the Medical Board as permitted or required by law; and
- implementation of the duties of a medical peer review committee, member, agent, or employee of the committee.

To be accredited, health-care facilities, such as hospitals, typically must establish a process to monitor and evaluate the quality of care provided to patients. Hospitals establish peer review – or quality assurance – plans, which specify such things as participants in peer review, circumstances requiring peer review, the process for conducting a peer review, and possible outcomes of a peer review proceeding.

Under the peer review statute, medical peer review committees, as well as individual physician, physician assistant, and acupuncture licensees and students, must report relevant information to the Board if, in the opinion of the individual or the committee, a physician poses a continuing threat to the public welfare through the practice of medicine.[3]

- To encourage peer review, the Medical Practice Act provides immunity from civil liability to persons, medical peer review committees, and health-care entities that participate in peer review proceedings, as long as they do so without malice.[4] The Act also makes medical peer review records confidential and communication to the peer review committee privileged.[5] In addition, the Act specifies that peer review documents and reports are not available for discovery or court subpoena and may not be introduced into evidence in any action for damages.[6] However, a peer review committee may waive this privilege.[7]



Peer review participants are immune from civil liability if they do so without malice.

- Federal and state guidelines govern medical peer review. In the Health Care Quality Improvement Act of 1986, the U.S. Congress established standards for hospital peer review committees and provided immunity for those involved in peer review.[8] Texas opted into the federal law early, making it apply to professional reviews actions or medical peer reviews conducted on or after September 1, 1987.[9] In addition, state law authorizes certain health-care entities, such as hospitals, to form medical peer review committees and outlines peer review committees' authority to evaluate medical and health-care services.[10]

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.

- The Board's ability to disclose peer review documents in a formal or contested case hearing is unclear. As a result, the Board has difficulty enforcing the provision of the Medical Practice Act that establishes peer review action as grounds for the Board to discipline a physician. The Act authorizes the Board, after being informed of a peer review action, to take disciplinary action against a licensee if the Board finds that the peer review action was based on unprofessional conduct or professional incompetence that was likely to harm the public. The Board also must find that the peer review action was appropriate and reasonably supported by evidence submitted to the Board.[11] However, to prove that a peer review action was indeed appropriate and reasonable, the Board often must – through its subpoena and investigatory authority – rely on peer review documents. The Act gives clear authority to the Board to disclose these documents during its informal disciplinary proceedings, but does not clearly extend this authority to cases heard before an administrative law judge at the State Office of Administrative Hearings (SOAH).

The Medical Practice Act authorizes the Board to discipline a physician based on a peer review action.

- Because the statute is unclear on the Board's ability to disclose peer review documents in disciplinary hearings, the Board has experienced differing rulings by SOAH judges on whether this information may be disclosed and admitted into evidence in contested case hearings. Some

SOAH judges have allowed information from peer reviews to be admitted for purposes of showing the basis of the Board's case, and that the case is jurisdictional. Other SOAH judges have not allowed any peer review information to be admitted, even to show how the case got to the Board. Such rulings harm the Board's ability to prepare contested cases against physicians the Board believes have violated the Act based on peer review actions it deems to be appropriate and reasonable. Without this peer review information, the Board has difficulty taking action against physicians for conduct it believes may harm the public.

- Confusion also exists as to what is considered confidential in peer review documents. During the course of an investigation, a peer review committee compiles records, correspondence, and other documents, including information that is not produced specifically by or for the committee's investigation, but may be presented during peer review committee proceedings. Examples of such information include patient medical records or hospital pharmacy records. While this information may become part of a peer review record, the information is otherwise available. Clarifying that records that were not produced specifically by or for a medical peer review committee are not confidential, but are subject to discovery would enable the Board to use pertinent information to enforce the Act in formal hearings.

Recommendations

Change in Statute

5.1 Clarify the Board's ability to disclose peer review documents in disciplinary 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. Although the Board would be able to disclose peer review documents at SOAH, this recommendation would clarify that peer review documents are not available for discovery for other purposes, as outlined in existing statutory provisions regarding confidentiality of peer review records. Specifically, peer review documents produced by or for a medical peer review committee are not available for discovery or court subpoena and may not be introduced into evidence in any action for damages, including a medical professional liability action.[12]

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.

Impact

These recommendations clarify the Board's responsibility and authority to discipline physicians who have been the subject of certain adverse peer review actions. Specifying that the Board may disclose peer review records in a formal hearing before the State Office of Administrative Hearings, but

clarifying that doing so does not open the door for these records to be used in a civil action, would allow the Board to effectively enforce the Medical Practice Act without chilling the ability of hospitals and other health-care entities to use peer review to evaluate patient care and physician performance. The Medical Board would still have to judge the reasonableness and appropriateness of peer review actions before seeking disciplinary action, and peer review action must still be brought in good faith and without malice. In addition, clarifying which documents used in a peer review proceeding are privileged and confidential would allow both participants in the peer review process and the Board to evaluate and investigate known or suspected problems with full knowledge of what information could later be admissible at trial.

Fiscal Implication

These recommendations would not have a fiscal impact to the State.

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[1] Texas Occupations Code, sec. 164.051(a)(7).

[2] Texas Occupations Code, sec. 160.002(a).

[3] Texas Occupations Code, sec. 160.003.

[4] Texas Occupations Code, sec. 160.010.

[5] Texas Occupations Code, sec. 160.010 and sec. 160.007(a).

[6] Texas Occupations Code, sec. 160.006(c).

[7] Texas Occupations Code, sec. 160.007(e).

[8] 42 U.S.C. ch. 117 (2002).

[9] Texas Occupations Code, sec. 160.001.

[10] Texas Health & Safety Code, sec. 161.0315.

[11] Texas Occupations Code, sec. 164.051(a)(7).

[12] Texas Occupations Code, sec. 160.006(c).

Issue 6

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

Summary

Key Recommendations

- Restrict nondisciplinary rehabilitation orders to impaired physicians who have not also violated the standard of care.
- Require the Board to define the roles and responsibilities for professional associations in rehabilitation orders.

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.

Conclusion

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. Sunset staff found that while private rehabilitation orders serve as a valuable incentive to encourage physicians to seek treatment for impairment, the Board should limit private orders to those practitioners who have not harmed the public by violating the standard of care. Also, while professional organizations can play a key role in a physician's rehabilitation, the Board should provide clearer direction to these entities when including them in monitoring a physician. Doing so would help ensure that impaired physicians get the treatment they need, that the Board can accurately monitor licensees under rehabilitation orders, and that the public is protected.

Support

The Board issues rehabilitation orders to applicants and licensees with impairment issues.

- The Medical Practice Act recognizes substance abuse, including drunkenness and excessive use of drugs, narcotics, and other substances, as grounds for disciplinary action or refusal to issue a license.[1] Licensees and other health-care practitioners as well as organizations, such as hospitals and professional associations, must report an impaired physician, physician-in-training, physician assistant, acupuncturist, or surgical assistant to the Medical Board if the licensee poses a continuing threat to the public. The textbox, *Reporting Impairment*, outlines some of the most common ways the Board learns about an impaired physician.

Reporting Impairment

The Board finds out about an impaired physician through the following reporting mechanisms:

- physician self-reporting;
- complaints filed by the public or other healthcare professionals;
- medical peer review committee actions; and
- reports filed by law enforcement agencies or other licensing entities.

In 2003, the Legislature directed the Medical Board to give priority to complaints involving impaired physicians.[2] After conducting an investigation and finding that a licensee is impaired, the Board may issue a public order temporarily suspending the physician's license until it determines that the licensee may safely and competently practice medicine. The Board may also probate the suspension under terms and conditions such as drug testing, restrictions on practice, attendance at Alcoholics Anonymous or Narcotics Anonymous meetings, and psychiatric evaluation and treatment.[3]

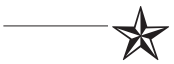
- The Board may also issue a private, nondisciplinary rehabilitation order to physicians who self-report their impairment to the Board. The Board began offering private rehabilitation orders in 1993 to provide an incentive to a licensee or applicant to seek assistance with drug and alcohol problems that present a potentially dangerous limitation or inability to practice medicine with reasonable skills and safety.[4] When issuing a private rehabilitation order, the Board may impose the same terms and conditions on the physician as with a public order. However, unlike a public order, private rehabilitation orders are not made available to the public, including hospitals, and are not subject to open records requests.

- Professional associations, such as the Texas Medical Association, Texas Osteopathic Medical Association, Texas Academy of Physician Assistants, and county medical societies, typically provide rehabilitation programs for impaired physicians. A licensee may self-report a substance abuse impairment to one of these organizations instead of or in addition to the Board. Unless the organization believes that the licensee poses a continuing threat, the organization is not required to notify the Board about the impaired licensee.

The use of private rehabilitation orders does not protect the public when it shields standard-of-care violations.

- Physicians who violate the Medical Practice Act may receive a private rehabilitation order, even though a patient may have been harmed as a result of their impairment. If the Board finds that a physician with a

private rehabilitation order has violated the standard of care or committed a criminal act, the Board may also issue a public agreed order addressing the violation. In these cases, the public order does not reference the physician's impairment, even though it may have been a contributing factor in the offense or substandard medical care. Because the physician's impairment is confidential, the public order addressing the violation may lack key information or details of the Board's findings. As a result, some public orders do not inform the public about an impaired physician's ability to safely practice.

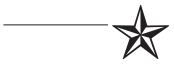


Less than half of licensees under Board order for impairment are known to the public.

- The Board does issue public orders for physicians with impairments who have violated the standard of care. Such orders are open to the public, including information about the impairment. However, of the 183 practitioners under drug and alcohol testing as part of a Board order in 2004, less than half – or 87 – have public rehabilitation orders that are open to the public.

- Because licensees are only eligible for private rehabilitation orders if they self-report, physicians may notify the Board of their impairment primarily because they know someone else – such as another physician, a patient, or a family member – plans to report them. If, after a physician self-reports, someone files a complaint with the Board, the physician may still be eligible for the private rehabilitation order. While using private rehabilitation orders to encourage licensees to self-report a substance abuse problem serves a valuable purpose, shielding licensees who have violated the standard of care does not protect the public. Because the public does not know that an impairment caused a physician to provide substandard medical care, the public cannot make an informed decision about the physician.

- In some cases, physicians who have violated the standard of care as a result of their impairment may only receive a private Board order that addresses the issue of impairment, while the complaint relating to the standard-of-care violation is dismissed. For example, the Board received a complaint from a patient alleging substandard medical care during an emergency room visit. During the informal settlement conference, the physician admitted to violating the standard of care as a result of a drug addiction. The Board reviewed the findings and determined that the violation occurred only because of the physician's impairment. The Board issued a nondisciplinary private order and dismissed the standard-of-care complaint. As a result, the complainant received a letter stating that the Board had reviewed the complaint, determined it was unfounded, and the case was dismissed. The complainant had no way of knowing that the Board had disciplined the physician under a private rehabilitation order.



The Board's private rehabilitation order appears to shield impaired physicians who have harmed the public.

The role of county medical societies and other professional organizations in the Medical Board's compliance program is unclear.

- County medical societies, which are local organizations comprising physicians in a community, are unsure of their role and responsibilities in the Board's compliance program. The Board often directs physicians

under a private or public rehabilitation order to participate in a local County Medical Society Physician Health and Rehabilitation program. These programs typically offer convenient Alcoholics Anonymous meetings designed specifically for medical professionals and maintain an active list of other area resources that may assist the physician's rehabilitation efforts.

After issuing a disciplinary order, the Board asks a county medical society to submit regular compliance progress reports on the physician. However, the Board does not clearly define the type of information needed from the county medical society, the format of the information, or the frequency of the reports. For example, the Board may ask a county medical society to monitor whether the physician attended Alcoholics Anonymous, but will not specify the information the Board needs, such as the number of times the physician attended meetings.

- Because the Board has not defined what information it wants, reports submitted may not provide the Board with a full picture of how the practitioners are doing. As a result, the Board does not have complete information when determining if a licensee under a rehabilitation order has demonstrated fitness to practice medicine.

Other health licensing agencies' rehabilitation orders provide better public protection.

Most states do not offer private rehabilitation orders to licensees who have violated the standard of care.

- The Texas State Board of Nurse Examiners, Dental Examiners, Veterinary Medical Examiners, and State Board of Pharmacy do not offer private rehabilitation orders to impaired licensees who have also violated their practice act. For example, an impaired dentist reported to the Board for a standard-of-care violation receives a public order for no less than a five-year term. As a result, this information is available for the public to use when deciding on a dental care provider. Likewise, an impaired pharmacist who has also violated the practice act receives a five-year Board order, which is available to the public.

- Many states, such as New York, Illinois, and Michigan, do not offer private rehabilitation orders to impaired physicians. For example, New York's Office of Professional Medical Conduct sends physicians who self-report impairment and have not violated the standard of care or committed a criminal act into an inactive license status. The licensee is reinstated only after the physician is able to prove both competency and sobriety. If a standard-of-care violation has occurred or a conviction made in relation to impairment – such as driving while intoxicated (DWI) – the Office of Professional Medical Conduct sanctions the physician under a public order.

Recommendations

Change in Statute

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

This recommendation would clarify that applicants and licensees with a current condition or history of substance or alcohol abuse are eligible for a private, nondisciplinary order only if the licensee has not violated the standard of care as a result of the impairment. The Board would decide what standard-of-care violations are, just as it currently does in enforcing the Medical Practice Act and its rules. 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 apply to physicians-in-training, physician assistants, acupuncturists, and surgical assistants as well.

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

Under this recommendation, 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.

Impact

These recommendations would allow licensees who recognize that they have an impairment problem to seek help and access treatment under a private rehabilitation order before they violate state laws or Board rules or harm the public. Conversely, prohibiting those licensees who have violated the standard of care from being eligible for a private rehabilitation order would provide consumers with complete information as they make decisions regarding their health-care providers.

Fiscal Implication

These recommendations would not have a fiscal impact to the State.

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[1] Texas Occupations Code, sec. 164.051 (a)(4)(B)-(C).

[2] Texas Occupations Code, sec. 154.056 (a)(1) and SB 104.

[3] Texas Administrative Code, Title 22, part 9, rule 190.4 (E).

[4] Texas Administrative Code, Title 22, part 9, rule 180.1 (b)(1).

Issue 7

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

Summary

Key Recommendation

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

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.

Conclusion

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 are subject to the Board's disciplinary authority. Regulated physicians must follow strict safety guidelines regarding anesthesia administration, including the maintenance of emergency supplies and equipment and transportation agreements with local emergency services. However, several exemptions to regulation requirements exist.

Sunset staff evaluated the Board's ability to regulate physicians who provide office-based anesthesia and found that while most exemptions relate to facilities licensed by another entity, exempting physicians who use moderate sedation potentially reduces the Board's ability to protect the public. Patients who receive moderate sedation from exempt physicians are at risk because such physicians do not have to follow the Board's safety guidelines and may be unprepared to handle unforeseen emergencies. 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.

Support

The Medical Board regulates physicians' use of anesthesia to ensure the quality and safety of office-based surgery.

- In 1999, after a child died from anesthesia complications during a routine office-based procedure, the Legislature began requiring the Medical Board to regulate physicians who provide anesthesia services in an outpatient setting. Outpatient settings include a facility, clinic, office, or any other setting not part of a licensed hospital or ambulatory surgical center, both of which are regulated by the Texas Department of State Health Services. Medical industry professionals estimate that about one in 10 outpatient procedures are performed in office-based settings.[1] Common office-based surgeries include vasectomy, colonoscopy, endoscopy, liposuction, and other cosmetic surgery procedures.[2]

- State law requires the Board to establish, in cooperation with the Nurse Board, minimum standards for anesthesia services provided by a physician or certified registered nurse anesthetist in an outpatient setting. The Legislature specified that the rules must be designed to protect the health, safety, and welfare of the public and include requirements relating to:

  – general anesthesia, regional anesthesia, and monitored anesthesia care;

  – patient evaluation, diagnosis, counseling, and preparation;

  – patient monitoring to be performed and equipment to be used during a procedure and during post-procedure monitoring;

  – emergency procedures, drugs, and equipment, including education, training, and certification of personnel, as appropriate, and protocols for transfers to a hospital;

  – the documentation necessary to demonstrate compliance with law; and

  – the period in which protocols or procedures covered by rules of the board shall be reviewed, updated or amended.[3]

- Physicians who perform office-based surgical procedures requiring anesthesia must register their practice site with the Board and comply with rules regarding the safe administration of anesthesia. The Board has authority to discipline registered physicians who violate anesthesia regulations. The textbox, *Office-Based Anesthesia Safety Requirements*, outlines the safety standards and guidelines that physicians at registered sites must follow.[5] Currently, 99 physicians have registered 107 practice sites with the Board.

Office-Based Anesthesia Safety Requirements

The Board requires physicians to follow American Society of Anesthesiologists standards and guidelines for the administration of anesthesia. Safety requirements include:

- a preanesthetic evaluation;
- obtaining informed consent regarding potential risks and complications;
- regularly checking anesthesia equipment;
- continuous monitoring of patients during anesthesia;
- transportation agreements with emergency medical services;
- maintaining back-up electrical power; and
- maintaining certain emergency supplies, such as a defibrillator for cardiopulmonary resuscitation.

- The Medical Practice Act includes eight exemptions from Board regulation of outpatient anesthesia services, as detailed in the textbox, *Office-Based Anesthesia Exemptions*. Most of the provisions exempt facilities already licensed or accredited by other organizations or government agencies that have strict anesthesia safety standards, such as hospitals or surgical centers. The Act also exempts physicians who only use local anesthesia and those who use sedating and pain-killing drugs in doses that do not have a probability of placing a patient at risk for loss of independent breathing, also known as moderate or conscious sedation. The chart, *Anesthesia Continuum*, highlights the main types of anesthesia. The number of physicians exempt from the Board's regulation cannot be estimated.

***Office-Based Anesthesia Exemptions*[4]**

The Medical Practice Act provides eight exemptions from the State's office-based anesthesia regulation, including:

- outpatient settings where only local anesthesia is used;
- outpatient settings where moderate anesthesia is used in doses that do not have a probability of placing patients at risk for loss of the patient's life-preserving protective reflexes, such as independent breathing;
- licensed hospitals;
- licensed ambulatory surgical centers;
- clinics on land federally recognized as tribal land;
- facilities maintained by a state or local government entity;
- federal clinics; and
- outpatient clinics accredited by the Joint Commission on Accreditation of Healthcare Organizations, the American Association for the Accreditation of Ambulatory Surgery Facilities, or the Accreditation Association for Ambulatory Health Care.

- According to medical professionals, the majority of licensed physicians are exempt from the Board's anesthesia regulation because they practice in licensed or accredited facilities. Additionally, most physicians practice in licensed or accredited practice sites because insurance plans generally only reimburse physicians for procedures that take place within such facilities.

***Anesthesia Continuum*[6]**

Local anesthesia	Provides numbness to a small, limited area of the body, such as the skin around a mole. The Medical Board does not regulate local anesthesia.
Moderate/Conscious sedation	Creates an altered level of consciousness through the use of medications that relieve pain and make the patient drowsy. The Medical Board does not regulate physicians who induce conscious sedation with drug doses not likely to affect a patients' ability to breathe independently.
Regional anesthesia	Typically involves the injection of aesthetic medication in or near the spinal canal to block sensation for a specific region of the body, such as below the waist for childbirth. The Board regulates this type of anesthesia.
General anesthesia	Involves the total loss of consciousness, pain, sensation, and protective airway responses. The Board regulates the administration of general anesthesia in outpatient settings.

Lack of regulation of moderate sedation places the public at risk of bodily injury or death.

- Exempt physicians may perform office procedures requiring moderate sedation without having to comply with the Board's safety requirements, regardless of the scope or complexity of the surgical procedure. For example, these physicians do not have to conduct a preanesthesia patient evaluation, use equipment that continuously monitors patient vital signs, or maintain emergency supplies used by regulated physicians and those who work in accredited facilities. As a result, patients have no assurance that these physicians can adequately monitor their status or respond to an emergency if one should arise.

  Exempt physicians can use moderate sedation without meeting safety requirements.

  Because physicians using moderate sedation are exempt from Board regulations, the Board cannot discipline such physicians for failure to meet anesthesia safety requirements. Consequently, the Board cannot effectively act to prevent a problem, but may only get involved after a more serious medical standard-of-care issue has arisen.

- Despite recent improvements to anesthesia drugs and equipment, individuals can still have unexpected, potentially life-threatening reactions to and complications from drugs used for any procedure requiring more than local anesthesia. Experts say that the line between moderate sedation and deep anesthesia can be easily crossed if too much sedative is administered.[7] For example, an adequate drug dose for moderate sedation in one patient may prove inadequate for another patient, and the increased dose may result in the patient being placed at risk of losing the ability to breathe independently. The textbox, *Selected Texas Office-Based Surgery Incidents*, details unexpected anesthesia complications that occurred in outpatient settings.

Selected Texas Office-Based Surgery Incidents

The Medical Board investigated the following cases regarding office-based surgery incidents.

Case One: A patient died after sinus surgery because of oversedation, inadequate staffing and monitoring of anesthesia, and failure to safely manage complications from anesthesia. The physician sedated the patient at increased drug doses without documenting the reason for the higher doses. Forty minutes into the surgery, the physician noticed that the patient had a serious decrease in oxygen levels. The physician attempted to ventilate the patient, but placed the tube into her esophagus instead of a breathing airway. The patient was transported to a hospital for emergency treatment. She died three days later.

Case Two: A patient sustained lasting injuries after a cosmetic procedure during which a series of preventable mishaps occurred.

- The physician sedated the patient with Valium. Unexpectedly, the patient became unconscious and unresponsive. The physician refused to call 911 for fear of bad publicity.
- Just prior to the procedure, a repairman informed the physician that the pulse-monitoring equipment was not working. The physician began the surgery without the equipment and with the patient still unconscious. During the procedure, he discovered that the patient's pulse was decreasing and administered oxygen until she could be awoken.
- After the procedure, the physician sent the patient home with pager and phone numbers in case she experienced problems. The patient experienced side effects, including an eye injury incurred during surgery. The physician did not return her phone calls, and during a follow-up exam weeks later, told the patient she was fine, despite continued side effects.
- The patient continues today to cope with serious side effects from the procedure.

- Exempt physicians do not have to inform patients of the potential complications of office-based anesthesia. As a result, unless told otherwise by their physicians, patients may assume that procedures requiring mild to moderate anesthesia carry no risk, or that the physician has adhered to safety standards provided in other settings, such as a hospital or ambulatory surgical center. Also, unless informed by the physician or the physician's staff, patients may not have the opportunity to learn about potentially life-threatening complications that can arise from the use of even safe anesthesia drugs administered at moderate levels.

Unexpected, life-threatening complications can arise during use of anesthesia.

Exempting physicians from regulation of moderate sedation is inconsistent with other Texas health-care practices and other states' medical practice laws.

- In Texas, licensing boards for podiatrists and dentists regulate all licensees using office-based anesthesia, regardless of the scope of the surgery performed. All licensees using anesthesia in an office must register with their board and follow specific safety guidelines. These boards do not exempt any licensees or facilities from board regulation of office-based anesthesia, even for low doses of sedatives such as Valium. Regulations for both boards require the use of a preoperative patient evaluation, maintenance of specific safety equipment and medical supplies, and continuous monitoring of sedated patients by the licensee. The licensee and other office staff must also be trained in basic life support, including cardiopulmonary resuscitation.

The Texas Podiatry and Dental boards regulate all licensees using office-based anesthesia, regardless of the scope of the surgical procedure.

- Deaths and injuries associated with unregulated office-based anesthesia have prompted some states to adopt strict standards for the administration of all levels of office-based anesthesia. Currently, 20 states have some form of office-based surgery regulation, such as statutory regulation of anesthesia, voluntary guidelines, or requirements for accreditation or licensure of outpatient practice sites. Regulation by other states generally includes requiring or encouraging physicians to comply with guidelines similar to the American Society of Anesthesiologists' office-based surgery guidelines for the scope of procedures regulated by that state.

  For example, before regulating all office-based anesthesia in 2002, Florida had a high number of deaths and injuries associated with cosmetic surgeries, as noted in the chart, *Florida Office-Based Procedure Deaths and Injuries*. Since instituting strict safety procedures Florida has experienced a lower incident of injuries and deaths associated with office-based anesthesia.[8] Other states, including Ohio and Alabama, have followed Florida's lead and established stronger safety requirements for office-based surgeries, including the regulation of moderate sedation.

Florida Office-Based Procedure Deaths and Injuries		
	2000-2002 (no regulation)	**2002-2003 (regulation in place)**
Number of procedures	141,404	77,772
Number of deaths	13	2
Number of injuries	93	18

Recommendation

Change in Statute

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

Under this recommendation, 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.

Impact

Requiring physicians who administer drugs that induce an altered state of consciousness to register with the Board and adhere to minimum safety standards would allow the Board to better protect the public by providing a higher standard of patient safety, reducing risks and liability. Patients would have the ability to make informed decisions about surgical procedures, and would have assurance of careful monitoring during surgical procedures, the presence of needed equipment and personnel, and the availability of emergency care and transportation if complications should arise.

Fiscal Implication

This recommendation would not result in a significant fiscal impact to the State. Physicians currently exempt from office-based anesthesia regulation would be required to pay the $600 biennial registration fee to cover the cost of regulation. Because the number of physicians who would be required to register with the Board is not known, the increase in physicians paying the registration fee cannot be estimated.

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[1] Federation of State Medical Boards, *Report of the Special Committee on Outpatient (Office-based) Surgery*. Online. Available: www.fsmb.org. Accessed: August 25, 2004.

[2] Karen B. Domino, M.D., "Office-Based Anesthesia: Lessons Learned From the Closed Claims Project," *American Society of Anesthesiologists Newsletter*, vol. 65, no. 6 (June 2001), pp. 9-15. Online. Available: depts.washington.edu/asaccp/ASA/Newsletters/asa65_6_9_11.shtml. Accessed: September 2, 2004; and New York Times, *Anesthesia, Without a Knockout Punch*. Online. Available: www.nytimes.com/2004/07/27/health/27anes.html?ei=1&en=4606eelcd806a656&e. Accessed: July 27, 2004.

[3] Texas Occupations Code, sec. 162.102 (b).

[4] Elizabeth Douglas, "Presence of an Anesthesiologist During Office Surgery Saves Lives," *Anesthesiology News* (August 2004).

[5] Texas Administrative Code, Title 22, part 9, rule 192.

[6] American Society of Anesthesiologists. www.asahq.org/patientEducation/officebased.htm. Accessed: September 3, 2004.

[7] Lauran Neergaard, "Deaths Raise Concern About Sedation In Offices," The Associated Press (March 1999). Online. Available: www.canoe.ca/Health9903/18_anesthesia.html. Accessed: September 8, 2004.

[8] Elizabeth Douglas, "Presence of an Anesthesiologist During Office Surgery Saves Lives," *Anesthesiology News* (August 2004).

Issue 8

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

Summary

Key Recommendations

- Authorize the Acupuncture Board to approve licensing and enforcement actions.
- Strengthen the Acupuncture Board's enforcement authority to include summary suspension and cease-and-desist orders.
- Streamline the Acupuncture Board's process for approving continuing education.
- Clarify the Texas Higher Education Coordinating Board's authority to approve degree programs for acupuncture schools in Texas.

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.

Conclusion

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. The Acupuncture Board also approves all continuing education courses and, until recently, acupuncture degree programs in the state. The Sunset review found that requiring Medical Board approval for license applications and disciplinary action is inefficient, wastes resources, and delays licensing and enforcement actions.

Authorizing the Acupuncture Board to approve its own applications for licensure and enforcement actions, streamlining the process for approving continuing acupuncture education, and clarifying that the Acupuncture Board does not approve degree programs would yield a more streamlined licensing process, increase public safety, and save agency resources.

Support

The Acupuncture and Medical boards share responsibility for the regulation of acupuncture in Texas.

- The Legislature established the Texas State Board of Acupuncture Examiners in 1993 as an advisory board to the Texas State Board of Medical Examiners. The Acupuncture Board has nine members, appointed by the Governor, including four licensed acupuncturists, two physicians with experience in acupuncture, and three public members. The Acupuncture Board makes recommendations to the Medical Board for final approval of applicants for licensure, disciplinary actions, and rules to regulate the practice of acupuncture in Texas. On its own initiative, the Acupuncture Board approves continuing education courses and providers, and, until recently, authorized Texas' acupuncture schools to award degrees. The Acupuncture and Medical boards currently regulate more than 650 acupuncturists.

- From its beginning, the Acupuncture Board authorized acupuncture schools to award master of science degrees, outside the oversight of the Texas Higher Education Coordinating Board. The Acupuncture Board did so under its powers as the state agency responsible for licensing these schools' graduates.[1,2] Under the Acupuncture Board's rules, these acupuncture schools had to be accredited by the Accreditation Commission for Acupuncture and Oriental Medicine to be recognized by the Acupuncture Board.[3] For more information on Texas' acupuncture schools, see the accompanying textbox, *Acupuncture Schools in Texas*.

Acupuncture Schools in Texas

Acupuncture schools in Texas include:

- Academy of Oriental Medicine at Austin;
- American Academy of Acupuncture and Oriental Medicine, Houston;
- Dallas College of Oriental Medicine; and
- Texas College of Traditional Chinese Medicine, Austin.

The Accreditation Commission for Acupuncture and Oriental Medicine has accredited all four schools.

In February 2004, at the request of the Coordinating Board, the Attorney General issued an opinion ruling that acupuncture schools are not exempt from the Coordinating Board's regulation and may not use the term "college" or award degrees without Coordinating Board approval. The Attorney General noted that while the Acupuncture Board may set the standards that an applicant must meet to receive a license, this authority does not allow the Acupuncture Board to approve acupuncture schools or degrees.[4]

Medical Board oversight of acupuncture licensing and enforcement actions does not provide added public protection and creates an unnecessary layer of regulation.

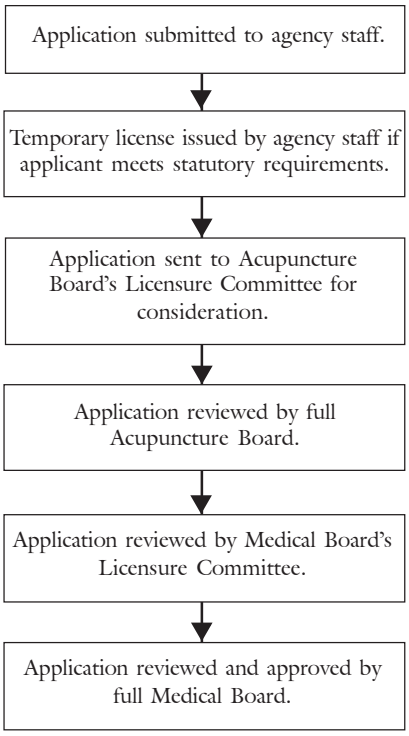
- Requiring the Medical Board to approve all of the Acupuncture Board's licensure recommendations requires additional staff resources and delays the approval of licenses. The chart, *Acupuncture Licensing Process*, outlines the steps involved in approving an acupuncturist's application for licensure. The Medical Board devotes minimal time to the review of acupuncture applications and has never denied an acupuncture application for licensure recommended by the Acupuncture Board. Because agency staff provides a thorough analysis of license applications and Acupuncture Board members also review applications, the additional oversight provided by the Medical Board offers no additional benefit. In fact,

Medical Board members have noted that their approval of acupuncture license applications is merely a formality.

- Medical Board review of all the Acupuncture Board's enforcement actions provides no added public protection. The Acupuncture Board receives very few complaints. Over the past five years, the Board has received 16 complaints. Of these, only four have resulted in Board action. The Acupuncture Board fully prosecutes any complaint it does receive before recommending disciplinary action against a licensee. Staff investigates the case; a panel of Board members hears it in an informal settlement conference; the Board's Discipline and Ethics Committee reviews it; and, finally, the full Board considers it. Because the Acupuncture Board consists of both physician and acupuncture members, the Board is able to provide expertise in both medical and acupuncture statutes and practice that the Medical Board cannot match. The Medical Board has never rejected a recommendation for enforcement action from the Acupuncture Board.

- The Medical Board's oversight of the Acupuncture Board appears incongruous compared to its oversight of the Physician Assistant Board. While acupuncturists can work independent of physicians, their oversight board relies almost entirely on the Medical Board for final action. Physician assistants, on the other hand, cannot practice without the close supervision of physicians, yet their oversight board issues licenses and approves disciplinary actions without Medical Board review.

Acupuncture Licensing Process



Total Number of Days: 130

The Acupuncture Board lacks authority to protect the public from immediate danger.

- The Acupuncture Board does not have authority to summarily suspend a license. The Medical Board must approve all Acupuncture Board enforcement actions, therefore delaying the time in which a temporary suspension order is approved. Although the Board has never received a complaint warranting temporary suspension, authority to temporarily suspend a license could be needed, as acupuncturists work with needles and prescribe herbal supplements, both of which could have harmful effects.

- Licensing agencies should have enforcement authority not only over its licensees, but over those who engage in the unlicensed activity of the profession. Currently, the Acupuncture Board is unable to take action against unlicensed practitioners. Cease-and-desist orders provide a step that agencies may take on their own to stop unlicensed activity without going to court. Cease-and-desist orders also provide for faster action by regulatory agencies, especially when violators of these orders are subject to additional sanctions, such as administrative penalties.

The Acupuncture Board's process for approving continuing education is inconsistent and time-consuming.

- The Acupuncture Board has not established guidelines for approving continuing education courses. As a result, the types of courses approved and the number of credit hours that may be earned vary for no good reason. For example, courses that are approved one year for six hours of credit may not receive the same amount of credit the next year, or may not be approved at all. Also, acupuncture philosophies differ among practitioners, so as the makeup of the Board changes, so do the Board's priorities. Without guidelines, the Board cannot ensure consistent approval of continuing education courses and providers.

- The process for approving continuing education courses dominates the Board's activities. The Board's Education Committee reviews each application to provide continuing education and determines how the proposed course relates to the practice of acupuncture, if the credentials of the provider are acceptable, and how many credit hours the Board should approve for attending the course. At its May 2004 meeting, the committee took the entire meeting to discuss four courses. Once the committee meeting recommended approval to the full Board, the Board spent additional time discussing continuing education.

The types of continuing education courses and number of course hours approved by the Board vary for no good reason.

- Other health-care licensing boards in Texas and other state acupuncture boards have more streamlined approaches to approving continuing education. For example, the Medical and Physician Assistant boards rely on professional associations to provide continuing education. Other state acupuncture boards, such as Maryland and Illinois, use a similar process in which agency staff references a preapproved list, mainly consisting of acupuncture schools and associations, to process continuing education-provider applications. The textbox, *Standard Approved Providers*, cites examples of common approved providers in the acupuncture profession.

Standard Approved Providers

Other states, such as Maryland and Illinois, recognize courses that are relevant to the practice of acupuncture and are approved by the regulatory board or are sponsored by professional organizations, including:

- National Acupuncture and Oriental Medicine Alliance;
- American Association of Acupuncture and Oriental Medicine;
- Accreditation Commission for Acupuncture and Oriental Medicine;
- National Certification Commission for Acupuncture and Oriental Medicine; and
- state acupuncture associations.

The authority to approve degree programs at Texas acupuncture schools is unclear.

- A recent interpretation of the law regarding which state entity has authority over acupuncture schools has affected Texas acupuncture students' ability to earn a degree, which had been a requirement for licensure. Beginning in 1993, the Acupuncture Board approved degree programs for acupuncture schools in Texas under its statutory authority.

The Texas Higher Education Coordinating Board said at the time that it was not its responsibility to approve such schools. However, in February 2004, the Attorney General ruled that the statute did not give the Acupuncture Board the authority to approve acupuncture degree programs, but that in fact, it was the Coordinating Board's responsibility to do so. The ruling invalidated degree programs at the state's four acupuncture schools until they could satisfy the same kinds of requirements applicable to institutions of higher education for medicine, pharmacy, and even chiropractic. As a result, acupuncture students – including those currently enrolled – are no longer eligible to receive degrees. While the Acupuncture Board quickly changed its rules to ensure that current and future students are eligible for licensure based on completing the program, students at Texas' schools now earn a diploma, while most acupuncture schools outside of Texas award degrees. The confusion about acupuncture degree programs in the state means that students who go to a Texas acupuncture school, and do not obtain a degree, may have difficulty getting licensed in other states.

- Which state entity approves other professional schools is more clearly defined than it is for acupuncture schools. For example, Texas chiropractic schools are subject to oversight by the Coordinating Board and not the Texas Board of Chiropractic Examiners, although the two chiropractic schools in Texas are exempt from regulation because they are accredited by the Southern Association of Colleges and Schools. Any new chiropractic school in the state would, thus, be subject to the Coordinating Board's authority, if not accredited by the Southern Association of Colleges and Schools.

Recommendations

Change in Statute

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

This recommendation would allow the Acupuncture Board to 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.

This recommendation would grant the Acupuncture Board 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. This recommendation would also allow the Acupuncture Board, without Medical Board approval, 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.

Under this recommendation, 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 could 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.

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

Impact

These recommendations would provide the Acupuncture Board with more efficient licensing and enforcement processes. Acupuncture licensees would receive full licensure more quickly and the public would be more effectively protected by more timely approval of enforcement actions. Clarifying the Texas Higher Education Coordinating Board's authority for approving acupuncture degree programs would not prevent the Acupuncture Board from continuing to establish high standards for licensure. This clarification would, however, eliminate the time and resources the Acupuncture Board spends on the issue.

Fiscal Implication

These recommendations would not result in a fiscal impact to the State.

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1 Texas Occupation Code, sec. 205.101 and 205.206.

2 Texas Education Code, sec. 61.303.

3 Texas Administrative Code, Title 22, part 9, rule 183.4 (h).

4 Op. Tex. Att'y Gen. GA-0114 (2004).

Issue 9

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

Summary

Key Recommendations

- Continue the Board's authority to waive prescriptive delegation requirements.
- Eliminate the prescriptive delegation registration requirement and authorize the Board to establish rules that require physicians to record delegation.

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.

Conclusion

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 requirements and the committee expire in 2005. Also, Sunset staff review found that requiring practitioners to register prescriptive authority with the Board is not necessary to protect the public. Eliminating the registration requirements, and authorizing the Board to continue issuing waivers would provide a more efficient process for ensuring that Texans have access to health care.

Support

Physicians can delegate prescriptive authority to physician assistants and advanced nurse practitioners.

- Physicians have the authority to delegate the carrying out or signing of prescription orders to physician assistants and advanced nurse practitioners. Under this authority, a physician assistant or advanced nurse practitioner can independently prescribe dangerous drugs and controlled substances, such as codeine, Vicodin, and Valium, based on their own diagnoses.[1] The supervising physician remains responsible for any acts performed by a physician assistant or advanced nurse practitioner under the physician's delegated authority.

- The Medical Practice Act addresses prescriptive delegation at four types of medical practice sites: sites in medically underserved areas, physician primary practice sites, alternate sites, and facility-based sites. For more information on each of these, see the table, *Physician Practice Sites*. The Act and Board rules establish minimum standards for a physician to delegate prescription authority, including delegation terms and supervision requirements, which vary according to practice site.

Physician Practice Sites	
Medically underserved	Site located in an urban or rural area with a medically underserved population, as defined by the Texas Board of Health, or its successor, the State Health Services Council.
Primary	Site where the supervising physician spends the majority of time, including a school clinic.
Alternate	Site other than a primary practice site, within 60 miles of the primary practice site.
Facility-based	Licensed hospital or licensed long-term care facility.

Physicians may seek a waiver from site and supervision requirements for prescriptive delegation.

- Physicians who are unable to meet the site and supervision terms may petition the Medical Board for a prescriptive delegation authority waiver. The Board does not have the authority to waive the number of sites where a physician can delegate prescriptive authority or the number of physician assistants or advanced nurse practitioners to whom a physician can delegate. The Board can, however, waiver other requirements that can burden physicians, such as the amount of chart review or on-site supervision they must provide.

- Requests for waiver are considered by the Prescriptive Delegation Waiver Committee, an advisory committee to the Medical Board. The 15-member committee includes five physicians, five physician assistants, and five advanced nurse practitioners, chosen by the Medical Board from a list of candidates recommended by professional associations. To take action, three members from each profession must agree. The committee submits its recommendations to the Medical Board's Standing Orders Committee, which recommends rejection or approval to the full Board.

Since its creation in 2001, the Prescriptive Delegation Waiver Committee has received 17 requests for a waiver, nine of which have been reviewed and sent to the Standing Orders Committee. Of those nine requests, the Prescriptive Delegation Waiver Committee recommended approval of eight and denial of one. However, the Standing Orders Committee approved four, denied three, and sent two back to the Prescriptive Delegation Waiver Committee for more information.

- Physician assistants and advanced nurse practitioners and the physician who supervises them must notify the Medical Board annually of their delegated prescriptive authority. The Board receives about 5,000 prescriptive authority delegation registrations each year. Licensees must provide identifying information, such as the licensee's name, title, license number, and the contact information for the supervising physician.

The Prescriptive Delegation Waiver Committee does not provide a beneficial layer of oversight to the waiver approval process.

The Board's authority to waive prescriptive delegation requirements is scheduled to expire.

- Statutory provisions authorizing the Board to waive prescriptive delegation requirements expires September 1, 2005, unless reauthorized by the Legislature. However, the Board's authority to waive the site or supervision requirements for a physician to delegate prescriptive authority serves a valuable purpose. By waiving the requirements in some cases, the Board has an avenue for ensuring that delegation requirements do not cause an undue burden without a corresponding benefit to patient care. Waivers may reduce the amount of on-site supervision that a physician must provide and other burdensome requirements that may reduce a patient's access to care.

  For example, a physician asked for a waiver of the requirement that an alternate practice site be within 60 miles of the primary practice site. After the Board was satisfied that the delegating physician had adequate supervision over the advanced nurse practitioner and had established safeguards for providing quality patient care, the Board approved the waiver. As a result, patients at the alternate site have access to medical care that otherwise would not be available in their area.

- The Prescriptive Delegation Waiver Committee, which is also set to expire, is not needed to review waiver requests. Since the committee was established in 2001, it has only received 17 requests for a waiver. Although the committee primarily deliberates on waiver requests via e-mail, maintaining contact with committee members requires valuable staff resources, yet provides little benefit. Staff performs much of the research for the waiver requests, plus the same information that the committee considers is presented to the Board's Standing Orders Committee. The Medical Board could easily absorb the function of the Prescriptive Delegation Waiver Committee.

Registering prescriptive delegation authority with the Medical Board provides no useful information.

- The Medical Board does not use the registration information required of physicians, physician assistants, and advanced nurse practitioners for prescriptive delegation authority for any beneficial purpose. Requiring

registration of prescriptive delegation authority does not prevent a physician assistant or advanced nurse practitioner from illegally prescribing, nor does it make it more difficult. Registration also does not provide the agency with any information that could assist staff in conducting investigations. Should a complaint arise about a physician or physician assistant concerning prescribing, the Medical Board or Physician Assistant Board has – or in the case of an advanced nurse practitioner, the Nurse Board – the authority to take disciplinary action, and would investigate whether proper prescriptive delegation occurred.

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.

This recommendation would remove the requirement that physicians, physician assistants, and advanced nurse practitioners 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.

Impact

These recommendations would provide the Board with a more efficient process for regulating prescriptive delegation authority. Continuing the Board's ability to waive certain prescriptive delegation authority requirements would give the Board and licensees flexibility in seeing that health-care needs are addressed, while maintaining quality patient care. Eliminating registration requirements would allow the Board to devote its resources to more beneficial tasks.

Fiscal Implication

Because the Prescriptive Delegation Waiver Committee reviews requests for waiver via e-mail, the committee does not incur any travel costs. Also, the Board does not collect a fee for registering prescriptive delegation authority. Thus, these recommendations would not have a fiscal impact to the State.

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[1] Physician assistants and advanced nurse practitioners can only prescribe schedule III, IV, and V drugs and the prescription cannot exceed 30 days.

Issue 10

Licensing Surgical Assistants Does Not Provide Added Public Protection That Warrants State Oversight.

Summary

Key Recommendation

- Abolish the surgical assistant license.

Key Findings

- The Medical Board licenses and regulates surgical assistants.
- Licensing surgical assistants does not provide additional public protection that warrants state oversight.
- The Surgical Assistant Advisory Committee has fulfilled its purpose.
- Only two other states license surgical assistants.

Conclusion

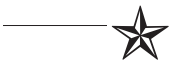
In 2001, the Medical Board began issuing a license to individuals who practice surgical assisting. However, the license is not needed unless the individual uses the title "surgical assistant." As a result, the Board has established licensing requirements for a process to license applicants, yet few individuals have applied for the license. The Medical Board relied on the Surgical Assistant Advisory Committee in developing licensing requirements.

The Sunset review found that issuing a surgical assistant license does not provide any additional public protection, as the license does not prevent anyone from practicing surgical assisting. In addition, surgical assistants must be approved by a hospital or facility to assist in the operating room and can only perform acts under the direct supervision of a licensed physician, who is accountable for the surgical assistant's acts. Also, the Surgical Assistant Advisory Committee has fulfilled its purpose of assisting the Medical Board in establishing a surgical assistant licensing program. Given the limited public protection provided by the license, eliminating the license and the advisory committee would not increase potential harm to patients, but instead would allow the Medical Board to place greater focus on regulating physicians, who maintain responsibility for anyone performing surgical assisting under their direction, and have the most impact on public safety.

Support

The Medical Board licenses and regulates surgical assistants.

- During surgery, a physician is assisted in the operating room by other health-care professionals, including surgical assistants. A surgical assistant stands across from a surgeon at the operating table and, under direct supervision, assists the surgeon in performing a surgical procedure. In the past, another licensed physician typically performed most surgical assistance, but today surgeons often choose nonphysicians, such as nurses and physician assistants, to assist them during surgery. Surgical assistants practice under the delegation of a licensed physician, so a surgical assistant's responsibilities vary according to the physician-surgical assistant relationship. The textbox, *What Do Surgical Assistants Do?,* outlines common surgical assisting duties.



Surgeons often choose nonphysicians to assist them during surgery.

What Do Surgical Assistants Do?

Surgical assistants may perform any procedure delegated by a physician. A surgical assistant's scope of practice can include the following procedures:

- determines needed equipment;
- assists in the moving, positioning, and draping of the patient;
- clamps and ties blood vessels to control bleeding during surgical entry;
- cuts tissue per surgeon's directive;
- retracts tissue and exposes operating field area during operative procedures;
- keeps the operative area dry and sterile;
- inserts drainage tubes per surgeon's directive;
- assists in closure of all wound layers;
- applies sutures and wound dressings;
- assists with patient resuscitation during cardiac arrest or other life-threatening events in the operating room; and
- performs other duties deemed necessary and directed by the surgeon.

- In 2001, the Medical Board began issuing a surgical assistant license to practitioners who meet certain requirements. Statute provides several exemptions for the license, including registered nurses; licensed physician assistants; other licensed health-care workers acting within the scope of their license; surgical assistant students; federal employees; and any person acting under the delegated authority of a licensed physician. Without a surgical assistant license, a practitioner cannot use the title "surgical assistant," but can perform the same procedures as someone with a license. The textbox, *License Requirements*, details the qualifications needed to obtain a license in Texas.[1] In fiscal year 2004, the Board had 259 licensed surgical assistants.

License Requirements

To receive a surgical assistant license from the Medical Board, an individual must meet the following requirements:

- pass an exam approved by the Medical Board;
- hold at least an associate's degree from an educational program that is substantially equivalent to the education required for a registered nurse or physician assistant who specializes in surgical assisting;
- complete at least 2,000 hours of full-time work as an assistant in surgical procedures under the direct supervision of a licensed physician for the three preceding years; and
- possess a current certification by a national certifying body approved by the Medical Board.

- The Medical Board has approved three national organizations to certify surgical assistants. Certification requirements differ among these three national organizations, although individuals typically must meet certain

education or training requirements, as well as pass a surgical assisting exam offered by the certifying organization. Certified surgical assistants must undergo recertification every two years, including completing continuing education courses, and they must maintain this certification to be licensed by the Board.

- The Surgical Assistant Advisory Committee, created in 2001, consists of six members appointed by the president of the Medical Board. Five members must be either a practicing surgical assistant with at least five years clinical experience or a licensed Texas physician who supervises a surgical assistant. One member must be a registered perioperative nurse with at least five years of clinical experience. The advisory committee meets at the request of the Medical Board.

Unlicensed individuals can perform the same acts as a licensed surgical assistant.

Licensing surgical assistants does not provide additional public protection that warrants state oversight.

- The surgical assistant license does not provide added benefit to the public. Because a physician can delegate surgical assisting duties to anyone the physician believes is competent, the license does not prevent unlicensed individuals from performing the same acts as a licensed surgical assistant. In fact, offering a surgical assistant license may mislead the public to believe that all individuals who practice surgical assisting hold a license from the Board. In addition, despite holding a license, a licensed surgical assistant can only practice under the direct supervision of the physician who delegated the acts.

- Through a separate credentialing process, hospitals determine which health-care practitioners – including those who practice surgical assisting – are authorized to practice at their facilities. To practice surgical assisting, an individual must have privileges at a hospital as well as a physician willing to delegate the responsibilities, regardless of whether the individual holds a surgical assistant license. When credentialing someone to practice surgical assisting in a facility, hospitals typically look at such things as training, education, and letters of recommendation or sponsorship. Hospitals also verify any state or national certifications.

- Many individuals who practice surgical assisting hold other types of licenses or certifications. For example, registered nurses and physician assistants often assist surgeons. Physician assistants can take additional coursework and pass a national certifying exam that illustrates their proficiency in surgical assisting. The Texas Board of Nurse Examiners does not license registered nurses who provide surgical assisting duties, but rather requires its licensees who hold a national certification in surgical assisting to register with the Nurse Board.

After grandfathering, only 31 individuals have received a surgical assistant license by meeting licensing requirements.

- Few individuals who practice surgical assisting hold a Texas surgical assistant license. Since licensure requirements went into effect September 1, 2002, only 31 individuals have received a surgical assistant license by meeting the licensing requirements established by the Medical Board. An additional 228 individuals received a license under grandfather provisions adopted by the Board. Of the 228 grandfathered licensees, 120 individuals must complete specific academic course work within three years of receiving the license or else the license will expire.[2]

- The Board has never disciplined a surgical assistant, and has received only two complaints regarding surgical assistants. Because the physician maintains responsibility for delegated acts, complaints regarding standard of care would be directed at the physician, with whom the Medical Board has a larger interest and should be focusing its time. In fact, the two complaints against surgical assistants received by the Board in fiscal year 2004 alleged that a surgical assistant falsely represented that the person was a physician.

- Because national certification requirements widely vary, staff devotes time and resources to evaluating whether an applicant meets licensure qualifications or satisfies the grandfather requirements. For example, few applicants have successfully completed an educational program in surgical assisting, so staff must establish whether the educational program the applicant completed complies with the guidelines for program accreditation established by the Commission on Accreditation of Allied Health Education Programs. As a result, staff resources are diverted from the regulation of physicians, who have responsibility for surgical assistants.

The surgical assistant advisory committee has met four times since it was established in 2001.

- The Texas Sunset Act requires an assessment of less restrictive or alternative methods of regulation that could adequately protect the public. Staff found that few people have applied for a surgical assistant license, few complaints have been received by the Medical Board, and a license is not needed to perform the actual duties of a surgical assistant. Also, hospitals and other health-care facilities have established effective methods for issuing credentials and allowing an individual to practice surgical assisting. As a result, the level of regulation created by requiring the Medical Board to issue a surgical assistant license is not needed.

The Surgical Assistant Advisory Committee has fulfilled its purpose.

- The Surgical Assistant Advisory Committee no longer serves a needed function. Created in September 2001, the advisory committee assisted the Medical Board in establishing qualifications for the surgical assistant license, setting fees for the license, and determining disciplinary guidelines. The advisory committee, which meets at the Medical Board's request, has convened four times, although the advisory committee has not met in the past year. In addition, the Medical Board voted at its June 2004 meeting to abolish the Board's Ad Hoc Committee on Surgical Assistants, a Board subcommittee, because the committee was no longer needed and the Board's Licensure Committee could assume the responsibilities.

- Since creation of the license and establishment of licensing requirements, the Medical Board has not convened the advisory committee for advice on scope-of-practice or other policy issues concerning surgical assistants. Medical Board and advisory committee members and staff say that policy issues can be addressed by the Medical Board, which ultimately has authority for regulating surgical assistants and adopting rules related to surgical assistants. In addition, the advisory committee does not review applications for licensure or deliberate on any complaints received; the Medical Board performs these functions. Further, should the Medical

Board need advice on an issue relating to surgical assistants, the Board has authority to establish an ad hoc advisory committee at any time.

- The Texas Sunset Act requires an evaluation of the extent to which the advisory committee is needed and is used. Because the advisory committee's primary role of helping the Medical Board establish licensing requirements has been accomplished, the committee is no longer needed. In addition, the Medical Board's use of the committee has been infrequent. Since the committee was created, it has convened four times for a total of six hours.

Only two others states regulate surgical assistants.

- Texas is one of only three states that licenses or certifies surgical assistants. Illinois and Kentucky both require surgical assistants to register with the Board. The Kentucky Medical Board received authority to license surgical assistants in spring of 2004. The Kentucky Board intends to begin accepting applications by the end of the year.

Recommendation

Change in Statute

10.1 Abolish the surgical assistant license.

This recommendation would eliminate the requirement that the Medical Board license and regulate surgical assistants. The recommendation also would eliminate the Surgical Assistant Advisory Committee. The Medical Board would continue to protect the public by regulating the practice of medicine, including licensed physicians who delegate surgical assisting functions during surgical procedures.

Impact

Eliminating the requirement that the Medical Board license surgical assistants would allow the Medical Board to focus on regulating physicians, who are responsible for anyone performing a delegated act under their authority. Individuals performing surgical assistant duties would still need to be granted hospital privileges to practice in a facility.

Fiscal Implication

This recommendation would not result in a significant fiscal impact to the State. According to Board staff, regulating surgical assistants costs the agency more money and resources than revenue from license fees covers. As a result, eliminating the license would have a small positive fiscal impact. Members of the Surgical Assistant Advisory Committee do not receive a per diem or travel reimbursement, so abolishing the advisory committee would have no fiscal impact to the State.

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[1] A degree program must contain a clinical component and must include courses in anatomy, physiology, basic pharmacology, aseptic techniques, operative procedures, chemistry, microbiology, and pathophysiology.

[2] By the third anniversary of the date the surgical assistant license was issued, an individual must complete academic courses in anatomy, physiology, basic pharmacology, aseptic techniques, operative procedures, chemistry, and microbiology.

Issue 11

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

Summary

Key Recommendations

- Standardize the boards' licensing functions by requiring physician assistant and acupuncture applicants to pass a jurisprudence exam, authorizing staff to issue licenses, clarifying continuing education requirements, and allowing staggered license renewals.
- Improve the boards' ability to protect the public by granting them use of cease-and-desist orders, authorizing refunds as part of the agreed settlement process, and establishing a full range of penalties available as disciplinary sanctions.
- Update elements related to the policy body and agency administration, such as allowing medical faculty members to serve on the Medical Board, clarifying the requirement that the Senate confirms appointees to the boards, and authorizing a fee for the physician assistant inactive license.

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 Board's 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.

Conclusion

Various licensing, enforcement, and administrative processes in the Medical, Physician Assistant, and Acupuncture boards' statutes do not match model licensing standards developed by Sunset staff from experience gained through more than 80 occupational licensing reviews over the last 25 years. The Sunset review compared the boards' statutes, rules, and practices to the model licensing standards to identify variations. Based on these variations, Sunset staff identified the recommendations needed to bring the boards in line with the model standards.

Support

Regulating occupations, such as medicine, requires common activities that the Sunset Commission has observed and documented over more than 25 years of reviews.

- The mission of the Medical, Physician Assistant, and Acupuncture boards is to protect the public by ensuring that medical practitioners meet required qualifications, are competent, and adhere to established professional standards. To provide this protection, the boards regulate the practice of medicine and the practice of acupuncture in Texas. In fiscal year 2004, the boards licensed 55,993 physicians, 6,544 physicians-in-training, 3,453 physician assistants, 693 acupuncturists, and 259 surgical assistants. Also, the boards enforce state laws and rules by investigating complaints against practitioners and taking disciplinary action when necessary. In fiscal year 2004, the boards received 6,090 complaints and resolved 1,755, including 287 that resulted in disciplinary action.

- The Sunset Advisory Commission has a historic role in evaluating licensing agencies, as the increase of occupational licensing programs served as an impetus behind the creation of the Commission in 1977. Since then, the Sunset Commission has completed more than 80 licensing agency reviews.

  Sunset staff has documented standards in reviewing licensing programs to guide future reviews of licensing agencies. While these standards provide a guide for evaluating a licensing program's structure, they are not intended for blanket application. The following material highlights areas where the boards' statutes and rules differ from model standards, and describes the potential benefits of bringing the statutes and rules into conformity with standard practices.

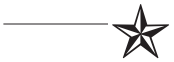
Licensing provisions of the boards' statutes do not follow model practices and could potentially affect the fair treatment of licensees and the agency's ability to protect consumers.

- ***Jurisprudence exam.*** An agency should ensure that licensees are familiar with the laws and rules under which they practice. Unlike the Medical Board, neither the Physician Assistant Board nor the Acupuncture Board requires applicants to pass a jurisprudence examination as part of licensure eligibility. As a result, licensees may be unaware of state laws or have limited knowledge about state regulations regarding issues that affect their practice. For example, acupuncturists have expressed confusion about whether they can use the term "doctor" as part of their professional title, although state law prohibits acupuncturists' use of the term.[1] In addition, physician assistants must understand the range of permissible activities under the delegated authority of a physician.[2] Requiring a jurisprudence exam for physician assistant and acupuncture licensure applicants would establish that practitioners have a clear understanding of the laws and policies that guide their professional practice.

Requiring a jurisprudence exam ensures that practitioners understand the laws and policies that guide their profession.

- ***Personal interview.*** An agency should establish fair licensing procedures that ensure public safety, while also taking care that such procedures do not unreasonably restrict entry into professional practice. Until recently, all physician applicants took the Medical Board's jurisprudence examination in Austin. During their Austin visit, applicants also met with agency staff for an interview, which involved staff checking medical school diplomas, identification cards, and other documents to verify each applicant's identity.

  Although the jurisprudence exam is now offered at testing sites throughout the country, the Medical Board still requires applicants to travel to Austin so staff can inspect their original medical school diploma and other documents for authenticity. Such a practice is unnecessary, however, as the Board receives assurance of an applicant's identity through other methods of primary source verification. For example, the Board receives copies of transcripts and other official documents directly from medical schools. Eliminating the requirement for personal interviews with applicants whose identity can be verified by other methods would reduce the burden on applicants and allow the agency to devote its resources to other licensing issues.



The Medical Board requires applicants to travel to Austin so staff can inspect their original medical school diploma for authenticity.

- ***Criminal convictions.*** Chapter 53 of the Occupations Code provides a general standard to guide licensing agencies in determining what crimes should affect licensure for that agency. In general, this law provides that a criminal conviction affects licensing qualifications when a crime relates to the profession, according to guidelines developed by the agency. These guidelines allow the agency to suspend or revoke a license, or to disqualify individuals from receiving a license or taking the exam because of specific criminal activities.

  The Medical, Physician Assistant, and Acupuncture boards have not developed rules to identify convictions, such as driving while intoxicated, that could affect the ability to practice safely. Rather, the boards rely on other statutory provisions that allow denial of a license for a felony conviction or a crime that involves moral turpitude. Adopting rules under Chapter 53 to establish convictions that could affect a license holder's ability to practice safely would provide the boards and the public with the clarity needed to determine which offenses warrant the denial of a license.

- ***License approval.*** An agency should have authority to issue a temporary license, under limited circumstances, to allow an applicant to practice before meeting all licensure qualifications. However, once an applicant meets all licensing requirements, the agency should issue a permanent license. Currently, after determining that an applicant meets all licensing requirements, staff issues a temporary license, which allows license holders to practice according to their profession's practice act. However, the applicant must wait for the appropriate board's licensing committee and full board to approve applications before receiving a permanent license and an official license number. The boards have never rejected a staff recommendation to approve a license, yet board approval sometimes takes place months after staff issues a temporary license, creating problems for licensees.

For example, because some employers or health-plan providers require an official license number before hiring or contracting with a practitioner, some licensees must delay employment or limit their practice until their board approves their permanent license, including an official license number. Authorizing staff to issue licenses to qualified applicants would allow licensees to start practicing immediately after receiving a license without posing a risk to the public.

- ***Continuing education.*** Proper protection of the public is dependent on practitioners having a working knowledge of recent developments and techniques used in their profession. Continuing education provides one means of ensuring continued competence. As such, the statute of a licensing agency should require the policy body to adopt a system of continuing education. The Physician Assistant Licensing Act allows a licensee to satisfy half of any informal continuing medical education hours required by statute to renew a license by providing volunteer medical services at a site serving a medically underserved population.[3] However, the Act does not specifically authorize the Physician Assistant Board to establish continuing medical education requirements.

The Physician Assistant Licensing Act does not specifically authorize the Board to establish continuing education requirements.

  The Board has adopted rules requiring physician assistants to complete 40 hours of continuing medical education annually; half of these hours must come from formal courses, while the remaining hours can be from informal methods.[4] Requiring the Physician Assistant Board to adopt a system of continuing education as a condition for license renewal would clarify the Board's authority for establishing continuing education requirements and bring the Board in line with current practices of other health-licensing agencies, both in Texas and other states.

- ***Late-renewal penalties***. Licensees who fail to renew their licenses on time should pay a penalty set at a level that is reasonable to ensure timely payment and that provides comparable treatment for all licensees. Although the Medical Board has adopted rules requiring physician assistants to pay a penalty for late license renewal, the Physician Assistant Licensing Act does not address late-renewal penalties. By not specifying a penalty amount or method for calculating the penalty, the Act potentially allows physician assistants to pay the normal renewal fee, regardless of how late the license renewal, which does not provide an adequate deterrent to late renewal. A fairer, more consistent practice would be to require delinquent licensees to pay 1-1/2 to two times the standard renewal fee. Doing so would standardize the Physician Assistant Board's renewal time frames and delinquent renewal fees with other licensing agencies.

The Medical Board should be able to stagger license renewals to best use staff time and resources.

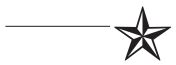
- ***Staggered renewals.*** An agency should have the authority to stagger license renewals to promote an even workload throughout the year. Currently, a physician's license must expire on the last day of the birth month of the license holder, requiring staff to process license renewals 12 times per year. However, staff has found that processing license renewals quarterly provides a more efficient schedule. Instead of requiring staff to renew licenses at specific intervals, the Medical Board should have the ability to stagger its license renewals according to a schedule that makes the best use of staff time and resources.

The Physician Assistant Licensing Act does not address staggering license renewals, although it does authorize the Physician Assistant Board to develop rules regarding license renewal. Specifying in statute that the Board has authority to stagger license renewals would give staff the ability to establish a renewal schedule for physician assistant licenses that evenly distributes the workload.

Nonstandard enforcement provisions of the Board's statute could reduce the agency's effectiveness in protecting consumers.

- ***Sanctions***. A licensing agency's range of penalties should conform to the seriousness of the offenses committed. Therefore, the agency's statute should authorize a full range of penalties. The general range of sanctions includes license revocation, license suspension, refusal to renew a license, probation of a suspended license, and reprimand. The Acupuncture Board's statute details the range of penalties available to sanction an acupuncturist, but does not include the authority to refuse to renew a license. Such a decision to refuse to renew a license could occur, for example, when a board finds that a licensee has failed to pay an administrative fine. Including refusal to renew a license as a sanction tool would allow the Acupuncture Board to have a full range of sanctions available as the Board – and the Medical Board, which ultimately approves all Acupuncture Board disciplinary actions – deliberates on enforcement actions.

  In addition, the Physician Assistant and Acupuncture boards do not have authority to accept the voluntary surrender of a license. The Medical Practice Act specifies that the Medical Board may accept the voluntary surrender of a physician's license, and requires the Medical Board to establish rules to determine when a practitioner who voluntarily surrendered a license is competent to return to practice.[5] The Board uses voluntary surrenders in disciplinary cases where it has found that a violation of the Medical Practice Act or Board rules has occurred, and the licensee agrees to give up the license instead of having the Board revoke it. Authorizing the Physician Assistant and Acupuncture boards to accept the voluntary surrender of a license would provide the boards with another method to remove incompetent licensees from these practices and would bring the boards in line with the same authority as the Medical Board.



The Physician Assistant and Acupuncture boards cannot accept the voluntary surrender of a license.

- ***Refund authority.*** The goal of restitution is to allow a complainant to receive a refund for some or all of what was lost as a result of the act that prompted the complaint and resulted in a violation of state laws or board rules. Refunds can be granted when a consumer has been defrauded or subjected to a loss that can be quantified, such as the cost of a medical examination. The boards' enforcement tools are designed to correct licensee behavior, but do not allow for repayment to the aggrieved party. Including refund authority as an additional enforcement tool would enable the boards to help a consumer who was harmed by a licensee.

- ***Cease-and-desist authority***. A licensing agency should have enforcement authority not only over its licensees, but over those who engage in the unlicensed activity of the profession. However, the standard range of sanctions against licensees does not apply to such unlicensed activity. While injunctive authority allows agencies to seek legal action to stop unlicensed activity, cease-and-desist orders provide an interim step that agencies may take on their own to stop unlicensed activity.

  The Medical and Physician Assistant boards lack authority to issue cease-and-desist orders. The agency's current process of issuing a warning letter to stop unlicensed practice is ineffective and lacks real enforcement authority, while seeking injunctions through the Attorney General can be cumbersome and time consuming. Cease-and-desist orders provide for faster action by regulatory agencies, especially when violators of these orders are subject to additional sanctions, such as administrative penalties. In addition, violations of cease-and-desist orders may help the agency obtain injunctive relief more easily.

Certain policy body and administrative requirements of the boards' statute could reduce the board's efficiency and flexibility to adapt to changing circumstances.

- ***Policy body composition***. Unless conflicts of interest exist, a member of the regulated profession who meets statutory qualifications should be eligible to serve on a policy body. The Medical Practice Act prohibits faculty members of a college of medicine from being appointed to the Medical Board.[6] This restriction prevents qualified members of the medical profession from serving on the policy body. Allowing the Governor to appoint a licensed physician who is on the faculty of a college of medicine to serve on the Medical Board would increase the pool of individuals with relevant expertise, and provide the Board with valuable input from the academic sector of the medical profession.

Prohibiting medical school faculty from appointment to the Medical Board prevents qualified individuals from serving.

- ***Appointment***. A licensing agency should be governed by a board appointed by the Governor and confirmed by the Senate. Although considered advisory boards, the Physician Assistant and Acupuncture boards both consist of nine members appointed by the Governor. However, statute does not require Senate confirmation of the Governor's nominees to these boards. Although in practice the Senate does confirm appointments to the Physician Assistant and Acupuncture boards, clarifying this requirement in statute would erase any potential confusion regarding how the nine members on each board are appointed and approved.

- ***Funding structure.*** A licensing agency should have authority to set fees for the licenses it issues. The Physician Assistant Board has an inactive license category, which allows licensees to take time off from the profession without having to reapply for licensure upon return to practice. Currently, 184 physician assistant licenses are inactive. While on inactive status, a physician assistant does not pay any fee to the Board and does not have to complete continuing medical education. However, to return a license to active status, physician assistants must prove that they have actively practiced within one of the preceding two years. If

they do not meet this requirement, the Board may impose conditions, such as completing a specified number of continuing medical education hours. Reviewing an application to return to active status and verifying the information consumes staff resources, yet physician assistants do not pay a fee. Requiring the Physician Assistant Board to establish a fee for its inactive license would allow the Board to cover its costs and would reflect comparable practices with other state agencies that offer an inactive license status.

Requiring a fee for a physician assistant inactive license would allow the Board to cover its costs.

Licensing and other fees for the Acupuncture Board are established by rules adopted by the Medical Board. Although the Medical Board has authority over the Acupuncture Board's rulemaking abilities, the Acupuncture Board should establish licensing and other fees in amounts that are reasonable and necessary to cover the cost of regulating acupuncturists, and recommend these fee levels to the Medical Board. Requiring the Acupuncture Board to recommend the specific fee levels would make its practices consistent with the Physician Assistant Board, which as an advisory board, also recommends fee levels to the Medical Board. Doing so also allows the Acupuncture Board, which has the most direct knowledge of the acupuncture profession and its licensees, to take an active role in setting fees to regulate acupuncturists in Texas.

Recommendations

Licensing

Change in Statute

11.1 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. To the extent possible, the boards could use the Medical Board's jurisprudence examination process as a model, including the consideration of examination administration through a statewide testing service. Rules regarding jurisprudence exams would need to be approved by the Medical Board, which has rulemaking oversight for the Physician Assistant and Acupuncture boards. Each board would develop an exam and begin exam administration by September 1, 2006. 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.

11.2 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.

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

This recommendation would allow staff to issue physician, physician assistant, and acupuncture licenses to individuals who meet all licensing requirements and do not warrant further consideration by the appropriate board's licensing committee. Staff would still forward applications as needed to the appropriate board for review. The Medical, Physician Assistant, and Acupuncture boards would still formally approve the licenses at regularly scheduled meetings, and licensees would be able to work in their profession before formal board approval. 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.

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

This recommendation would provide clear statutory authority for the Physician Assistant Board 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.

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

This recommendation would require the Physician Assistant Board to use the standard renewal fee as the basis for late renewal penalties. For example, the Board would charge a person whose license has been expired for 90 days or less the standard renewal fee plus a penalty equal to 1-1/2 times the renewal fee. For those whose licenses have been expired for more than 90 days, but less than one year, the boards would charge the standard renewal fee plus a penalty of twice the renewal fee.

11.6 Authorize the Medical and Physician Assistant boards to adopt a system under which 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 agency staff processes renewals for both boards – plus the Acupuncture Board – this recommendation would allow staff to determine the most efficient schedule for renewing licenses.

Management Action

11.7 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

11.8 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.

This recommendation would establish the full range of penalties for disciplinary actions against an acupuncturist licensed in the state. 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.

11.9 Authorize the Medical and Physician Assistant boards to require refunds as part of the agreed settlement process.

Under this recommendation, 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.

11.10 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 recommendation would also authorize the boards 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 of this report.

Policy Body & Administration

Change in Statute

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

This recommendation would remove the statutory prohibition against salaried faculty members at a college of medicine from serving on the Medical Board. 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.

11.12 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 voted by the Senate in the same process as other Governor appointees.

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

Under this recommendation, the Physician Assistant Board would set a renewal fee for its inactive licensee. 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.

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

This recommendation would require the Acupuncture Board to 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.

Impact

The application of these recommendations to the Medical, Physician Assistant, and Acupuncture boards would result in increased efficiency and consistency from fairer processes for licensees, additional protection for consumers, and standardization of procedures. The chart, *Benefits of Recommendations*, categorizes the recommendations according to their greatest benefits.

Benefits of Recommendations				
Recommendations	Efficiency of Operations	Administrative Flexibility	Fairness to Licensee	Public Protection
Licensing				
11.1 Require physician assistant and acupuncture applicants to pass a jurisprudence exam as a condition for licensure.				✓
11.2 Clarify that the Medical, Physician Assistant, and Acupuncture boards must address felony and misdemeanor convictions in the standard manner defined in the Occupations Code.			✓	✓
11.3 Authorize staff to issue licenses to qualified physician, physician assistant, and acupuncture applicants.	✓	✓	✓	
11.4 Clarify the Physician Assistant Board's responsibility to establish a system of continuing medical education.				✓
11.5 Change the basis for the Physician Assistant Board's late-renewal penalties.	✓			
11.6 Authorize the Medical and Physician Assistant boards to adopt a system under which licenses expire on various dates during the year.	✓	✓		
11.7 The Medical Board should discontinue its practice of requiring applicants to appear before the Board for a personal interview.	✓		✓	
Enforcement				
11.8 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.		✓		✓
11.9 Authorize the Medical, Physician Assistant, and Acupuncture boards to require refunds as part of the agreed settlement process.		✓		✓
11.10 Authorize the Medical and Physician Assistant boards to issue cease-and-desist orders.		✓		✓
Policy Body & Administration				
11.11 Allow medical faculty members to be eligible to serve on the Medical Board.		✓	✓	
11.12 Clarify that the Senate must confirm appointments to the Physician Assistant and Acupuncture boards.				✓
11.13 Authorize the Physician Assistant Board to establish a fee for individuals who hold an inactive license.		✓		
11.14 Require the Acupuncture Board to recommend licensing and other fees to the Medical Board.	✓	✓	✓	

Fiscal Implication

These recommendations would result in a small gain to the General Revenue Fund. Creating a statutory basis for the Physician Assistant Board's late-renewal penalty would result in a positive fiscal impact of $3,745 annually. Establishing a renewal fee for the physician assistant inactive license would result in a small positive fiscal impact. The agency would experience a cost to develop a jurisprudence exam, but this cost would be recovered in the examination fee. The Board would adjust license fees to compensate for the approximately $165,000 in revenue lost each year by eliminating temporary licenses.

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[1] Texas Occupations Code, sec. 104.003 and 104.004.

[2] Texas Occupations Code, ch. 157.

[3] Texas Occupations Code, sec. 204.1565.

[4] Texas Administrative Code, Title 22, part 9, rule 185.6(b)(1). Rules adopted by the Physician Assistant Board must be approved by the Medical Board, which has oversight for the Physician Assistant Board's rulemaking authority. As a result, although rules relating to continuing medical education were developed by the Physician Assistant Board, the Medical Board approved the rules.

[5] Texas Occupations Code, sec. 164.061.

[6] Texas Occupations Code, sec. 152.004(b).

Issue 12

Texas Has a Continuing Need to Regulate Physicians, Physician Assistants, and Acupuncturists.

Summary

Key Recommendation

- Continue regulating physicians, physician assistants, and acupuncturists in Texas.

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.
- Different organizational options for regulating licensed health-care practitioners offer advantages and disadvantages to the Board.
- A complete study of organizational options should also consider the results of the Sunset Commission's reviews of other health-profession licensing agencies completed during this review cycle.

Conclusion

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. The need for this regulation is addressed in this issue, as is a brief description of options for how to structure this regulatory effort. These options include continuing the three boards as they currently are configured, enhancing coordination through a council like the Health Professions Council, and consolidating the boards with other health-profession agencies. Recommendations regarding the structure of this regulation, as well as the regulation of other health-care practitioners, is addressed in the Licensing Reorganization Project report.

Support

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 began regulating physicians in 1837, when the State established the Board of Medical Censors. The Legislature reorganized the Board in 1907, giving it responsibility to examine and license physicians, and to discipline licensees who violated the Medical Practice Act. In 1993, the Legislature passed the Physician Assistant Licensing Act and established the Physician Assistant Board as an advisory board to the Medical Board. The Physician Assistant Board has authority to issue licenses and discipline physician assistants, but the Medical Board must approve its rules. Also in 1993, the Legislature created the Acupuncture Board, also as an advisory board to the Medical Board, which has final authority to license, discipline, and adopt rules related to acupuncturists.

- In fiscal year 2004, the boards regulated 55,993 physicians, 6,544 physicians-in-training, 3,453 physician assistants, 693 acupuncturists, and 259 surgical assistants. Also in fiscal year 2004, the boards received 6,090 complaints, of which 1,900 were jurisdictional. That year, the boards resolved 1,755 complaints, with 287 resulting in sanctions, including 33 license revocations.

Texas has a continuing need for regulating physicians, physician assistants, and acupuncturists.

- The practice of medicine affects all Texans. At one time or another, all Texans must seek medical care. All three boards seek to protect the public by ensuring that physicians, physician assistants, and acupuncturists are qualified, competent, and adhere to established professional standards. To protect the public from the unprofessional, improper, and incompetent practice of medicine, the boards enforce laws that outline the practice of medicine in Texas and provide an avenue for consumers to lodge a complaint if they receive substandard care.

The boards enforce laws that outline the practice of medicine in Texas.

- Physicians play a primary role in Texans' health care. They conduct physical exams; diagnose and treat illnesses and injuries; prescribe and administer medications, including controlled substances; order, perform, and interpret diagnostic tests; and counsel patients on diet, hygiene, and preventive health care. Medical procedures, such as surgery, performed by physicians can have life-saving results, but can also pose significant risks.

- Physician assistants serve an increasingly significant role in the provision of medical services to Texans. Under the supervision of a licensed physician, physician assistants examine patients; diagnose and treat illnesses; order and interpret tests; assist in surgery; and prescribe medication. In some clinics, a physician assistant may be the principal care provider, as a physician is present only one or two days a week.

- The practice of acupuncture, an ancient form of medical treatment that originated more than 5,000 years ago, has become a common medical procedure in the United States, including in Texas. Acupuncture involves inserting needles into certain points on the body, administering thermal or electric treatments, and recommending herbal supplements. Acupuncturists treat a variety of conditions, including allergies, arthritis, depression, tendinitis, and substance abuse.

All 50 states regulate physicians and physician assistants, and most states regulate acupuncturists.

- The chart, *Regulation of Medicine in Other States*, describes the structure of state agencies that regulate physicians, physician assistants, and acupuncturists in the United States. All states regulate physicians, although the organizational structure varies. In 14 states, doctors of

Regulation of Medicine in Other States

Profession	Number of States	Independent Agency	Health Professions Agency	General Umbrella Agency	Advisory to Medical Board	Regulated by Medical Board
Physicians	50	(27) AL, AR, AZ,* GA, ID, KS, KY, LA, MA, MD, ME,* MN, MS, NC, ND, NH, NM, NV,* OH, OK,* OR, SC, SD, TX, VT,* WV,* WY	**(9)** CT, FL,* IN, IA, NE, RI, TN,* VA, WA*	**(14)** AK, CA,* CO, DE, HI, IL, MI,* MO, MT, NJ, NY,* PA,* UT,* WI	n/a	n/a
Physician Assistants	50	(3) AZ, GA, IA	**(7)** CT, IN, MA, MI, MO, NE, RI	**(4)** CA, IL, NY, UT	**(9)** DE, KS, KY, MN, NJ, TN, TX, VA, WA	(27) AK, AL, AR, CO, FL, HI, ID, LA, MD, ME, MS, MT, NC, ND, NH, NM, NV, OH, OK, OR, PA, SC, SD, VT, WI, WV, WY
Acupuncturists	40	(4) AR, NC, NM, WV	**(8)** CT, FL, IN, MD, NH, RI, TN, WA	**(12)** AK, CA, CO, HI, ID, IL, ME, MO** NY, UT, VT, WI	**(5)** MA, MN, NJ, TX, VA	(11) AZ, GA, IA, LA, MT, NE, NV, OH, OR, PA, SC

* These states have separate agencies or oversight boards to regulate doctors of medicine and doctors of osteopathy.
** In Missouri, the practice of acupuncture is regulated by the state chriopractic board.

medicine and doctors of osteopathy are regulated by separate agencies. Physician assistants are regulated in all 50 states, with most state's accomplishing this regulation through the medical board. Forty states regulate acupuncturists, with this regulation occurring through the state medical board about one-third of the time.

Different organizational options for regulating licensed health-care practitioners offer advantages and disadvantages to the Board.

- The regulation of health-care practitioners – including physicians, physician assistants, and acupuncturists – could occur through several organizational structures, such as an independent board, a coordinating council similar to the Health Professions Council, or a consolidation of similar licensing agencies. The advantages and disadvantages of each of these organizational structures are described in the chart, *Organizational Structure Options*.

- Traditionally, Texas has approached the regulation of most health-care professions through an independent agency that pays for itself through licensing and professional fees, focuses on good customer service, and provides expertise for the regulation of its licensees. Under the current structure, the Medical Board operates as an independent agency, while the Physician Assistant and Acupuncture boards serve as advisory bodies to the Medical Board. A staff of 133 supports the three boards and the regulation of physicians, physician assistants, and acupuncturists.

- The Health Professions Council (HPC) currently functions as a coordinating council for 15 health-care professional licensing agencies representing 35 professional licensing boards and programs. Member agencies colocate in one state office building to facilitate resource sharing, including shared board and conference rooms, an imaging system, courier services, and information technology staff. HPC is currently making plans to coordinate human resources and financial activities among member agencies. The Legislature augmented the activities of HPC in 2003 by establishing the Office of Patient Protection, which will assist consumers with complaints about HPC member agencies.

  While HPC is a coordinating body with few staff that basically brokers services among its member agencies, it could be given additional authority and resources to enable it to perform member agencies' administrative functions, leaving them to perform only licensing and enforcement functions. However, because the Medical Board is currently a net contributor of administrative services to HPC, it would have less to gain from such an arrangement than many of the smaller health licensing agencies.

- A single umbrella health licensing agency could regulate all of the health professions currently regulated under 35 separate boards and programs. A public board would oversee all regulation, assisted by advisory committees that could provide expertise in the regulation of the various health-care professions. The structure of the agency could be modeled after the Texas Department of Licensing and Regulation (TDLR), which has a structure for occupational and professional examination, licensing,

Under the current structure, the Medical Board is an independent agency, while the Physician Assistant and Acupuncture boards serve as advisory bodies.

Organizational Structure Options			
Type of Organization	**Description**	**Advantages**	**Disadvantages**
Independent Agency	Independent boards appointed by Governor to represent physicians, physician assistants, and acupuncturists, and make final decisions for regulation with own staff and budget.	• Expertise in profession applied to regulation of licensees. • Better accountability for licensing and enforcement decisions. • Improved customer service by Board and staff dedicated to single profession.	• Duplication of effort with other licensing agencies performing common functions. • Limited coordination with agencies with similar responsibilities.
Coordinating Council	Board appointed by Governor to make final decisions for regulation with own staff for licensing and enforcement. Receives some or all administrative support from coordinating council composed of comparable agencies, such as the Health Professions Council, which may rely on staff from member agencies or may employ its own staff.	• Administrative efficiency from standardizing functions among member agencies. • Better focus of limited resources on core licensing and enforcement functions.	• Less autonomy for Board in meeting administrative program needs. • Fracturing of administrative services among agencies, with some favored more than others. • Duplication of effort with other licensing agencies performing common functions.
Consolidation of Similar Agencies	Independent, Governor-appointed boards with decision-making authority or advisory boards that make recommendations to consolidated licensing oversight board for regulation of separate health-care practitioners as part of unified regulation of all health professions.	• Single point of contact for consumers to obtain information or lodge complaints. • Improved coordination and standardization of rules and policies, especially among similar professions. • Improved economy of scale for administrative, licensing, and enforcement functions. • Reduced potential for regulated profession to dominate regulations.	• Neglect of individual professions in favor of larger, more powerful groups. • Diminished customer service and accountability, resulting in increased response times for licensing and enforcement actions. • Lack of staff expertise in a specific profession.

and enforcement for more than 20 regulatory programs. The agency's public board receives assistance from statutorily created advisory committees, composed of regulated trades, businesses, industries, and occupations.

A complete study of organizational options should also consider the results of the Sunset Commission's reviews of other health-profession licensing agencies completed during this review cycle.

- Sunset reviews of many other health-profession licensing agencies have been completed during the current review cycle. The textbox, *Health-Care Professional Boards Under Sunset Review*, lists the professional licensing agencies that have undergone a Sunset review this cycle.

- The Sunset Commission delayed its decisions on continuation of these agencies until Sunset staff had completed reviews of all professional licensing agencies. Results of these reviews may indicate that further administrative efficiencies could be gained among these agencies. Opportunities may also exist to provide for greater coordination and consistent regulation across Texas' health-profession licensing agencies. Thus, the Sunset Commission is able to base its recommendations regarding continuation and organizational structure on the most complete information.

Health Licensing Boards Under Sunset Review – 2005

State Board of Acupuncture Examiners
Texas Board of Chiropractic Examiners
Texas State Board of Examiners of Dietitians
Texas State Board of Examiners of Marriage and Family Therapists
Texas State Board of Medical Examiners
Texas Midwifery Board
Texas Optometry Board
Texas State Board of Examiners of Perfusionists
Texas State Board of Pharmacy
State Board of Physician Assistant Examiners
State Board of Podiatric Medical Examiners
Texas State Board of Examiners of Professional Counselors
Texas State Board of Examiners of Psychologists
Texas State Board of Social Work Examiners
State Board of Veterinary Medical Examiners

Recommendation

Change in Statute

12.1 Continue regulating physicians, physician assistants, and acupuncturists in Texas.

Under this recommendation, the State would continue to regulate physicians, physician assistants, and acupuncturists. The recommendation for the structural organization of the agencies that perform this regulation is addressed in the Licensing Reorganization Project report.

Impact

The State should continue to regulate physicians, physician assistants, and acupuncturists, as these practitioners play a significant role in providing health care to Texans. The structure of this regulation is addressed in the Licensing Reorganization Project report.

Fiscal Implication

This recommendation would not have a fiscal impact to the State.

Across-the-Board Recommendations

Texas State Board of Medical Examiners	
Recommendations	**Across-the-Board Provisions**
Update	1. Require public membership on the agency's policymaking body.
Modify	2. Require provisions relating to conflicts of interest.
Already in Statute	3. Require unbiased appointments to the agency's policymaking body.
Update	4. Provide that the Governor designate the presiding officer of the policymaking body.
Update	5. Specify grounds for removal of a member of the policymaking body.
Update	6. Require training for members of the policymaking body.
Update	7. Require separation of policymaking and agency staff functions.
Already in Statute	8. Provide for public testimony at meetings of the policymaking body.
Update	9. Require information to be maintained on complaints.
Apply	10. Require the agency to use technology to increase public access.
Apply	11. Develop and use appropriate alternative rulemaking and dispute resolution procedures.

Texas State Board of Physician Assistant Examiners	
Recommendations	**Across-the-Board Provisions**
Update	1. Require public membership on the agency's policymaking body.
Update	2. Require provisions relating to conflicts of interest.
Apply	3. Require unbiased appointments to the agency's policymaking body.
Apply	4. Provide that the Governor designate the presiding officer of the policymaking body.
Update	5. Specify grounds for removal of a member of the policymaking body.
Apply	6. Require training for members of the policymaking body.
Modify	7. Require separation of policymaking and agency staff functions.
Apply	8. Provide for public testimony at meetings of the policymaking body.
Update	9. Require information to be maintained on complaints.
Apply	10. Require the agency to use technology to increase public access.
Apply	11. Develop and use appropriate alternative rulemaking and dispute resolution procedures.

Texas State Board of Acupuncture Examiners	
Recommendations	**Across-the-Board Provisions**
Update	1. Require public membership on the agency's policymaking body.
Update	2. Require provisions relating to conflicts of interest.
Already in Statute	3. Require unbiased appointments to the agency's policymaking body.
Already in Statute	4. Provide that the Governor designate the presiding officer of the policymaking body.
Already in Statute	5. Specify grounds for removal of a member of the policymaking body.
Update	6. Require training for members of the policymaking body.
Update	7. Require separation of policymaking and agency staff functions.
Already in Statute	8. Provide for public testimony at meetings of the policymaking body.
Already in Statute	9. Require information to be maintained on complaints.
Apply	10. Require the agency to use technology to increase public access.
Apply	11. Develop and use appropriate alternative rulemaking and dispute resolution procedures.

AGENCY INFORMATION

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:

- 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. 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.

Organization

Policy Body

Texas State Board of Medical Examiners

The Texas State Board of Medical Examiners consists of 19 voting members – 12 licensed physicians and seven public members – appointed by the Governor and confirmed by the Senate. Of the 12 physicians, nine must be doctors of medicine and three must be doctors of osteopathic medicine. All 12 physician members must have been licensed in Texas for at least three years, actively engaged in the practice of medicine for at least five years, and participated in medical peer review at a health-care facility for at least three years. The Governor designates the Board president; Board members elect a vice president and secretary-treasurer. The chart, *Texas State Board of Medical Examiners*, identifies current Board members. Although required to meet at least four times a year, the Board typically meets six times a year.

Texas State Board of Medical Examiners

Member	City	Qualification (Specialty)	Term Expires
Lee S. Anderson, M.D., President	Fort Worth	Physician (Ophthalmology)	2009
Larry Price, D.O., Vice President	Belton	Physician (Cardiovascular Diseases)	2009
Nancy M. Seliger, Secretary-Treasurer	Amarillo	Public Member	2005
Jose M. Benavides, M.D.	San Antonio	Physician (Internal Medicine)	2005
Patricia S. Blackwell	Midland	Public Member	2007
Christine L. Canterbury, M.D.	Corpus Christi	Physician (Obstetrics/Gynecology)	2007
Melinda S. Fredricks	Conroe	Public Member	2009
David E. Garza, D.O.	Laredo	Physician (Family Practice)	2005
Roberta M. Kalafut, D.O.	Abilene	Physician (Physical Medicine & Rehabilitation)	2007
Amanullah Khan, M.D.	Dallas	Physician (Oncology)	2009
Thomas D. Kirksey, M.D.	Austin	Physician (Cardiothoracic and Vascular Surgery)	2007
Eddie J. Miles, Jr.	San Antonio	Public Member	2007
Keith E. Miller, M.D.	Center	Physician (Family Practice)	2009
Elvira Pascua-Lim, M.D.	Lubbock	Physician (Psychiatry)	2007
John W. Pate, Jr., M.D.	El Paso	Physician (Plastic Surgery)	2007
Annette P. Raggette	Austin	Public Member	2009
Joyce A. Roberts, M.D.	Scroggins	Physician (Family Practice)	2005
Paulette B. Southard	Alice	Public Member	2005
Timothy J. Turner	Bellaire	Public Member	2009

The Medical Board sets policies and adopts rules, grants licenses, approves disciplinary actions, and hires the agency's Executive Director. Many of the Board's responsibilities are carried out in subcommittees, which are described in Appendix A, *Board Subcommittees*. The full Board accepts, modifies, or rejects committee recommendations. In addition, two statutorily created committees assist the Board. The Surgical Assistants Advisory Committee consists of six members appointed by the president of the Medical Board.

Also, the Prescriptive Delegation Waiver Committee consists of 15 members, appointed by the Medical Board from a list recommended by professional associations.

The Board also has oversight authority over the Texas State Board of Physician Assistant Examiners in the area of rulemaking; and the Texas State Board of Acupuncture Examiners in the areas of rulemaking, licensure, and approval of disciplinary action.

Texas State Board of Physician Assistant Examiners

The Texas State Board of Physician Assistant Examiners consists of nine members – three physicians assistants, three physicians, and three public members – appointed by the Governor. The physician assistant members must hold an active Texas license, be currently practicing, and have at least five years of clinical experience as a physician assistant. Physician members must hold a Texas license and currently supervise physician assistants within their practice. Each year, Board members elect a presiding officer and a secretary.

The chart, *Texas State Board of Physician Assistant Examiners*, identifies current Board members. Currently, one of the physician member positions is vacant. The Board meets four times a year.

Texas State Board of Physician Assistant Examiners

Member Name	City	Qualification	Term Expires[1]
Timothy Webb, Presiding Officer	Houston	Public Member	2001
Stephen H. Benold, M.D., Secretary	Georgetown	Physician	2005
Michael H. Belgard, PA-C	San Augustine	Physician Assistant	2003
G. Al Bendeck, PA-C	Slaton	Physician Assistant	2005
Margaret K. Bentley	DeSoto	Public Member	2003
Pamela W. Clark	Corpus Christi	Public Member	2005
Dwight M. Deter, PA-C	El Paso	Physician Assistant	2001
Tony G. Hedges, D.O.	Littlefield	Physician	2001

The Physician Assistant Board approves applicants for licensure, participates in disciplinary proceedings of licensees, and takes enforcement action against physician assistants who violate the Physician Assistant Licensing Act and Medical Board rules. The Physician Assistant Board also makes recommendations to the Medical Board regarding rules to regulate physician assistants. The Board has established three subcommittees, which are described in Appendix A.

Texas State Board of Acupuncture Examiners

The Texas State Board of Acupuncture Examiners consists of nine members – four acupuncturists, two physicians experienced in the field of acupuncture, and three public members – appointed by the Governor. The acupuncturist members must have at least five years of experience in the field of acupuncture in Texas and may not hold a license as a physician. The Governor selects the presiding officer, and members elect an assistant

presiding officer and a secretary-treasurer. The chart, *Texas State Board of Acupuncture Examiners*, identifies current Board members. Currently, one of the acupuncturist member positions is vacant. The Board typically meets four times a year.

Texas State Board of Acupuncture Examiners			
Member Name	**City**	**Qualification**	**Term Expires[2]**
Everett G. Heinze, Jr., M.D., Presiding Officer	Austin	Physician	2001
Meng-Sheng Linda Lin, L.Ac., Assistant Presiding Officer	Richardson	Acupuncturist	2003
Claire H. Smith, Secretary-Treasurer	Dallas	Public Member	2005
Sheng Ting (Sam) Chen	Austin	Public Member	2009
Pedro (Pete) V. Garcia	Frisco	Public Member	2003
Hoang Xiong Ho, L.Ac.	San Antonio	Acupuncturist	2007
Dee Ann Newbold, L.Ac.	Austin	Acupuncturist	2005
Terry Glenn Rascoe, M.D.	Temple	Physician	2007

As an advisory board, the Acupuncture Board recommends rules to regulate acupuncturists, applicants for licensure, and disciplinary actions against acupuncturists to the Medical Board for final approval. Acupuncture Board members participate in disciplinary proceedings concerning acupuncturists and approve continuing education courses and providers. The Acupuncture Board has established four subcommittees, described in Appendix A.

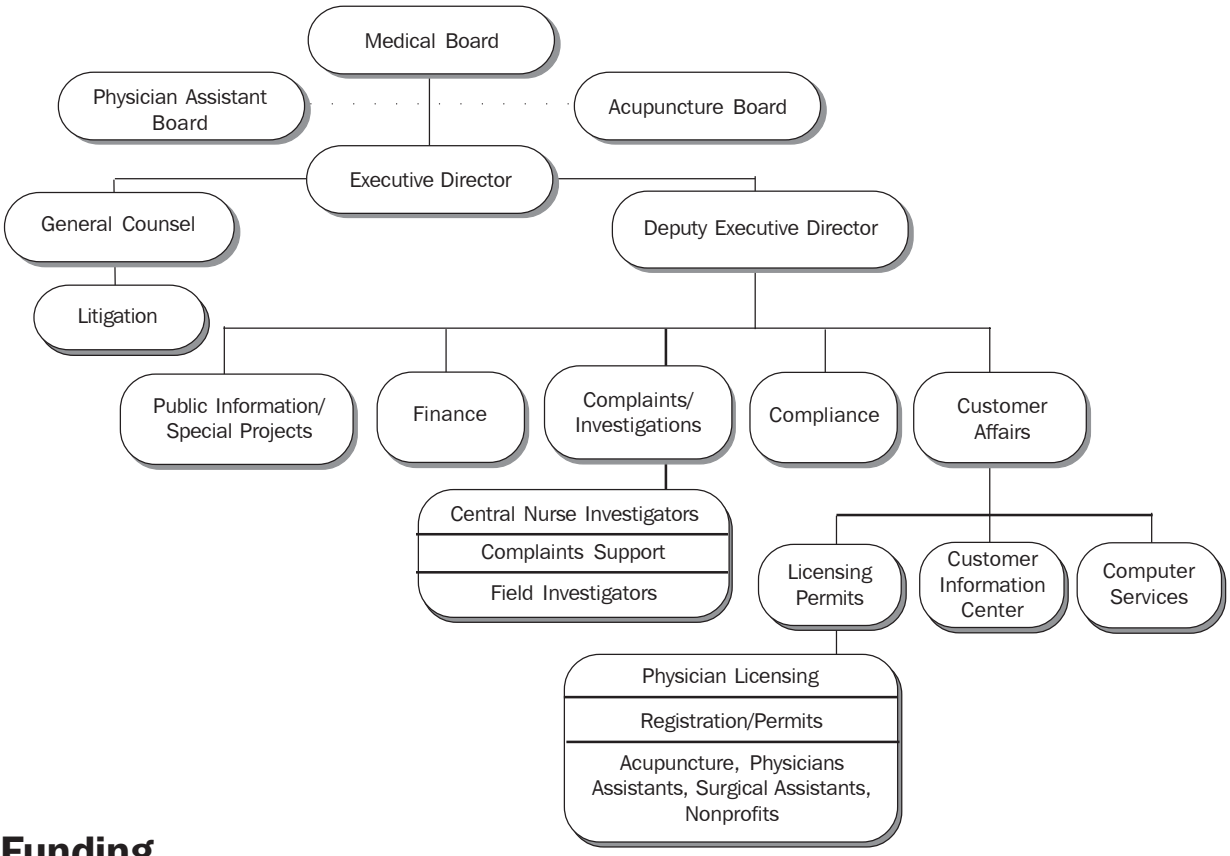
Staff

The agency has a staff of 133. Of these, 28 work in the field and the others work at the agency's headquarters in Austin. The Executive Director, under the direction of the Medical Board, manages the agency's day-to-day operations and implements policies set by the boards. Employees work in seven divisions: Central Administration, Complaints/Investigation, Compliance, Customer Affairs, Finance, Legal, and Public Information/ Special Projects. Staff processes license applications and renewals, investigates complaints, and ensures a licensee's compliance with Board orders. The *Medical Board Organizational Chart*, outlines the agency's divisions.

The Medical Board is also a member of the Health Professions Council (HPC), which coordinates functions among various health-care licensing agencies. Medical Board staff provides assistance to HPC in areas such as budgeting and general accounting.

Appendix B compares the agency's workforce composition to the minority civilian labor force. Generally, the agency falls below the civilian workforce standards; however, this is because the agency has a small number of employees in some job categories.

Texas State Board of Medical Examiners Organizational Chart



Funding

Revenues

In fiscal year 2004, regulation of physicians, physician assistants, and acupuncturists generated revenue of about $25 million through various fees and assessments. As licensing agencies, the boards cover their administrative costs through licensing, renewal, and examination fees. Revenue generated through these fees totaled more than $13 million in fiscal year 2004, and is deposited in the General Revenue Fund. In January 2004, the Medical Board began collecting an $80 surcharge on each physician license to fund the agency's enhanced enforcement program. Revenue from the $80 fee is deposited in the Physician Enforcement Account, a dedicated account within the General Revenue Fund, and totaled more than $3 million in fiscal year 2004.

In 2004, physicians began paying an $80 surcharge for the agency's enhanced enforcement efforts.

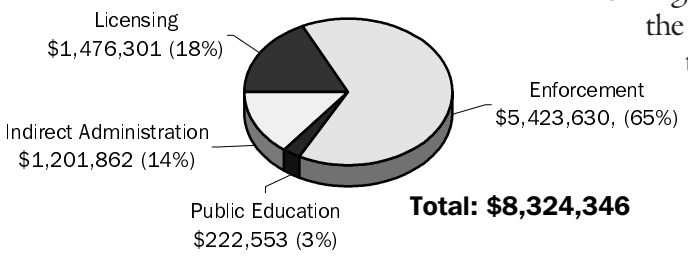
In addition to their regular license renewal fee, physicians annually pay a $200 professional fee. Revenue from this fee, which totaled more than $11 million in fiscal year 2004, is not used to cover the agency's operating costs, but goes to the General Revenue Fund and the Foundation School Fund to be spent on other state purposes. Physicians pay a $4 fee and physician assistants and acupuncturists pay a $5 fee for the Texas Online system, which allows practitioners to renew their licenses via the Internet, and a $1 fee for the Office of Patient Protection, which acts as an ombudsman to health-care consumers who want to file a complaint against licensed health-care professionals. The table, *License Fees*, details the licensing and renewal fees currently charged by the boards.

License Fees						
Description	Board Fee	Professional Fee	Texas Online	OPP[3]	Enforcement Surcharge	Total Fee
Physician license application	$600	$200	$0	$0	$5	$805
Physician annual renewal[4]	$130	$200	$4	$1	$80	$415
Physician Assistant license application	$200	$0	$5	$0	n/a	$205
Physician Assistant annual renewal	$150	$0	$5	$1	n/a	$156
Acupuncture license application	$300	$0	$5	$0	n/a	$305
Acupuncture annual renewal	$250	$0	$5	$1	n/a	$256
Surgical assistant license application	$300	$0	$5	$0	n/a	$305
Surgical assistant biennial renewal	$400	$0	$0	$2	n/a	$402

Expenditures

In fiscal year 2004, the Medical Board – which oversees revenues and expenditures for all three boards – spent $8,324,346 on four strategies: licensing, enforcement, public education, and indirect administration, as detailed in the chart, *Strategies*. In addition, the Legislature has directed the Board and other licensing agencies that pay the costs of regulatory programs with fees levied on licensees to cover direct and indirect costs appropriated to other agencies. Examples of these costs include rent and utilities paid by the Texas Building and Procurement Commission and employee benefits paid by the Employees Retirement System. In fiscal year 2004, these direct and indirect costs for the Board totaled $1,068,791.

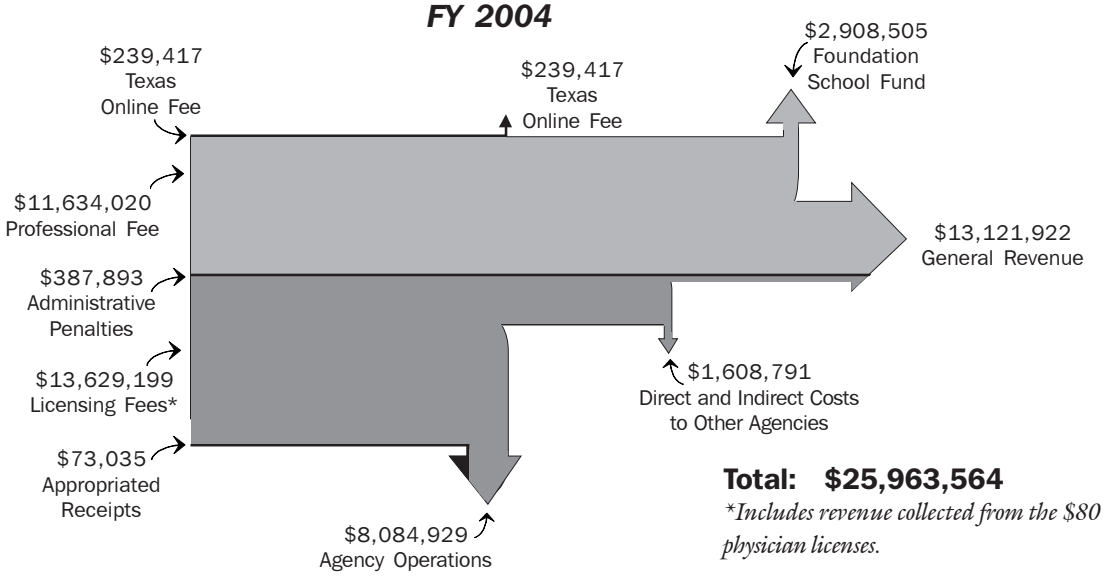
Strategies



The chart, *Flow of Agency Revenue and Expenditures*, breaks down the agency's revenues and expenditures for fiscal year 2004. Subtracting the agency's operating expenses and the direct and indirect costs incurred by other agencies from total revenues, the agency generated more than $13 million to be used for state purposes other than regulating its licensees.

Appendix C describes the agency's use of Historically Underutilized Businesses (HUBs) in purchasing goods and services for fiscal years 2000 to 2003. The agency uses HUBs in the categories of professional services, other services, and commodities. The agency fell short of the State's goal for professional services and other services because the services purchased were not available from a HUB vendor. Examples of such services include court-reporting services and medical records review. In the category of commodities, the agency was restricted to using a sole-service provider for its contract for information technology.

Flow of Agency Revenues and Expenditures
FY 2004



Total: $25,963,564

**Includes revenue collected from the $80 surcharge on physician licenses.*

Agency Operations

To ensure that only qualified individuals provide medical services in Texas, the Medical, Physician Assistant, and Acupuncture boards perform two core regulatory functions: licensing and examination, and enforcement.

Licensing and Registration

The boards issue licenses to four groups of health-care providers – physicians, physician assistants, acupuncturists, and surgical assistants. In addition, the agency has 12 other permit and registration programs, which are detailed in Appendix D.

Physicians

Under the Medical Practice Act, physicians may provide medical services such as diagnosing and treating disease and injury, performing surgery, and prescribing medication. To become a licensed physician in Texas, applicants must meet education, experience, and examination requirements specified in the Act and Board rules, and satisfy four criminal and disciplinary background checks, as highlighted in the textbox, *Physician Licensure Requirements*. The flow chart, *Becoming a Physician*, details the process an individual must complete to be eligible for licensure in Texas. In fiscal year 2004, the Board regulated 55,993 physicians and 6,544 physicians-in-training.

Physician Licensure Requirements

To receive a license to practice medicine in Texas, a person must meet the following requirements.

- Be at least 21 years old.
- Graduate from an accredited medical school.
- Complete at least one year of postgraduate training.
- Pass a national exam and the state's jurisprudence exam.
- Undergo criminal background and sex offender database checks.
- Undergo national physician disciplinary action checks conducted by national organizations.

Education. An applicant must graduate with a doctor of medicine (M.D.) degree from a medical school accredited by the Liaison Committee on Medical Education, or with a doctor of osteopathy (D.O.) degree from a medical school accredited by the American Osteopathic Association Bureau

Becoming a Physician

Pre-Medical School Education – 4 years

- Complete at least 60 course work hours of science, such as biology, chemistry, and physics. Course work is usually part of an undergraduate degree at a 4-year college or university.
- Take the Medical College Admissions Test.

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Medical School – 4 years

- Years 1 & 2: Classes in basic medical sciences, such as anatomy, biochemistry and biology.
- End of Year 2: Students take USMLE I or COMLEX I, which tests basic science knowledge.
- Years 3 & 4: Clinical clerkship, which includes classes on prevention, diagnosis, and treatment of illnesses and disorders, and observation of medical procedures.
- End of Year 4: Students take USMLE II or COMLEX II, which tests knowledge of prevention, diagnosis, and treatment of medical conditions.

↓

Postgraduate Training – 3+ years

- Physicians attend postgraduate training, commonly known as residency, to develop expertise in a specific area of medicine. Physicians train at a teaching hospital, working with patients under the supervision of licensed physician instructors.
- Physicians complete as many years of training as required by their chosen specialty, generally completing three to five years in residency.
- At the end of the first year of training, physicians take the USMLE III or COMLEX III, which tests clinical competence.

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Licensing and Speciality Certification

- After completing at least one year of postgraduate training, physicians may apply for a medical license with the Medical Board.
- Once all training is complete, and BME has issued a license, physicians may apply for specialty certificates with boards affiliated with the American Board of Medical Specialists or the Bureau of Osteopathic Specialties.

Allopathic and Osteopathic Medicine

Two types of physicians may be licensed for independent practice in the United States – allopathic and osteopathic physicians. Both types of physicians attend a four-year medical school to learn medical and clinical science, complete a minimum of one year of postgraduate training, and take a national exam to be eligible for licensure. Both physicians may diagnose and treat disease and injury, perform surgery, and prescribe medications. Additionally, osteopathic and allopathic physicians work in the same hospitals and medical practices, and may be certified by the same medical specialty boards. The key difference between the two physician types is that osteopathic physicians receive additional training in osteopathic manipulative treatment, in which hands are used to diagnose, treat, and prevent injury and illness.

of Professional Education. The textbox, *Allopathic and Osteopathic Medicine,* describes the differences between allopathic and osteopathic physicians. Despite the different degree types, medical doctors and doctors of osteopathy receive the same license and provide the same services. Texas has eight accredited schools – seven medical schools and one osteopathic school.[5]

Experience. After graduating from medical school, applicants must complete at least one year of postgraduate training, also known as a residency. Individuals apply to residency programs in a specialized area of medicine, such as radiology or pediatrics, then are matched to a program by the National Resident Matching Program. During residency, physicians provide medical services to patients at teaching hospitals and clinics under the supervision of licensed physician instructors. While only required to have one year of training to apply for a license, most physicians complete three to five years of training, depending on the requirements of their chosen medical specialty. After completing a residency, some physicians complete up to three years of additional subspecialty training, called a fellowship, which allows them to become specialized in a narrow field of medicine. Physicians may apply for full licensure after the first year of residency, although most wait until the last year of the residency to apply.

Examination. To become licensed as a physician in Texas, applicants must pass a national written examination. Applicants with a medical degree take the United States Medical Licensing Examination (USMLE), developed by the National Board of Medical Examiners and the Federation of State Medical Boards. Osteopathic applicants may take the USMLE or the Comprehensive Osteopathic Licensing Examination (COMLEX), developed by the National Board of Osteopathic Medical Examiners. Both exams are administered at testing centers throughout the United States and Canada. Each computerized exam consists of three parts, taken at various points during medical school and residency, that evaluate knowledge of medical and clinical science, and clinical competence. The

percentages of applicants who pass the national exam are outlined in the chart, *U.S. Licensing Exam Passage Rates*.

The Medical Board also requires applicants to pass its jurisprudence exam, which tests knowledge of the Medical Practice Act, Board rules, and other laws that apply to the practice of medicine in Texas, such as state and federal drug laws. Applicants take the computerized exam, written by Board staff, at testing sites throughout the United States.

U.S. Licensing Exam Passage Rates, 2003

	USMLE			COMLEX	
	U.S. School Graduates		Foreign Graduates	U.S. School Graduates	Foreign Graduates
	M.D.	D.O.			
Part One – Percent Passing					
First-time takers	93%	74%	65%	91%	n/a
Retakers	62%	44%	42%	63%	
Part Two – Percent Passing					
First-time takers	96%	88%	79%	93%	n/a
Retakers	64%	50%	47%	66%	
Part Three – Percent Passing					
First-time takers	95%	92%	68%	90%	n/a
Retakers	65%	67%	47%	66%	

International applicants. Applicants who graduate from international medical schools must meet additional requirements to be eligible for a physician license in Texas. Such individuals must prove that their medical education is substantially equivalent to a Texas medical school education; complete three years of a Board-approved postgraduate training program in the United States or Canada; have a certificate issued by the Educational Commission for Foreign Medical Graduates; and demonstrate ability to communicate in English.[6] The Board considers license eligibility for international applicants on a case-by-case basis. In fiscal years 2003 and 2004, the Board received 1,378 applications from international applicants; of these, all but 115 were approved.

International applicants must prove equivalency with Texas medical education.

Specialty-Board Certification. After licensure, most physicians receive certification for specialty practice from national specialty boards affiliated with the American Board of Medical Specialties (ABMS) or the Bureau of Osteopathic Specialties (BOS); osteopathic practitioners may be certified by either, depending on training. Certification assures the public that a physician has completed an approved training program and has the proven ability to provide competent care in a specialty area of practice, such as surgery, family practice, pediatrics, or obstetrics and gynecology. Physicians do not have to become certified in a specialty, although most do. The most common specialties for Texas physicians are listed in the textbox, *Specialty Practice*.[7]

Specialty Practice

The 10 most common specialties for Texas physicians include the following.

- Internal Medicine
- Family Practice
- Pediatrics
- Obstetrics & Gynecology
- Anesthesiology
- Radiology
- Psychiatry
- General Surgery
- Orthopedic Surgery
- Ophthalmology

Requirements for certification vary by specialty board, but generally include a specific number of years of training and passage of an exam. Some specialties require recertification exams throughout a physician's career to monitor competency. The Medical Board recognizes ABMS and BOS specialty board certifications, but does not issue a license for specialties; instead, all physicians receive a general license that allows them to practice medicine in Texas. Although physicians may practice outside of their specialty, the Board holds licensees responsible for

following the standard of care of the specialty they are practicing. For a complete list of specialties recognized by ABMS and BOS, and thus, the Medical Board, see Appendix E, *Physician Specialty Boards*.

Physician Assistants

Physician assistants (PAs) provide medical services under the supervision of licensed physicians. Although a physician can delegate almost any act to a physician assistant, common PA duties include performing physical exams, diagnosing and treating diseases and injuries, and prescribing medications.

Physician Assistant Licensing Requirements

- Have a degree from an accredited school.
- Pass a national certification exam.
- Must have practiced full-time as a PA, or have been a student or faculty at a PA program within either of the last two years prior to applying for licensure.
- Undergo a DPS background check.

To become a licensed physician assistant in Texas, applicants must meet education and examination requirements specified in statute and Medical Board rules, as well as other qualifications, as detailed in the textbox, *Physician Assistant Licensing Requirements*. The flow chart, *Becoming a Physician Assistant*, outlines the process an individual must complete to be eligible for licensure in Texas. In fiscal year 2004, the Board regulated 3,453 physician assistants.

Becoming a Physician Assistant

Pre-PA School Education – Four years

- Texas PA programs require a bachelor degree for admission, with emphasis on science courses such as anatomy, chemistry, and biology.
- Must take the Graduate Record Examination (GRE).

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Physician Assistant School – Two years

- Year One: Classes in anatomy, patient evaluation and diagnosis, pharmacology, clinical medicine, and psychiatry.
- Year Two: Clinical rotations in areas such as pediatrics, emergency medicine, obstetrics and gynecology, and surgery.

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Licensing and Certification

- After graduation, all PAs must pass the Physician Assistant National Certifying Examination to become eligible for licensure in Texas.
- After receiving national certification, PAs may apply for licensure with the Physician Assistant Board.

Education. Applicants must graduate from a physician assistant program accredited by the Accreditation Review Commission on Education for the Physician Assistant. Texas has eight accredited programs, which take about two to three years to complete.[8] Students complete courses in medical and clinical science and spend more than 1,000 hours in supervised, clinical rotations.

Examination. Applicants must pass the Physician Assistant National Certifying Examination, developed and administered by the National Commission on Certification of Physician Assistants. The computerized exam, administered at testing sites throughout Texas, tests general medical and surgical knowledge. Also, at the time of initial licensure, applicants must hold an active national certification, which they obtain by passing this same national examination. To maintain national certification, physician assistants must take a recertification exam every six years and complete 50 hours of continuing education annually. Recertification of national credentials is not required to renew a license in Texas, however.

Experience. In addition to education and examination requirements, applicants for a physician assistant license also must meet experience requirements. Applicants must have, on a full-time basis, actively practiced

as a physician assistant, been a student at an approved physician assistant program, or worked on the active teaching faculty of an approved physician assistant program within either of the last two years before applying for a license. Full time means at least 20 hours per week for at least 40 weeks during a year.

Supervision and delegation. Once licensed, physician assistants must practice under the continuous supervision of a physician; however, neither the Physician Assistant Licensing Act nor the Medical Practice Act requires the supervising physician's constant physical presence. In general, Medical Board rules permit physician assistants to practice only at sites where the supervising physician is present at least 20 percent of the site's listed business hours, with exceptions relating to the practice setting. When the physician is not present, the physician assistant and the supervising physician must be able to easily communicate with each other via telephone, radio, or other telecommunication device.

The Medical Practice Act authorizes physicians to delegate the provision of medical services to physician assistants, as described in the textbox, *Physician Assistant Practice*. The Act also details specific prescriptive tasks physicians may delegate to physician assistants.

Physician Assistant Practice

The scope of practice for physician assistants depends upon the delegatory decisions made by the supervising physician, who has responsibility for services provided by a physician assistant. The Medical Practice Act provides authority for physicians to delegate the provision of medical services to physician assistants. Scope of practice decisions are generally made by taking into consideration the physician assistant's education and experience, the physician's delegatory comfort level, and the needs of the patients in a practice. Physician assistants' statutory authority includes the ability to:

- take medical histories;
- perform physical examinations;
- prescribe medications, including dangerous and some controlled substances, at designated practice sites;
- diagnosis and treat medical problems; and
- assist at surgery.

Acupuncturists

Acupuncturists provide health-care services through the use of acupuncture, the prescription of herbal supplements, and other nontraditional practices. The textbox, *The Practice of Acupuncture*, further explains what constitutes the practice of acupuncture.

To become a licensed acupuncturist in Texas, applicants must meet certain education and examination requirements specified in statute and Medical Board rules, as well as other requirements listed in the textbox, *Acupuncture Licensing Requirements*. The steps to become a licensed acupuncturist are further detailed in the flow chart, *Becoming an Acupuncturist*. In fiscal year 2004, the Acupuncture Board regulated 693 acupuncturists.

The Practice of Acupuncture

Acupuncture, a form of Chinese medicine dating back more than 3,500 years, is becoming increasingly common in the United States. In 2003, nearly one in 10 adults in the United States received acupuncture treatment. Practitioners place special needles into specific points on the body to help conduct energy to treat a variety of medical conditions, including headaches, osteoarthritis, insomnia, and postsurgical pain. Acupuncturists also use other treatment modalities, such as dietary and exercise recommendations and the prescription of Chinese herbal medicines.

Acupuncturists in Texas may not provide services unless the patient has seen a physician for the condition to be treated within six months of the acupuncture appointment. No physician referral or evaluation is needed to treat smoking addiction, weight loss, or substance abuse.

Education. To become an acupuncturist, an individual must complete an education program accredited by the Accreditation Commission for Acupuncture and Oriental Medicine. More than 50 accredited acupuncture and Oriental medicine schools exist nationwide, with four accredited programs in Texas – two in Austin, one in Dallas, and one in

Acupuncture Licensing Requirements

- Be at least 21 years old.
- Graduate from an accredited acupuncture school.
- Pass a national exam.
- Undergo a DPS background check.

Becoming an Acupuncturist

Pre-Acupuncture School Education – Four years

- A minimum of 60 course hours of college credit in natural, behavioral, and social sciences, and mathematics, usually completed as part of an undergraduate degree at a 4-year college or university.

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Acupuncture School – Three years

- Includes classes in Chinese medicine, acupuncture points and technique, Chinese herbology, anatomy and physiology, microbiology and pharmacology, and acupuncture assessment and treatment.
- Students engage in supervised clinical practice throughout their education.

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Licensing and Certification

- All acupuncturists must pass the national certification examination for acupuncture and Oriental medicine examination to be eligible for licensure in Texas. The six-part exam tests knowledge of oriental medicine, acupuncture point locations, biomedicine, Chinese herbology, and Asian bodywork therapy; however, passage of the biomedicine and Asian bodywork therapy portions of the exam is not required for licensure in Texas.
- Complete a clean-needle technique course and pass the related exam.
- After passing the clean-needle technique and national exams, acupuncturists may be eligible for licensure with the Acupuncture Board.

Houston.[9] Generally, acupuncturists attend school for about three years. During this time, students learn about topics such as acupuncture point location, needling techniques, nutrition, biomedical science, and herbal medicine.

Although the Acupuncture Board has no formal training requirements for licensure, students typically complete about 1,000 hours of supervised clinical practice as part of their education. In addition to a formal training program, applicants must also complete a clean-needle technique course, developed and administered by the Council of Colleges of Acupuncture and Oriental Medicine. The one-day course is held in cities throughout the United States, including Austin and Dallas.

Examination. Individuals must pass the National Certification Commission for Acupuncture and Oriental Medicine examination. The exam contains six modules, which include Chinese medicine, herbology, acupuncture, point location, Asian bodywork, and biomedical science. However, acupuncture applicants do not have to pass the biomedical science and Asian bodywork portions of the exam to receive a Texas license. The national examination is administered three times a year, at 26 cities in the United States, including Austin, Houston, and Dallas. The Acupuncture Board also requires applicants to pass a clean-needle technique practical exam, provided throughout the United States in conjunction with the clean-needle technique course mentioned above.

Surgical Assistants

The Medical Board began licensing surgical assistants in 2001. Surgical assistants assist physicians in the operating room and must have a license to use the title surgical assistant. However, a doctor may delegate surgical assisting duties to a qualified and trained individual acting under the physician's supervision. Individuals may qualify for a surgical assistant license by meeting educational and examination requirements specified in statute and Medical Board rules, outlined in the textbox, *Surgical Assistant Licensing Requirements*. Applicants must have at least an associate's degree that is substantially equivalent to that received by a registered nurse or physician assistant who specializes in surgical assisting, complete 2,000 hours of supervised practice, pass a national exam, and hold a current national certification. In fiscal year 2004, the Board regulated 259 surgical assistants.

Surgical Assistant Licensing Requirements

- Pass a national exam.
- Hold at least an associate's degree.
- Possess a current national certification.
- Perform at least 2,000 hours of surgical assisting under the direct supervision of a licensed physician in the three years before applying for licensure.
- Undergo a DPS background check.

License Renewal

To renew their licenses, physicians, physicians assistants, acupuncturists, and surgical assistants must complete continuing education. The chart, *Continuing Education*, shows the number of hours required for each licensee group. Staff randomly audits about 1 percent of license renewals each year to verify continuing education compliance. Physicians traditionally have renewed their licenses annually, but will begin biennial renewal in 2005; surgical assistants also renew biennially. Physician assistants and acupuncturists renew their licenses annually. Physicians, physician assistants, and acupuncturists may complete their renewals through the Texas Online system. More than 75 percent of physicians and physician assistants renewed their licenses online in fiscal year 2003. Acupuncturists began online renewals in August 2004.

Continuing Education

	Formal Hours	Informal Hours	Total Hours
Physicians	12	12	24
Physician Assistants	20	20	40
Acupuncturists	17	0	17
Surgical Assistants	9	9	18

Enforcement

Enforcement activities play a critical role in the Medical, Physician Assistant, and Acupuncture boards' ability to protect Texans' health, safety, and welfare. The boards enforce state laws and Medical Board rules by investigating complaints against licensees, taking disciplinary action if necessary, and monitoring licensees' compliance with disciplinary orders. In 2003, the 78th Legislature strengthened the Medical Board's enforcement authority by providing additional statutory direction and increased resources. As a result, the Medical Board's enforcement process changed significantly between fiscal years 2003 and 2004. Changes will continue into fiscal year 2005, as the Board implements provisions from the recent legislation. For more information on recent legislative action, see the textbox, *Key Provisions From Senate Bill 104.*

Key Provisions From Senate Bill 104

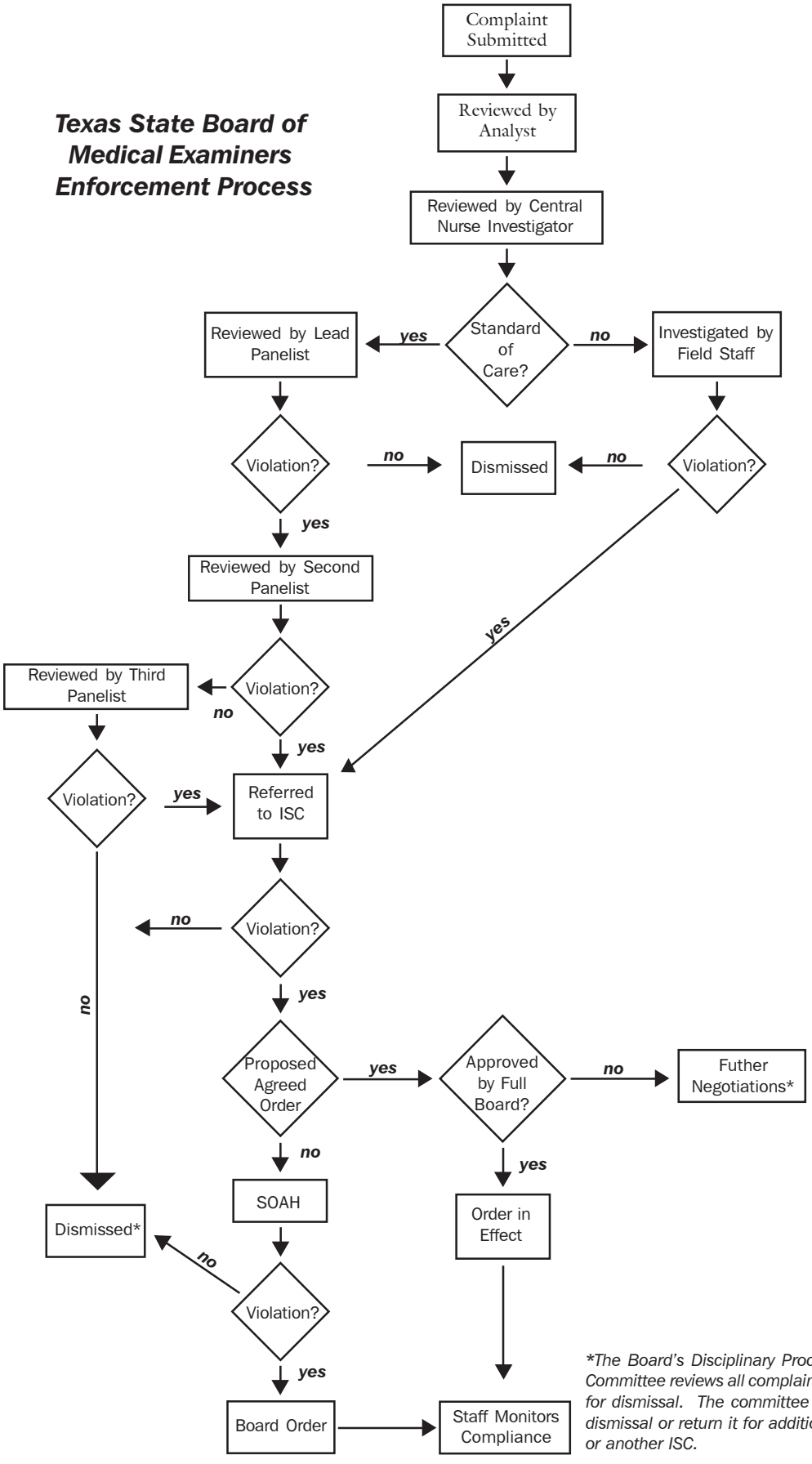
- Provided additional funds, including an $80 surcharge on physician license renewals, and employees to enhance enforcement efforts.
- Set statutory deadlines for complaint investigations and litigation.
- Created a panel of expert physicians to review standard-of-care complaint cases.
- Required immediate investigation of a violation of a disciplinary order or of a complaint against a license holder currently under a disciplinary order.
- Clarified the Board's authority to temporarily suspend a license.
- Deleted requirement that insurers send all notice of claim letters to the Board.

Because the same staff serves all three boards, the enforcement processes for physicians, physician assistants, and acupuncturists are similar. The chart, *Enforcement Process,* shows how the boards resolve complaints. The process involves three primary steps: investigation, litigation, and compliance.

Investigations

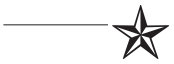
The majority of complaints received by the boards are filed by the public, although agency staff, hospitals, professional organizations, and other governmental agencies also initiate complaints. In addition, statute authorizes the Medical Board to file a complaint when it receives reports of paid claims and lawsuits against physicians that are based on allegations of professional liability. When the agency receives a written complaint, agency staff conducts a preliminary review to determine whether the complaint

Texas State Board of Medical Examiners Enforcement Process



**The Board's Disciplinary Process Review Committee reviews all complaints recommended for dismissal. The committee can approve the dismissal or return it for additional investigation or another ISC.*

falls under the agency's jurisdiction. Jurisdictional complaints go to one of five central nurse investigators, who typically contact the complainant and licensee, clarify the allegations, and determine whether the complaint should proceed, based on jurisdiction, in which case it becomes a filed complaint. In fiscal year 2004, the boards received 6,090 complaints and determined they had jurisdiction in 1,900 of them. In comparison, in fiscal year 2003, the boards received 4,942 complaints, 1,775 of which were jurisdictional. By far, the majority of complaints received relate to physicians. About 40 percent of complaints are against physicians that the Medical Board has previously investigated or disciplined.



About 40 percent of complaints are against physicians the Medical Board has previously investigated or disciplined.

From the time a complaint is filed, the Medical Board has 180 days to complete the investigation and set a date for hearing.[10] One of 20 field investigators receives the complaint and contacts the complainant and the licensee and assembles documents and records related to the case. For complaints that do not allege a violation of the standard of care, the field investigator reviews the evidence and prepares and submits a report to the Austin office with a recommendation to dismiss or proceed. For standard-of-care complaints filed against physicians, the field investigator sends all the collected evidence and data to a member of the Board's expert physician panel who practices in the same or similar specialty as the physician being investigated.

The panelist reviews the case to determine if the physician violated the standard of care. If the panelist does not believe such a violation occurred, the panelist writes a report and sends the case back to the field investigator, who summarizes the panelist's findings in a final report for Austin enforcement staff. All cases recommended for dismissal, whether they involve standard of care or not, are referred to the Medical Board's Disciplinary Process Review Committee for review and final approval. For standard-of-care cases in which the panelist finds that a violation did occur, the panelist writes a report that goes to a second panelist, who either corroborates the first panelist's findings that a violation occurred, or disagrees, requiring the opinion of a third panelist. At this point, the majority opinion of the panel is reflected in a final report written by one of the panel members. Field investigators summarize all of the expert panelists' reports and submit a final report to Austin for review by enforcement staff. The Physician Assistant and Acupuncture boards do not have expert panelists, but may use consultants on standard-of-care cases. Four times a week, agency staff holds quality assurance meetings to review complaint cases and determine whether a case should be prosecuted, dismissed by the appropriate board, or investigated further.

Litigation

The Legal Division prosecutes, through both formal and informal methods, all disciplinary actions brought by the boards against licensees and permit holders. In fiscal year 2004, the Investigations Division referred 519 cases to the Legal Division, about the same as in fiscal year 2003.

After receiving a case, the Legal Division holds an informal settlement conference (ISC) between the licensee and a two-member panel. Both public members and members of the profession from the appropriate board

District Review Committees

Under the Medical Practice Act, the Medical Board has designated four District Review Committees, representing different parts of the state, to assist in informal hearings. The Governor currently appoints four physicians and one public member to each committee, bringing the membership total to 20. District Review Committee members serve side-by-side with Board members on informal settlement conference panels for cases against physicians.

sit on ISCs. For physicians, panel members may also be members of a District Review Committee, described in the accompanying textbox. No staff members sit on ISC panels, although a staff hearings counsel attends each ISC to ensure consistency and to assist the panel in running the meeting.

During ISCs, staff attorneys present the agency's case to the panel members. Both staff and the licensee may use witnesses and other experts to support their case. Complainants have the option of attending the ISCs. The ISC panel can recommend dismissal, recommend an agreed order consisting of terms and conditions of disciplinary action, refer the case to a temporary suspension or restriction hearing, or refer the case to the State Office of Administrative Hearings (SOAH) for a contested case hearing. Sanctions available to the boards include revocation, probation, public reprimand, administrative penalty, restriction, injunction, and suspension. In addition, the boards may also include other conditions in a final disposition, such as requiring a licensee to take continuing education on a certain topic or to complete a seminar.

All agreed orders – those that the licensee signs and does not appeal – are sent to the appropriate board. The boards can accept an order as is, reject it and send it back to the ISC, or modify the order, in which case the licensee must agree to the changes. In fiscal year 2004, the boards held 420 ISCs, down from 477 in fiscal year 2003. Statistics on the results of ISCs can be found in the chart, *Informal Settlement Conferences*.

Informal Settlement Conferences, FY 2004

	ISCs Held	Dismissals	Agreed Orders	Referrals to SOAH
Medical Board	402	152	295	43
Physician Assistant Board	17	9	9	1
Acupuncture Board	1	2	0	1
Total	**420**	**163**	**304**	**45**

When an ISC does not result in a recommendation for dismissal or an agreed order, the case goes to SOAH for a contested case hearing before an administrative law judge, who recommends action in the case, subject to final approval by the appropriate board. For cases at SOAH, the boards are represented by one of four staff attorneys. The agency filed 45 cases at SOAH in fiscal year 2004, down from 49 in fiscal year 2003.

For individuals practicing without a license, the agency forwards the case to the District Attorney to prosecute as a Class A misdemeanor, or refers the complaint to the Attorney General's Office to request an injunction or civil penalties. In fiscal year 2004, the boards resolved 1,755 complaints, with 287 resulting in sanctions against a licensee. Also, in fiscal year 2004, the Medical Board held nine temporary suspension hearings and the Physician Assistant Board held one, for a total of 10. The table, *Disciplinary Actions*, highlights statistical information about the boards' disposition of complaint cases in fiscal year 2004.

Complaint resolution time was reduced by all the boards in FY 2003.

The Medical Board took an average of 250 days to resolve complaints in fiscal year 2003, a drop from 271 the previous year. Both the Physician Assistant and Acupuncture boards saw a significant drop in the average complaint resolution time: the Physician Assistant Board went from 309

Disciplinary Actions – FY 04[1]

Type of Allegation/Violation	Enforcement Action							
	Total	Revocation/ Surrender	Suspension	Restriction	Reprimand	Administrative Penalty	Rehab Order	Dismissed
Practice Inconsistent With Public Health and Welfare[2]	1,067	8	6	40	12	25	3	973
Unprofessional/ Dishonorable Conduct[3]	457	7	2	12	10	25	1	400
Disciplinary Action by Another Jurisdiction	24	0	4	1	3	3	1	12
Disciplinary Action by Peer Group	38	2	2	4	0	4	0	26
Repeated or Recurring Medical Malpractice[4]	12	0	0	1	0	1	0	10
Misdemeanors Involving Moral Turpitude[5]	18	3	1	2	1	0	0	11
Impairment	97	6	6	15	3	0	18	49
Total	**1,713**	**26**	**21**	**75**	**29**	**58**	**23**	**1,481**

[1] For complaints that include more than one type of disciplinary actions, complaint is listed in the most serious sanction category.

[2] Complaints include not meeting the standard of care, negligence in performing medical services, failure to obtain informed consent, prescribing without establishing a physician-patient relationship.

[3] Complaints include engaging in sexual contact with a patient, committing a felony, violating a Board order, providing medically unnecessary medical services, failing to complete CME, failing to maintain confidentiality of patient, failing to timely respond to communications from a patient or the Board.

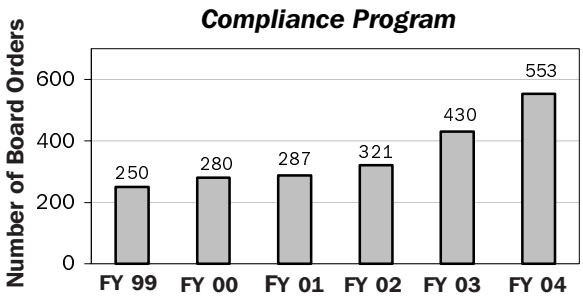
[4] Includes repeated or recurring meritorious health-care liability claims. A claim is considered meritorious if there is a finding by a judge or jury that licensee was negligent in the care of a patient or if there is a settlement of a claim without the filing of a lawsuit or a settlement of a lawsuit against a licensee in the amount of $50,000 or more. Claims are repeated or recurring if they are three or more claims in any five-year period.

[5] Complaints involve dishonesty, fraud, deceit, misrepresentation, deliberate violence, or reflect adversely on a licensee's honesty, trustworthiness, or fitness to practice under the scope of the person's license.

days in fiscal year 2003 to 250 days in fiscal year 2004, while the Acupuncture Board went from 563 days to 250 days during that same time period.

Compliance

The Compliance Division monitors licensees who are under a disciplinary – or Board – order to ensure that they comply with the terms and conditions throughout the duration of the order. The agency has eight compliance officers throughout the state. Compliance officers design a monitoring plan for each order, meet regularly with the licensee, and file monthly field reports. Typically, each compliance officer has about 70 open cases at any given time, although as the graph, *Compliance Program*, indicates, the number of cases



managed by the Compliance Division has increased dramatically in recent years. Board orders can be in effect for long periods of time – some as long as 10 years. In fiscal year 2004, the Compliance Division monitored 553 licensees. This number has doubled in the past five years.

The Compliance Division also oversees the agency's alcohol- and drug-screening program. About one-third of orders require drug testing. The boards conduct compliance with a drug-testing order separately from other types of compliance, although the compliance officer remains the licensee's primary contact at the agency. Licensees in the drug-testing program call an automated system daily to check if they must undergo drug testing that day. If so, they go to a designated facility for the drug test. A contracted vendor provides testing facilities nationwide. In fiscal year 2004, 183 licensees were under drug-screen orders.

To gather information to show whether or not a licensee is adhering to the conditions of a Board order, compliance officers make site visits, such as to a licensee's office, review a licensee's records, and talk to a licensee's co-workers. Licensees who do not follow the requirements in the Board order must attend an informal settlement conference and be subject to additional sanctions. Not cooperating with a compliance officer, such as missing meetings, is grounds for being subject to additional disciplinary action.

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[1] Physician Assistant Board members whose terms have expired continue to serve until a new appointment is made.

[2] Acupuncture Board members whose terms have expired continue to serve until a new appointment is made.

[3] For their first renewal, licensees pay a $5 fee for the Office of Patient Protection; in subsequent years, the fee is $1. As a result, the fee for a first renewal increases by $4.

[4] On January 1, 2005, physicians will begin renewing their licenses biennially. As a result, the biennial license renewal fee will be $750.

[5] Accredited medical schools in Texas include Baylor College of Medicine; Texas A&M University Health Science Center; Texas Tech University Health Sciences Center; University of Texas Health Science Center at San Antonio; University of Texas Houston Medical School; University of Texas Medical Branch at Galveston; University of Texas Southwestern Medical Center at Dallas; and University of North Texas Health Science Center at Fort Worth.

[6] To receive a certificate from the Educational Commission for Foreign Medical Graduates (ECFMG), an international medical school graduate must graduate from a medical school listed in the International Medical Education Directory; have the school verify medical education credentials directly to ECFMG; pass USMLE steps 1 and 2; and obtain a J-1 visa.

[7] American Board of Medical Specialties, "Geographic Distribution of Diplomates by General Certificate," (2004). Online. Available: www.abms.org/Downloads/Statistics/Table7.PDF. Accessed: August 18, 2004.

[8] Accredited physician assistant programs in Texas include programs at Baylor College of Medicine; Interservice at Fort Sam Houston; Texas Tech University School of Allied Health; University of North Texas Health Science Center; University of Texas Health Science Center at San Antonio; University of Texas Medical Branch Department of Physician Assistant Studies; University of Texas at Pan American; and University of Texas Southwestern Allied Health Sciences School.

[9] Accredited acupuncture schools in Texas include Academy of Oriental Medicine; American College of Acupuncture and Oriental Medicine; Texas College of Traditional Chinese Medicine; and Dallas College of Oriental Medicine.

[10] The Physician Assistant and Acupuncture boards do not have time frames for complaint resolution outlined in statute.

APPENDICES

Appendix A

Board Subcommittees

Medical Board

Disciplinary Process Review	Makes recommendations regarding resolution and disposition of cases and approves, adopts, modifies, or rejects recommendations from Board staff or representatives regarding actions to be taken on pending cases. Also gives final approval for complaint dismissals.
Executive	Oversees general Board activities, such as reviewing meeting agendas, maintaining records of committee actions, delegating tasks to other committees, reviewing contract negotiations, and handling urgent matters that arise between Board meetings.
Finance	Reviews staff reports regarding fiscal matters, presents budget needs to the Legislature and other state officials, and makes recommendations to the Board regarding any aspect of Board finances.
Legislative/ Long Range Planning	Makes recommendations regarding changes to the Medical Practice Act, the regulation of medicine, and Board and agency efficiency, goals, functions, and responsibilities. Also assists in the preparation and delivery of information to the Legislature.
Licensure	Reviews applications and makes eligibility determinations regarding applicants for licensure. Also reviews licensing rules and makes recommendations to the Board regarding changes or implementation of such rules.
Public Information/ Physician Profile	Develops and reviews information for distribution to the public, including newsletters and press releases. Also studies and makes recommendations regarding all aspects of physician profiles.
Standing Orders	Oversees and makes recommendations regarding standing orders and standing orders rules, and makes recommendations concerning medical ethics. Also oversees acudetox specialist licensing and makes recommendations regarding issues concerning the Acupuncture and Physician Assistant boards.
Telemedicine	Reviews and makes recommendations concerning all aspects of the practice and regulation of telemedicine.

Appendix A

Board Subcommittees

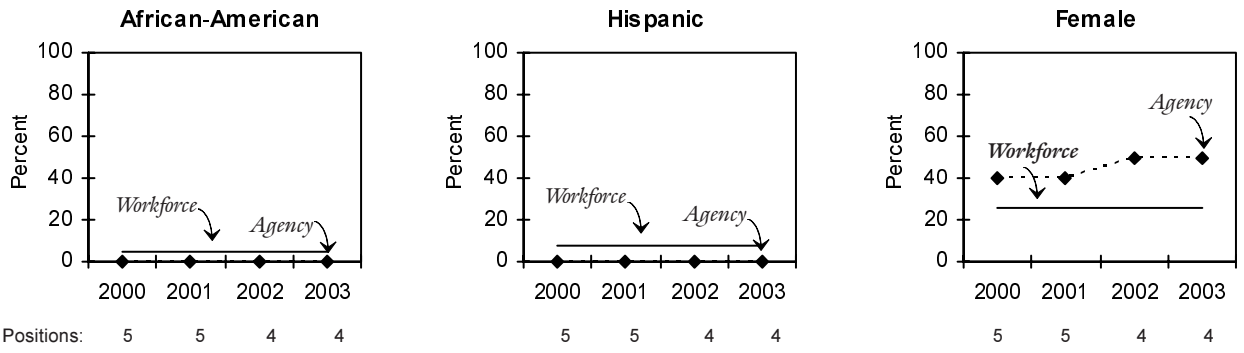
	Physician Assistant Board
Disciplinary and Ethics	Oversees the physician assistant disciplinary process, which includes monitoring the effectiveness of the process; making recommendations regarding resolution and disposition of cases; and approving, adopting, modifying, or rejecting recommendations from staff or Board representatives regarding pending cases. Also studies and makes recommendations regarding ethical concerns.
Licensure	Drafts, updates and reviews rules regarding licensure, and makes licensing determinations for applicants whose eligibility is in question.
Long Range Planning	Studies and makes recommendations regarding changes to physician assistant practice, and Board and agency efficiency, goals, functions, and responsibilities.
	Acupuncture Board
Discipline and Ethics Committee	Oversees the acupuncture disciplinary process, which includes monitoring the effectiveness of the process; making recommendations regarding resolution and disposition of cases; and approving, adopting, modifying, or rejecting recommendations from staff or Board representatives regarding pending cases. Also studies and makes recommendations regarding ethical concerns.
Education Committee	Drafts, updates, and reviews rules regarding educational requirements for acupuncture licensure and degrees, and consults with the Texas Higher Education Coordinating Board and acupuncture schools regarding acupuncture educational issues.
Executive Committee	Oversees general Board activities, such as reviewing requests from the public to appear before the Board, delegating tasks to other committees, making recommendations regarding changes to the regulation of acupuncture and future Board goals, and handling urgent matters that arise between Board meetings. Also assists the Medical Board in the preparation and delivery of information to the Legislature.
Licensure Committee	Drafts, updates and reviews rules regarding licensure, and makes licensing determinations for applicants whose eligibility is in question.

Equal Employment Opportunity Statistics

2000 to 2003

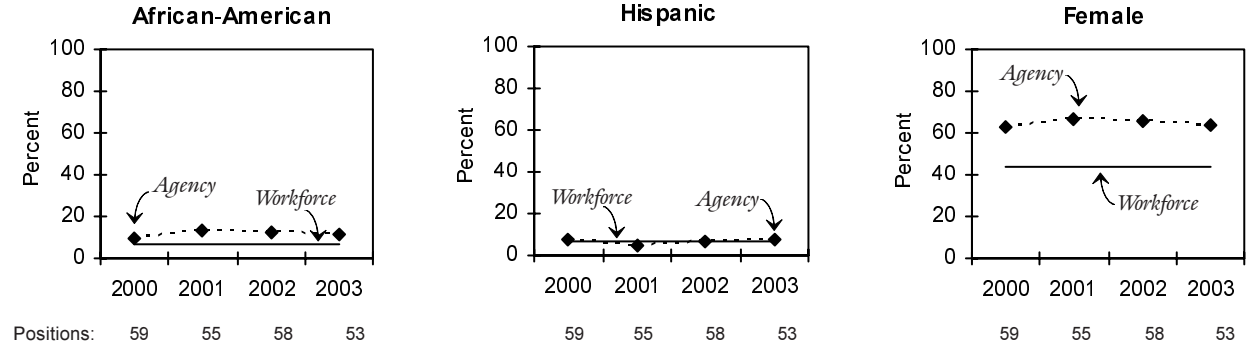
In accordance with the requirements of the Sunset Act, the following material shows trend information for the Texas State Board of Medical Examiners' employment of minorities and females in all applicable categories.[1] The agency maintains and reports this information under guidelines established by the Texas Commission on Human Rights.[2] In the charts, the solid lines represent the percentages of the statewide civilian workforce for African-Americans, Hispanics, and females in each job category. These percentages provide a yardstick for measuring agencies' performance in employing persons in each of these groups. The diamond-dashed lines represent the agency's actual employment percentages in each job category from 2000 to 2003. While the agency has exceeded some percentages, it has experienced trouble meeting others. However, the agency has few positions in some job categories, making it difficult to meet the percentages.

Administration



The agency fell short of the percentages for African-Americans and Hispanics every year, but exceeded the percentages for females each year.

Professional

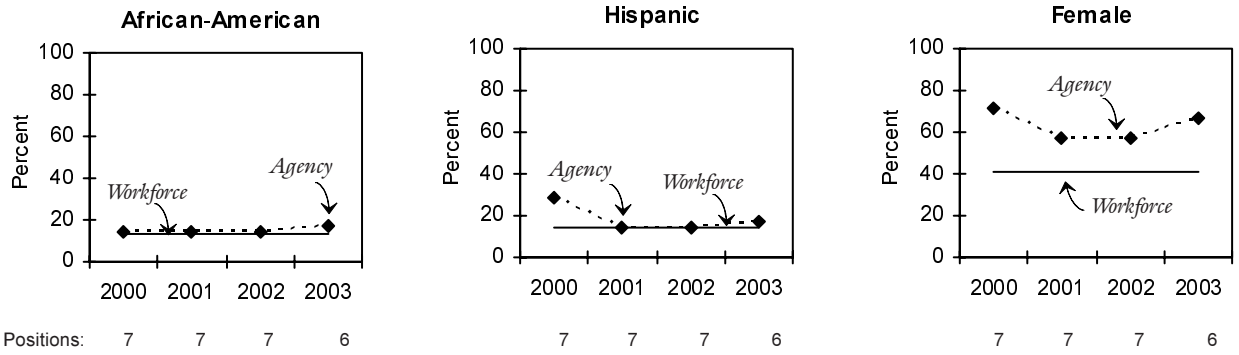


The agency exceeded the percentages for African-Americans and females every year, and exceeded the percentages for Hispanics every year except fiscal year 2001.

Appendix B

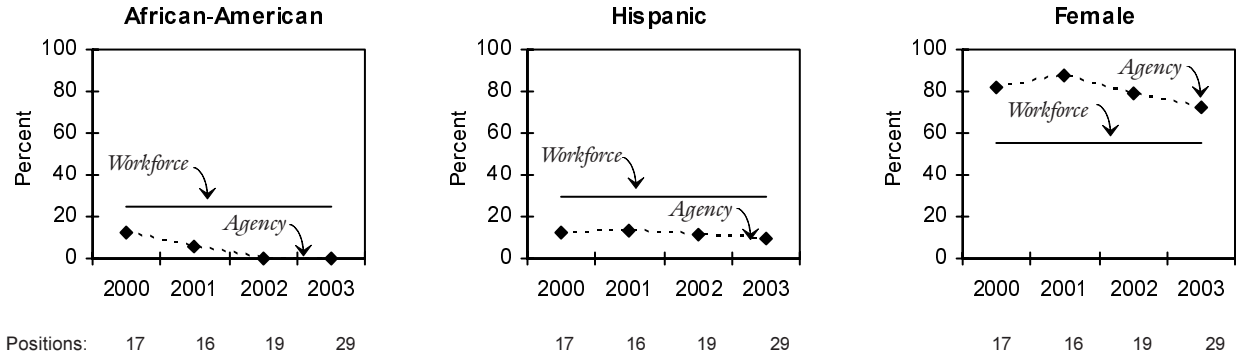
Equal Employment Opportunity Statistics

Technical



The agency exceeded the percentages for African-Americans, Hispanics, and females every year.

Para-Professional

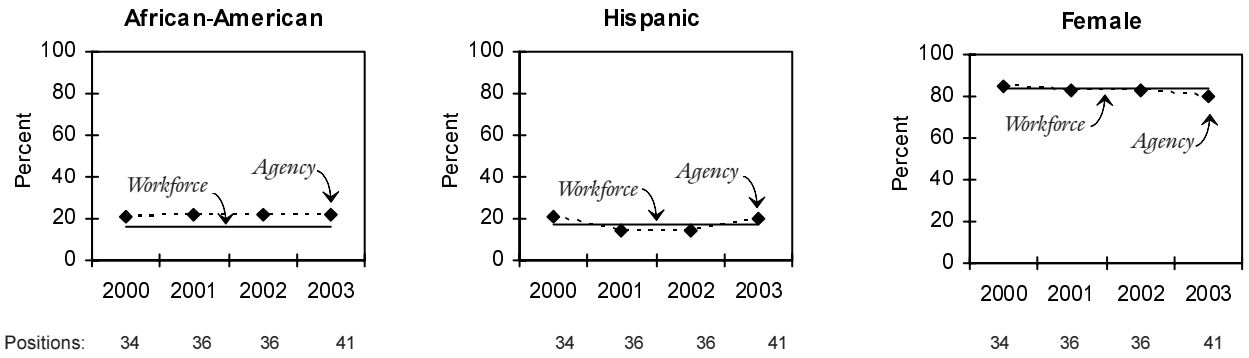


The agency fell short of the percentages for African-Americans and Hispanics every year, but exceeded the percentages for females each year.

Appendix B

Equal Employment Opportunity Statistics

Administrative Support



The agency exceeded the percentages for African-Americans every year. However, the agency only exceeded the percentages for Hispanics in fiscal years 2000 and 2003, and only exceeded the percentages for females in fiscal year 2000.

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[1] Texas Government Code, sec. 325.011(9)(A).

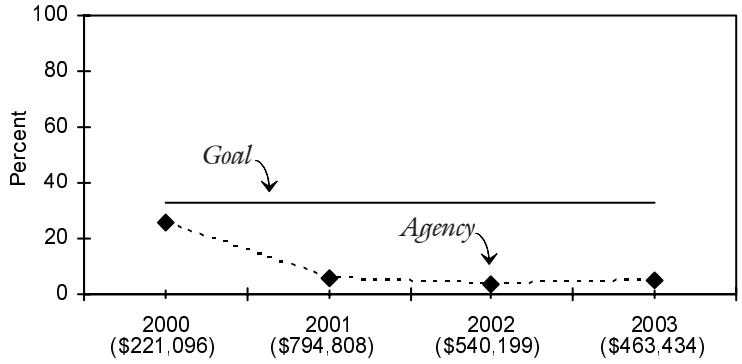
[2] Texas Labor Code, sec. 21.501. The Texas Human Rights Commission (HRC) has been the agency responsible for collecting and distributing EEO data. During the 2003 Session, the Legislature passed HB 2933 transferring the functions of HRC to a new civil rights division within the Texas Workforce Commission (TWC). The legislation is to take effect upon certification of the TWC civil rights division by the appropriate federal agency; no specific date has yet been established.

Historically Underutilized Businesses Statistics 2000 to 2003

The Legislature has encouraged state agencies to increase their use of Historically Underutilized Businesses (HUBs) to promote full and equal opportunities for all businesses in state procurement. The Legislature also requires the Sunset Commission to consider agencies' compliance with laws and rules regarding HUB use in its reviews.[1]

The following material shows trend information for the Texas State Board of Medical Examiners' use of HUBs in purchasing goods and services. The agency maintains and reports this information under guidelines in the Texas Building and Procurement Commission's statute.[2] In the charts, the flat lines represent the goal for HUB purchasing in each category, as established by the Texas Building and Procurement Commission. The diamond-dashed lines represent the percentage of agency spending with HUBs in each purchasing category from 2000 to 2003. Finally, the number in parentheses under each year shows the total amount the agency spent in each purchasing category. The agency has had difficulty meeting some of the State's HUB purchasing goals because the agency's spending in several categories was restricted to sole-source providers or the agency purchased items or contracts that were not available from HUB vendors.

Other Services

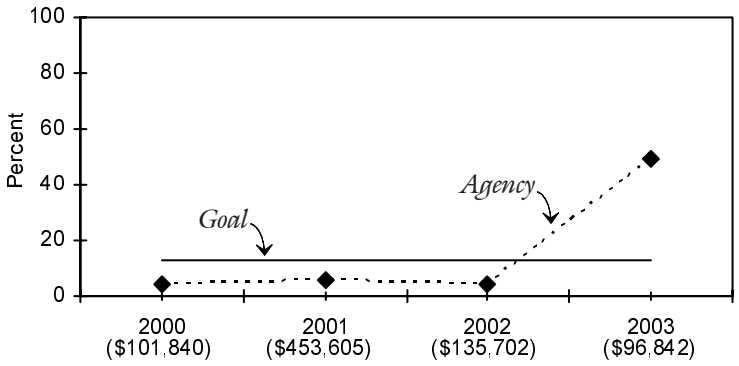


The agency fell short of the State's goal for HUB spending for other services each year, primarily because the services purchased were not available from a HUB vendor. Examples of these services include court-reporting services and medical records review.

Appendix C

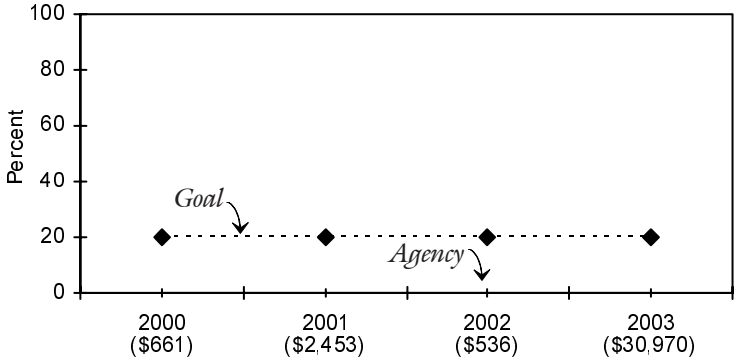
Historically Underutilized Businesses Statistics

Commodities



The agency fell short of the State's goal for HUB spending for commodities every year except fiscal year 2003 because the agency was restricted to using a sole-service provider for its contract for information technology.

Professional Services



The agency fell short of the State's goal for HUB spending for professional services each year because the agency's budget in this category was solely spent on its internal audit, which was not provided by a HUB vendor. As a result, the percent of the agency's spending on HUB's in this category was 0 percent each year.

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1 Texas Government Code, sec. 325.011(9)(B).
2 Texas Government Code, ch. 2161.

Texas State Board of Medical Examiners' Permit, Licensing, and Registration Programs

Type	Requirements	Scope of Practice	Fees	Persons Paying Fees in 2003
Acudetox Specialist Certification	• Must be a licensed social worker, professional counselor, psychologist, chemical dependency counselor, or vocational nurse. • Must complete a 70-hour auricular acupuncture course. • Must complete six hours continuing education annually.	• May insert acupuncture needles into five specific points in patients' ears to treat substance annual abuse, alcoholism, and chemical renewal dependency.	• $50 application fee • $25 annual renewal	• 25 • 97
Physician-in Training-Permit	• Must be a medical school graduate.	• Allows physicians to treat patients during postgraduate training, restricting the permit holder to the supervised practice of medicine that is part of and approved by the training program. The permit does not allow for the practice of medicine which is outside of the approved program.	• $60 permit fee • $60 renewal (18 month)	• 2,637 • 2,678
Telemedicine License	• Must be licensed to practice medicine in another state, with a clean disciplinary record. • Must be speciality board certified. • Must pass BME jurisprudence exam.	• Allows out-of-state doctors to treat up to 24 Texas patients annually, via the Internet.	• $800 application fee • $300 annual renewal	• 3 • 0
Faculty Permit	• Physician must hold license to practice medicine in another state, or have completed three years of postgraduate training; and be a salaried professor at a Texas medical school.	• Allows physicians to participate in clinical, patient care, and teaching activities at a Texas medical school. • Permit may be renewed three times, for total of four years.	• $110 permit fee	• 219
Distinguished Professor Temporary License	• Permit available for physicians who passed a licensing exam more than 10 years ago; SPEX exam waived. • Same licensing process as for physician application. • Must be on the faculty at a Texas medical school. • Must pass BME jurisprudence exam.	• Allows physicians to treat patients while instructing at a medical school for up to one year. • After one year, the physician may petition for full licensure, with school's endorsement.	• $805 application fee • $50 temporary license fee	• 16 • 18
Visiting Professor Permit	• Physicians are appointed as visiting professors by a Texas medical school.	• Allows individuals to participate in clinical, patient care and teaching activities at a medical school. • Permit is issued in one-month increments, for maximum of 24 months.	• $110 permit fee	• 24

Appendix D

Texas State Board of Medical Examiners' Permit, Licensing, and Registration Programs

Type	Requirements	Scope of Practice	Fees	Persons Paying Fees in 2003
Voluntary Charity Care Permit	• Must be a retired physician, formerly licensed in Texas.	• Allows physicians to wiave their registration fee. • Physician may only provide voluntary, free care to indigent populations. • Must maintain continuing medical education hours. • Prohibits physician from prescribing medications to self, friends, or family.	no fee	• 10
Noncertified Radiologic Technician (NCT)	• Must be registered with the Texas State Department of Health Service (TSDHS) and meet training program requirements; or • Perform radiologic procedures for a physician whom TSDHS granted a hardship exemption.	• Permits noncertified X-ray technicians to provide X-ray and bone density testing services in physician offices.	• $50 application fee • $50 annual renewal	• 632 • 1,064
Nonprofit Health Organization Certification	• Organization must be formed solely by Texas, licesened physicians, must be nonprofit, and run by a board made up of Texas licensed physicians.	• A certified health organization may carry out research, deliver health care, provide community and professional health education, or support medical education.	• $2,500 application fee • $1,000 biennial renewal	• 11 • 101
State Health Agency Temporary License	• Physician must hold license to practice medicine in another state. • Same process as for a physician application.	• Allows a physician to practice clinical or adminstrative medicine at a Texas state health agency, under the supervision of a licensed staff physician. • Permit valid for one year only, but may be reissued annually at the discretion of BME.	• $805 application fee • $50 temporary license fee	• 13 • 10
National Health Service Corp Permit	• Physician must hold a license to practice medicine in another state. • Must have a valid contract with the National Health Service Corp.	• Physician may only practice in Texas within the scope of their National Health Service Corp contract.	no fee	• 1
Postgraduate Research Permit	• Individuals must be a medical school graduate. • Must hold a research appointment at a Texas medical school.	• Permits a researcher, appointed by a Texas medical school, to research clinical medicine and/or basic science in medicine.	no fee	• 1

Appendix E

Physician Specialty Boards

The following specialty boards are recognized by the Texas State Board of Medical Examiners as valid providers of physician certifications.

Boards Affiliated With the American Board of Medical Specialities

American Board of Allergy & Immunology

American Board of Anesthesiology

American Board of Colon and Rectal Surgery

American Board of Dermatology

American Board of Emergency Medicine

American Board of Family Practice

American Board of Internal Medicine

American Board of Medical Genetics

American Board of Neurological Surgery

American Board of Nuclear Medicine

American Board of Obstetrics and Gynecology

American Board of Ophthalmology

American Board of Orthopaedic Surgery

American Board of Otolarynology

American Board of Pathology

American Board of Pediatrics

American Board of Physical Medicine and Rehabilitation

American Board of Plastic Surgery

American Board of Preventive Medicine

American Board of Psychiatry & Neurology

American Board of Radiology

American Board of Surgery

American Board of Thoracic Surgery

American Board of Urology

Appendix E

Physician Specialty Boards

Boards affiliated with the Bureau of Osteopathic Specialists and Boards of Certification

American Osteopathic Board of Anesthesiology

American Osteopathic Board of Dermatology

American Osteopathic Board of Emergency Medicine

American Osteopathic Board of Family Physicians

American Osteopathic Board of Internal Medicine

American Osteopathic Board of Neurology and Psychiatry

American Osteopathic Board of Neuromusculoskeletal Medicine

American Osteopathic Board of Nuclear Medicine

American Osteopathic Board of Obstetrics and Gynecology

American Osteopathic Board of Ophthalmology and Otolarynology

American Osteopathic Board of Orthopedic Surgery

American Osteopathic Board of Pathology

American Osteopathic Board of Pediatrics

American Osteopathic Board of Physical Medicine and Rehabilitation

American Osteopathic Board of Preventive Medicine

American Osteopathic Board of Proctology

American Osteopathic Board of Radiology

American Osteopathic Board of Surgery

Staff Review Activities

Sunset staff engaged in the following activities during the review of the Texas State Board of Medical Examiners, Texas State Board of Physician Assistant Examiners, and Texas State Board of Acupuncture Examiners.

- Worked extensively with agency staff.
- Attended Medical, Physician Assistant, and Acupuncture board and committee meetings and interviewed members from all three boards.
- Conducted interviews with District Review Committee and Surgical Assistant Advisory Committee members.
- Attended agency staff licensing and enforcement review meetings.
- Met with and solicited written comments from state and national interest groups and other stakeholders.
- Conducted interviews with individual physicians, physician assistants, acupuncturists, and surgical assistants.
- Attended informal settlement conference hearings and temporary suspension hearings conducted by agency staff, as well as contested cases held at the State Office of Administrative Hearings.
- Met with agency field staff.
- Toured a medical school and an acupuncture school and clinic.
- Observed the operations of the agency's customer call center.
- Reviewed agency documents and reports, licensing and enforcement data, complaint files, budget information, state statutes, legislative reports, previous legislation, and literature on issues relating to physicians, physician assistants, acupuncturists, and surgical assistants.
- Met with in person or interviewed over the phone staff from state legislative offices and executive agencies, including other health licensing agencies.
- Researched the functions of medical regulatory agencies in other states.

Sunset Review of the

Texas State Board of Medical Examiners

Texas State Board of Physician Assistant Examiners

Texas State Board of Acupuncture Examiners

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