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SENATE COMMITTEE ON HEALTH & HUMAN SERVICES SEP 05 1990

Minutes of June 27, 1990

Time: 10:00 am Lt. Governor's Committee Room

Present: Brooks, Chair; Johnson; Tejada.

With the Committee standing in recess, Senator Brooks called the public hearing to order.

The Chair welcomed members of the State Board of Medical Examiners and the public to the hearing and explained the purpose was to discuss the Board's disciplinary procedures, a recent State Auditor's report, implementation of recent legislation, and any potential legislative changes that should be considered by the 72nd Regular Session.

The Chair recognized the following spokespersons for the Board:

- Homer R. Goehrs, Executive Director, Texas State Board of Medical Examiners (TSBME)
- Robert L.M. Hilliard, M.D., President, TSBME
- Cindy Jenkins, Member, TSBME
- Penny Angelo, Member, TSBME
- C. Richard Stasney, M.D., Member, TSBME

Also present and providing technical information for the board were:

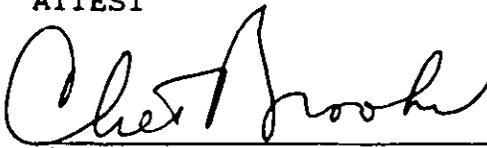
- Paul R. Gavia, Director of Enforcement, TSBME
- Ivan Hurwitz, Director of Licensure & Admin. Services, TSBME

The Chair recognized the following persons who offered testimony relating to the operations of the Board:

- Les Weisbrod, Attorney, Dallas
- C. Stratton Hill, Jr., M.D., M.D. Anderson Hospital, Houston
- Deborah Thorpe, R.N., M.D. Anderson Hospital
- Wellington Smith, Texas Doctors Group, Austin
- John H. Sortore, Texas Osteopathic Association, Fort Worth

Upon conclusion of testimony, Senator Johnson moved that the Committee stand recessed subject to the call of the Chair. The motion prevailed.

ATTEST

  
Chet Brooks, Chair

  
Linda Christofilis, Clerk

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SENATE HEALTH AND HUMAN SERVICES COMMITTEE  
JUNE 27, 1990  
TAPE 1

CHAIRMAN : Senator Tejeda, I understand, is on the way down from his office, so - - -

Come to order. We are ah standing in recess so we will ah go ahead and accommodate our witnesses here, ah here (inaudible - microphone noises) - - - ah, their information ah on whatever testimony they wish. This is a ah, a routine Oversight Committee hearing ah called for by a previous ah Resolution adopted by the Senate some time ago, ah, in which our committee would ah, ah try to monitor ah changes in our health related agencies, ah, and ah reg - both regulatory and licensure agencies, ah, and hopefully be in a posture to try to ah help those agencies resolve problems or ah identify problems that might require legislative ah action, either through ah statutory changes or clarifications or perhaps funding. Ah, we ah, we know that ah there's ah - the regulatory process is a, in many times, an adversarial process, ah, and therefore ah sometimes they just need a kind of impartial ah forum in which to ah try to sort out ah some of the problems that may be ah causing disputes or, or perhaps ah need clarification of legislative intent or some other - help in some other way. Ah, we have ah some specific issues we would like to look at this morning. Ah, we wanna do - we, we specifically have asked the Board for an update on ah the status of complaints and dispositions of those complaints. Ah, you'll recall that in 87 we had a, 1987, we had a very ah large and, and ah - at least troubling to some of us, a backlog of cases and we were getting ah some complaints from physicians who had complaints filed against them, because they couldn't get them cleared up, they couldn't get them heard. Ah, they felt that they, they were ah baseless complaints and, and needed to be cleared, and if it wasn't cleared they felt that they might have problems with their insurance or they might have problems with their staff (prejudices) or something else. Ah, and then ah on the other side of, of the coin we also had ah some people who felt their complaints were legitimate and they were concerned that ah a physician might continue practicing, ah, or might be - might continue using ah some procedure ah that ah the complainant felt ah they were not qualified or, or, or they had some problems ah in handling. So we really heard from both sides ah, ah about that backlog and we, the Legislature in 1987, made a, a very strong effort to try to put additional funding in ah, try to clarify some of the statutory language to give the Board ah, ah greater ah clarity about legislative intent, ah, and most of all, to try to be helpful ah in giving the Board of Medical Examiners the ah, the people ah, and ah the funding necessary ah to do their job ah well. And we ah continue to try to help ah with that. We looked at it again in, in 89 and even though we were having a, a troublesome revenue ah problem in 89 we still continued, I think, to ah adequately support the regulatory process ah in all of our state agencies and perhaps even made - hopefully made some improvements in some areas.

We want to look at the ah, ah use and effectiveness of the new one eight hundred ah public line. Ah, we'd like to ah also ah hear from you about implementation of new legislation that was passed in ah 1989; the Omnibus Health Care Rescue Act, ah, commonly known as House Bill 18; the ah Sample Drug Bill, Senate Bill 788; ah and the Intractable Pain Bill, Senate Bill 20 which was passed in the First Called Session, ah in 1989.

Ah, we also would like to ah look ah, ah with you at the state auditor's report ah and any response the Board of Medical Examiners might have to that report. Ah, we would like to ah

make a, a review, if we could, of disciplinary and licensing procedures ah currently in effect. Ah, and we'd also like to hear from any of our witnesses here today, ah either from the Board, staff of the Board, or from ah, from the public, ah either providers or consumers of services, ah, any ideas ah or any problems that you think should be addressed ah by the 72nd Legislature which will be meeting in - convening in January.

I appreciate the good attendance this morning and we'll try to get the ah hearing started immediately and I'll try to expedite it as much as possible to try to get a - get good information, but cover the ground that we badly need to cover ah in this very ah vital ah area of ah regulatory authority we have vested in the Board of Medical Examiners. Ah, and our - I think everyone's ultimate goal - - Senator Johnson, it's nice to see you - - ah, everyone's goal is to have ah good quality health care, good quality services for the patients. And ah, that's what we - I think is our, is our goal that everyone is striving for and I hope we're able to accomplish that.

: Senator Carriker wants to join us.

CHAIRMAN : Oh, Senator Carriker is going to sit in with us, that's excellent. Very nice to have you. Senator Carriker, by the way, was one of our - was a member of our Task Force on Rural Health Care which ah was the principle catalyst that developed our Omnibus Health Care Rescue Act and ah has ah worked very closely with this committee and with ah, with our - many of our members individually ah on specific health care issues. And we're very pleased to have Senator Carriker join us this morning too.

What I'd like to do ah is ah go ahead and call first ah our new Executive Director of the Board of Medical Examiners, ah, Dr. Homer Goehrs ah and then I would like to respectfully ask the ah director to introduce Board members ah who are here. I, I have a particular - I have cards too, ah I believe of our Board members and we'll call on them ah in whatever order they wish to speak, ah, if they would like to ah speak at today's hearing. We also have Paul Gavia here who is the Director of Enforcement with the Board of ah Medical Examiners. So ah, Dr. Goehrs if ah, if you go first.

GOEHRS : Alright sir, thank you very much. If you'd like for the Board members to come up as I introduce them?

CHAIRMAN : Sure, that would, that would be excellent. We could - we have plenty of chairs.

GOEHRS : Dr. Robert Hilliard is our president, he's from San Antonio.

CHAIRMAN : Right, Dr. Robert Hilliard.

GOES : Dr. Penny Angelo - Mrs. Penny Angelo, that's a quick (push up), ah from ah Midland. One of our public Board members.

CHAIRMAN : Okay.

GOES : Mrs. ah Cynthia Jenkins, from Stowell is another public ah member. And Dr. Richard Stasney from Houston here together with the Board members.

CHAIRMAN : Very good.

GOES : You have introduced ah - - -

CHAIRMAN : Oh, and yes, I, I forgot about one, one of my acquaintances of longest standing, Ivan Hurwitz who is here, and Ivan is Director of Licensure and Administration ah Services at the Board of Medical Examiners. Has been with the Board quite a long time and previously had ah first-hand battle experience in the legislative process before he joined the Board a number of years ago. Pleased to have Ivan here too.

HURWITZ : Thank you.

CHAIRMAN : Thank you very much. Just speak in whatever order you, you would like.

GOEHRS : Well if it pleases you Senator I'll just make a 15 minute or so summary and I think I can cover most of these unless you want to take the items individually.

CHAIRMAN : Alright. That's fine.

GOEHRS : Then we can go back and ah discuss them and ask the Board members to elaborate as they see fit.

We appreciate the opportunity to be here and to discuss these ah items. First I'd like to just turn over a flip chart that shows the mandates that we have from the Legislature, and I won't go over them but - can be looked at as we ah progress along.

First I would like to address the state auditor's report from April of this year. Ah, I believe you've all gotten that report. We have ah reviewed it. It's been ah through our Board process. And I can report that out of the 26 recommendations, all of them have been ah addressed and ah corrected. Action has been taken except for one, and we may want to discuss that later this morning concerning the local fund which has been through your committee and through the Legislature on several occasions. Ah, the most serious items, the internal control items, ah, which led to the investigation, have all been corrected and namely ah corrected by having two or more people handle money containing mail, ah reconciling accounts and accounts payable, and I think ah I can reassure you completely that with the procedures we have in place now, we ah will not see any recurrence of this sort of activity.

We have been through an additional financial ah audit ah in May that took two or three weeks, it was said to be a routine audit scheduled ah as all of the licensing boards were. And ah there were no recommendations that came out of that except as noted previously by the earlier audit that we addressed.

Concerning the ah 1989 legislative session there were three bills that ah affect this Board. Ah, the first is the Sample Drug Bill, ah, Senate Bill 788. We adopted rules and published those and we've had - at the end of April they were published, and we've had very little feedback concerning that. Ah, they were published in the Texas Medical Journal and they're coming out in our newsletter ah as well in the next few weeks. We don't anticipate a great deal of problem there.

Senate Bill 20, the Intractable Pain Act, ah - do you need to turn this on or are we alright?

CHAIRMAN : Oh, you're okay.

GOEHRS : Am I alright?

CHAIRMAN : It just picks up and records.

GOEHRS : Alright. Ah, the Intractable Pain Act was adopted. Guidelines have been created by the Texas Cancer Council and those are impressed, we're told. We've seen a rough copy of that. We've had no cases so far that ah have come as a result of that Act.

And the third, House Bill 18 which you referred to, the Rural Health Bill - we scheduled a hearing on May 18th, was well attended by some 60 or 70 people. As a result of that we elected to appoint an advisory committee along with an ad hoc committee of our Board. Ah, that ah group is going to meet on July 28th and will ah work out some of the guidelines for those rules. I expect we may have one more hearing after that before the rules are adopted.

So those are the three ah bills from the legislative session last year.

CHAIRMAN : Have you published the, the proposed ah rules on the ah Health Care (inaudible - overlapping conversation).

GOEHRS : House Bill 18? Yes, those were published in February.

CHAIRMAN : Okay. Do what?  
: (inaudible - not speaking into  
microphone).  
CHAIRMAN : Oh you withdrew to make some public - -  
-  
GOEHRS : Their still published and we're gonna  
discuss them and ah they haven't been finally adopted yet.  
: (inaudible - not speaking into  
microphone).  
CHAIRMAN : Have you had your public hearing for,  
for public response after publication?  
GOEHRS : For House Bill 18?  
CHAIRMAN : Uh huh.  
GOEHRS : Yes we had a public hearing on May ah  
18th, was it. And ah as a result of that we appointed the  
advisory committee and then ah an ad hoc committee. And we're  
going to have that meeting July 28th. Now I expect there'll be a  
public hearing after that.  
CHAIRMAN : Okay. So you have an ad hoc committee  
working on it too? Is that an ad hoc committee of the Board?  
GOEHRS : Of the Board.  
CHAIRMAN : Okay.  
GOEHRS : With 14 advisory committee people who  
attended the original hearing.  
CHAIRMAN : Okay.  
GOEHRS : Representing, as far as we can  
determine, all of the different viewpoints that we \_\_\_\_\_ to  
find.  
CHAIRMAN : Okay. And you're, you're aiming for a  
date in July for the public - - -  
GOEHRS : July 28th.  
CHAIRMAN : July 28th. If you would, ah, keep us  
informed because I think some of our members of our committee ah  
would like very much to - - -  
GOEHRS : We'll do that.  
CHAIRMAN : - - - be there and ah I would expect  
that, that ah Senator Carriker might as well because ah he worked  
very closely with some of the development of that Act and ah  
served on a task force that ah helped build, build at this, I  
guess is a good way to say it, helped develop it. Okay sir.  
GOEHRS : The ah next item I'd like to address is  
the investigative caseload ah which is on Page ah 6 in your  
packet that you have and is the next ah chart. It gives some  
graphic ah illustration of the load that's come about. We do  
appreciate the extra funding in 87. You can see that ah here,  
from 82 until this year, there's been a considerable increase in  
the cases opened, and paralleling, somewhat, the cases closed.  
About 258 percent increase in the cases that have ah come to us.  
We project in ah, ah fiscal year 90 that we'll get about 19 or  
1,800 total cases. Ah, the widening of the liability claims  
window in 1987 increased our cases in that category almost  
twofold, so that now the liability, the multiple liability cases,  
account for somewhere around 23, 25 percent of all of our  
caseload. And those oftentimes are a little more complex than  
some of the previous cases we've had.  
CHAIRMAN : Is it your impression that, that  
increase is, is ah in any way due to ah, ah people or their -  
either the ah complainants or their attorneys ah in effect trying  
to build a case for their litigation? Try to strengthen their  
litigation case?  
GOEHRS : There are a few cases of that sort but  
I'll turn to Paul Gavia for a more detailed ah - - -  
CHAIRMAN : Alright.  
GOEHRS : - - - answer to that.

GAVIA : Senator the ah multiple malpractice suits are reported to us as soon as the ah suit is filed, or a claim is filed. And we look at them independently. And since our cases are normally presented without patient names, \_\_\_\_\_ uh it's not very useful to (appoint attorney to all of them). We have a shorter time \_\_\_\_\_, it usually takes about 42 months to try a case, with us \_\_\_\_\_ six or eight months. Uh but, there are some--(inaudible). And uh, that's, that's not necessarily bad when you look at it \_\_\_\_\_ independent.

CHAIRMAN : And then you also, I know from ah some previous ah, ah conversation with the Board, you also from time to time get some insurance companies who seem to generate ah complaints for perhaps purposes of their own or maybe they really believe that ah there is a dangerous practice here that needs to be examined. Is that still pretty much the experience?

GAVIA : We receive some from insurance. Normally it's ah in the nature of overcharging, over treating.

CHAIRMAN : Oh, where they're trying to--

GAVIA : --Uh, as opposed to professional competence. But again we ah try to handle cases in such a way that a ah a physician who is in a higher rent can charge more and not be punished. We use a factor of (doubles), a results and values scale before we even look at, that, that allows rent and so forth to try to be reasonable in--

CHAIRMAN : Uh huh.

GAVIA : And again uh, the source of the complaints is, and it's somewhat important to us, but we always look them in (house). Someone who has a, a evil motive let's say for reporting to us, all it accomplishes is that we'll read his or her letter--

CHAIRMAN : --Uh huh--

GAVIA : --Uh it doesn't get \_\_\_\_\_ a physician brought for a hearing necessarily.

CHAIRMAN : Right. Okay.

JOHNSON : Could I ask a question of the gentleman? Ah, sir, when ah, when there is a complaint brought ah for - from an insurance company, you say it's normally for overcharging or over-treatment?

GAVIA : It is normally ah overcharging. Occasionally they may say that the \_\_\_\_\_ question of care, but it is usually uh they, they think the physician has what they call un-normal. That is, instead of charging a set price for an entire procedure, they charge a little bit for every, every step and it adds up to much more than the procedure would normally be.

JOHNSON : What, what is the background of the person who reviews that case? Are they ah - is it a physician who is aware of the treatment modalities or, what?

GAVIA : The background of the person at the insurance company?

JOHNSON : That your Board.

GAVIA : At my Board, fine. Ah, at our Board our investigators are ah, ah - let's see, we have 16. I think 11 of them are either registered nurses or physician assistants. Ah, the least experienced one has, I think, maybe seven years experience in ah clinical nursing and many of them have records (review, utilization review) either in a hospital ah or at uh, TMF \_\_\_\_\_ and when they come in they are ah given a set of records and asked to review and identify the issues and use that for a, a--

JOHNSON : So it's - but it's not a peer review of the records. I mean it's not someone with that same level at expertise that is making the judgment on ah physician decisions.

GAVIA : --Eventually it will \_\_\_\_\_, yes. But the investigation is run by a nurse or PA and uh, and the

investigator merely recommends. Then it comes in, if they recommend, they think there's been a violation, a \_\_\_\_\_ violation then they, they are brought in a physician \_\_\_\_\_ and he meets with uh, two members of our board or the district review committee members. At least one \_\_\_\_\_ the decision. Uh, and our public representatives participate in those panels as well. And their, they review and discuss with that physician, so at that time their either at least one physician discussing the uh--or likes to see, at that time--(inaudible).

JOHNSON : Okay so the investigator not only investigates but then ra--makes recommendations as well? Judge and jury.

GAVIA : Yes Ma'am. But those recommendations are subject to uh, uh approval or uh, both a reversal by their immediate supervisor, by me, by Dr. Goehrs, the Executive Director and we will uh, and have in the past either in objected cases for more workup, or if we didn't think was a violation by it from a medical or a legal viewpoint--(inaudible).

JOHNSON : Do you have a set of standards that determines what is over uh, what do you use as your set of guidelines?

GAVIA : For overcharging?

JOHNSON : Yes. Or over treatment.

GAVIA : Uh, over treatment is the uh, their on the standard for most of medicine, it is the standard of care which has to be proven in the testimony. Uh, what is the standard of care for a particular procedure for that particular patient at that time. Each patient is a little bit different. We, we have some--

JOHNSON : --Obviously. But, do you have a set of standards by which this person is uh, reviewing as they review the case? I mean what are your guidelines? What are your parameters? What, what makes your determination as to whether it's over treatment or overcharging?

GAVIA : Okay I'm gonna let Dr. Goehrs \_\_\_\_\_

GOEHRS : It, it would be the usual and customary treatment that's acceptable in the medical community.

JOHNSON : Okay and what is that? Do you have a list of that--

GOEHRS : --Well those are--

JOHNSON : --'Cause you don't have doctors doing this.

GOEHRS : We have doctors reviewing this at the time of the hearing.

JOHNSON : He just told me that investigators were nurses and--

GOEHRS : --At the time of the hearing we have physicians doing it. Uh, you mean in the investigation?

JOHNSON : But he indicated that you didn't always get to a hearing.

GAVIA : Uh, no Ma'am they do not all get to a hearing. And if, if the issues are, are uh not very straight forward we have uh, 50 to 60 physicians that we use as consultants to review records if we feel that we need to--

JOHNSON : --But who determine--what do you use as a parameter that you feel that you need to--is it a feeling that you have when you are judging a professional standard?

GOEHRS : It's the standard care in the community across the state that's understood through--

JOHNSON : --Well who kn--who--what individual--

GOEHRS : --medical schools and text books and published articles and the standard in that town.

JOHNSON : Clearly, but what are they? Do you have them written anywhere?

GOEHRS : I don't thin--

: (Inaudible, not speaking into a microphone).

JOHNSON : Well that's--excuse me, excuse me. I will address you in just a moment. Uh, for that standard of care for that particular case--

GOEHRS : --For each case--

JOHNSON : --When you have someone who is doing an investigation--

GOEHRS : --Yes--

JOHNSON : --Where you gonna make a decision as to whether it is over treatment or overcharging.

GOEHRS : It would be--

JOHNSON : --Over treatment would seem to be would be a little bit more uh, detailed and, than overcharging. You know, you can look around and see what charges are uh, for different areas across the state. But for a person who is not a peer, to look into a record and make a determination as to whether that person has indeed been guilty of over or under treatment or whatever, what do they use? I mean if it's not a physician making a judgement on a physician, what standards does the person who is not a physician using to determine the ri--to arrive at their decision as to whether it's gonna be a hearing, not gonna be a hearing, person's not guilty or they are.

GOEHRS : Well they, the investigator doesn't make that decision whether there will or won't be a hearing as Mr. Gavia said it's reviewed at several levels. So, that can be picked up. They have been trained, they the investigators have been trained as he pointed out, and they know pretty well what the standard of medical care is for most cases.

JOHNSON : Uh huh. What is their training? What is the course? You over it there at the examining board?

GOEHRS : Mr. Gavia said they are registered nurses or pa--

JOHNSON : --I heard that part.

GOEHRS : Yes.

JOHNSON : But that does not, I'm a registered nurse too.

GOEHRS : Yeah, uh huh.

JOHNSON : But that does not qualify me to judge a physician's uh, decision on a treatment of a patient. And I was trying to determine what standards does that person use to arrive at that decision. And I have a reason for asking, 'cause it seems very incon--your cases are very incongruent, they're inconsistent as to how you, these decisions are arrived at from my review of the cases and what's happened, and that's why I want to try to determine what you use as guidelines.

GOEHRS : Well we have nothing written beyond the general accepted medical standard throughout the state and uh, that's pretty well understood. But, Paul do you want to elaborate on the training that you have, further?

GAVIA : Uh--

GOEHRS : --Or our investigators.

GAVIA : The uh, standard for care is, is no where written down--(inaudible). It is something that is proved up at court through testimony of other physicians, (and) what was the minimum standard here of that patient at that time. Our mi--(inaudible due to overlapping conversation).

JOHNSON : --Uh, uh you know what? I understand all of that, and that is not the question I'm asking. What I am asking is, what is it, that the person who is not a peer can refer to, to make that determination?

GOEHRS : May I ask Dr. Hilliard to respond?  
: (Inaudible). We don't have  
a--(inaudible). They are talking other physicians in the same  
field, if it's orthopedics, talk to other (orthopods) in that  
same city and ask what would you charge for this, or what do you,  
how often would you treat this--

JOHNSON : --Charging okay, but the treatment.  
: (Inaudible). How many times a day  
would you have the patient go for physical therapy? You know,  
once a day, twice, four times a day \_\_\_\_\_. And  
those \_\_\_\_\_ opinions of other physicians in the same field  
and the same community. And bring that information back and  
making their decision, was this, you know, over treatment or not?  
And people saw it--

JOHNSON : --Oh--and, and how many do they  
interview? Is it a standard?

: Two, three--(Inaudible).

JOHNSON : So it's haphazard?

: Yes, if they get two or three that,  
that concur they will take it from there. If the first one says  
one thing and the second says something else, then they  
may--(inaudible).

JOHNSON : So the method is really kind of willy  
nilly, as depends on that person.

: (Inaudible)--because each case is  
entirely, it's different and each, you know, one time you  
treating the leg, one time you treating a brain. I had \_\_\_\_\_  
a uh, I was (giving patient review) of a plastic surgeon who had  
charged thirteen thousand for treating a leg that had multiple,  
multiple dressing changes and soaks and uh, \_\_\_\_\_.  
But this was the overly extensive care that led to  
the you know, overcharging \_\_\_\_\_  
produced a fifty thousand dollar bill for treating this leg. And  
uh so, you know, we would, as a \_\_\_\_\_ I kind of  
knew--(inaudible).

JOHNSON : But you are a peer.

: I am a peer, yes. Right.

JOHNSON : Now--

: The decision, the decision is  
ultimately made by a peer.

JOHNSON : Okay but--

: --Let me--

JOHNSON : --Okay but I did uh, I have not  
finished yet, I'm sorry. Uh, but I did uh, hear that at times  
this is not getting beyond this person just reviewing it. And my  
concern is standards. Do we arrive at decisions based upon  
clear, non-subjective standards? Or do we just do a willy nilly  
feeling?

: (Inaudible). I think the decision  
\_\_\_\_\_ made to dismiss at the \_\_\_\_\_ level, but not to, not  
to punish or reprimand uh, to sanction at that level is about  
\_\_\_\_\_. If uh, uh a lady said \_\_\_\_\_ Dr. \_\_\_\_\_  
\_\_\_\_\_ three dressing changes on his uh, \_\_\_\_\_ appendix,  
well she would know from being a nurse that that was not  
excessive, and that \_\_\_\_\_ dismiss--(inaudible).  
But if there were, if you said he came to him 20 times that makes  
him a little excessive there in that function, but a review would  
get opinions from that community. Or look at the chart, was  
there anything unusual (about) the patient that made that being  
justified and--(Inaudible). I think \_\_\_\_\_ those  
that \_\_\_\_\_ do not represent--(inaudible).

JOHNSON : Okay the reason I'm asking these  
questions, I have reviewed some cases where I thought they were  
extremely serious that were dismissed, and some that were

seemingly minor, but they were sanctioned heavily. And I, I just wanted to know what guidelines were used for this inconsistency?

CHAIRMAN : Well it's basically a, the process and there's a lot of judgement call in it I think as, as would be in any regulat--you know any--

JOHNSON : --Certainly I understand that Senator. But when they're glaring inconsistencies I think we have a responsibility to ask those questions.

CHAIRMAN : Sure I, I don't argue with that. Let me let Ms. Jenkins respond.

: (Inaudible).

JOHNSON : And identify yourself correctly.

JENKINS : I'm Cindy Jenkins, I'm a public member of the board. I don't believe we are a peer review organization. And I don't believe that, that the public would well--be well served by us being thought of as a peer review organization.

JOHNSON : I, I'm sorry. I don't even think you understood what I was talking about if you're thinking I'm a peer--

JENKINS : --I think I well understand.

JOHNSON : I didn't ask about--

JENKINS : --And I don't think--

JOHNSON : --I did not--

JENKINS : --Well--

JOHNSON : --Excuse me--

JENKINS : --Well I'm--

JOHNSON : --I'm responding to your, a statement that you made. And I'm, I'm trying to explain it from a standpoint of being concerned about standards. I didn't say that you were a peer review. Uh, if you heard that perhaps you didn't follow my line of questioning. I asked about standards, guidelines.

JENKINS : And you asked about peers \_\_\_\_\_--

JOHNSON : --And I asked about whether or not those judgements were made by a peer. And by that I meant someone with the same background, or someone from a totally different background, or a similar background who could have some knowledge, but not the expertise necessarily. Dr. Hilliard did go further to explain that they went out into the community and they did interview peers which were other practicing physicians. That is not necessarily peer review, but those are peers. Professional peers, who are practicing in the same field. And I wanted to know what standards were being used, and that is a standard. It is not written apparently. I think they ought to be, so they can be easily reviewed. Because I see glaring inconsistencies in material that I set up most of the night reading to get ready for this committee meeting. I prepare before I come to committee meetings, and I went to bed this morning at three o'clock. But in reading through all the material, I saw glaring inconsistencies. Now maybe they're not when you review them, but from the standpoint of a registered nurse, they are to me. So if I'm dear--differing in my opinion broadly from yours, then what makes any other registered nurse differ broadly from a physician or anyone else, or a public member who has no background in health training or medical training?

JENKINS : Can I finish?

CHAIRMAN : Yes.

JENKINS : I think the legislature in their wisdom, has put 12 doctors--and they're from all specialties on there, many, many times the doctor being disciplined is in a specialty that not one board member is familiar with, and certainly the public members are not--

JOHNSON : --I haven't even asked about, a question about a board member. I was asking about the investigators.

JENKINS : Okay, and I have never seen a case never reviewed at the informal settlement level that had not been interviews of experts in the field giving their opinion. But many times those opinions vary too. And there, there can be no written standard because every case is different. I mean if--

JOHNSON : --There ought to be some interim guidelines that someone follows to, to proceed into an investigation.

JENKINS : But if you have a guy that's--

JOHNSON : --For their own protection--

JENKINS : --doing a hand operation that is only performed maybe five times a year in the State of Texas and you're gonna sit down and write the standard of care for that, that surgery.

JOHNSON : I didn't say or ask a thing about a standard of care.

JENKINS : Or the standard of standard--

JOHNSON : --I said procedures for proceeding into an investigation.

JENKINS : --for overcharging or over treating, you can't do it. I mean it has to be the judgement of the board member.

JOHNSON : It needs to be done, and I think it can be done if you follow what I am trying to get at. And I'm not communicating very well. All of y'all are way off base from where I am. What I am talking about, is that when an investigator sets out to investigate--first of all I think it is a very serious matter to make a recommendation or a determination that a physician's license be suspended, cancelled or no action be taken, or whatever. That is serious. 'Cause we're basically talking about human lives, and professionals who are responsible for those human lives. It is not a flippant decision. It is a very serious one. So when someone goes out to start to investigate the practices of someone, I think that ought to be certain levels of standards, minimum standards, guidelines of which they proceed into this investigation to make sure that they've covered every area. I didn't say a thing about investigating whether a hand was burned. It's bigger, it's a bigger picture than that. I'm not thinking in that capsule. I'm thinking comprehensively, it ought to be a standard of--and I hope you don't spend a lot of time going out looking at whether a hand was burned, I really hope you don't. But if that patient brings a complaint to the board, then I think that physician and that patient or whatever ought to have uh, an opportunity to face each other on whatever that discrepancy is. But that is not my line of questioning. My concern has to do with consistency of developing your recommendation. Many, some of the recommendations that I have read are so different, I mean the cases are so very different with such glaring inconsistencies in the recommendations that have been arrived at. And if you don't use guidelines that can happen if you do it just willy nilly and opinionated and all that. But even if it isn't, if you don't document it, it has that appearance.

JENKINS : Are you talking about the recommendations to the hearing examiner? The proposed recommendations--

JOHNSON : --The investigators. I only ask questions about--

JENKINS : --I don't see--our investigators recommendations have always been maintained. Uh, they're kept confidential, I don't understand--the investigators

recommendation is in the, a file that's stamped confidential and, and it's not ever released from the agency. If it's a hearing examiner thing that's not even an employee of the agency. That's an attorney that is looking at the legal facts in the matter that were presented to him in making a recommendation.

JOHNSON : This gentleman said to me, or to this group, that when investigators go out, they look at the case and sometimes nothing happens because they don't find enough to take any action. And they'd recommend no action. And that closes it simply because it's no reason to take it any farther. Okay? Other times they make recommendations for further action. I asked him about the background of the investigators. Now at no time have I heard that a physician investigated anything. But this is a medical examiners board. Now, my, all I'm concerned about is your level of guidelines and standards that are used when you set out to do the investigation.

CHAIRMAN : Okay, the investigation process is what you're trying to center on.

JOHNSON : And you said you had none--

JENKINS : --If, if you could--I don't, if you're talking about you have seen recommendations that there's a varying opinion--

JOHNSON : --Extremely varied--

JENKINS : --And I'm asking--Okay - - what, who made these recommendations? Are you seeing the investigators' recommendations?

JOHNSON : Yes.

: The investigators recommendations are confidential and not subject to                      and we don't                      reports the courts have upheld the confidentiality. I, I don't think that's, that there, anyone outside our agency has ever seen an investigator's recommendation on a particular case.

JOHNSON : Okay--

: --They may be recommendations from the results--

CHAIRMAN : --But it come--

JOHNSON : --Even if it is never seen, what is the relevance of having it if it has no standards.

: What is the what now?

JOHNSON : The relevance--is it, is it relevant to have it, is it even important to have a recommendation if it's never, if it's not reviewed and you have no level of standards, and no guidelines for the process.

: It, it is reviewed. An investigator has only two options to recommend. Either they recommend that it be closed because there is not enough evidence or they recommend that we go to an informal settlement conference which is where that physician will meet with another physician. Even if they recommended it be closed, those cases are reviewed by a committee of my board to make sure that they be properly (closed)--

JOHNSON : --Now who is your board?

CHAIRMAN : The Board of Medical Examiners.

: The Board of Medical Examiners.

JOHNSON : Oh that's your board, okay. And

- there's a committee of five people uh, three MD's, one DO and one public representative who review even the cases that we recommend be closed. All of our cases, wherever they go, are reviewed by a committee of the board. Even those that go to an informal settlement conference, and after discussion with the physician, that panel recommends it be closed, even those recommendations are reviewed by a committee of my board to make sure that, that we're being consistent and the staff did not recommend a case be closed. Every, every investigative file is

either actually reviewed, or subject to review every, every month when my board meets.

JOHNSON : Okay and when they are reviewed, they look at the investigator's report only, right?

: No Ma'am.

JOHNSON : Okay what el--what do they review?  
: \_\_\_\_\_ if they recommend  
it be closed, the entire file is--

JOHNSON : --I, I don't care what the recommendation is.

: Alright.

JOHNSON : What do they review?

: At the minimum the entire file if it's gonna be closed. If it goes to an informal settlement conference, it will be the entire file plus whatever the physician who's coming in has to present. If it goes to an examiner hearing, there will be exhibits, transcript, whatever's available but it, it's a fair amount. And there would be uh, if it goes to examiner hearing, we have to prove our case through testimony, through physicians who will take a stand and testify that this particular event was a deviation of standard care. Every--there is not one state in the United States that has written down what standards of care are. Every court--

JOHNSON : --I haven't even asked you a questions about standards of care.

: No Ma'am but you were discussing the laws and I want to tell you, the reason they're not written down is because the element of proof that is required in any state or federal court in all 50 courts is to prove it through the testimony--

JOHNSON : --You're answering with information I haven't even requested. And you're go--

CHAIRMAN : --No but--

JOHNSON : --You're not answering what I have requested.

CHAIRMAN : But it's relevant though to the, to what happens through the whole process. You have to look at the whole process, and of course Senator Johnson's question as I understand it is, is key to the investigation standards uh, basically the standard conduct if you will uh, of how, how a uh an investigation is conducted prior to any formal uh, next step. Yes sir doctor, Dr. Stasney?

STASNEY : Senator Brooks uh, Senator Johnson, I'm Dick Stasney, a board member from Houston. You raised a good point and the point is that we need incredibly competent investigators. And we need a full staff, and you being an RN know what demand there is for RN's in the State of Texas.

JOHNSON : Why must it be an RN?

STASNEY : Well for example you need people with a medical background--

JOHNSON : --I agree--

STASNEY : --And it is very difficult to get very competent people with a medical background unless you pay them uh, a good salary. And we have 11 RN's in the investigators staff, it's tough to keep them. We're losing two. Uh, it's tough to keep real good attorneys. Paul is a superb attorney. We have uh a superb attorney that's leaving us to get more money. And if we're able to pe--

JOHNSON : --That's the way of the world--

STASNEY : --If, if were able to pay these people, the investigators and the attorneys more money uh, then I submit to you that there wouldn't be quite as much variation as you perceive now. Because the entire standards would be raised--

JOHNSON : --Well I'm gonna say it like the Governor tells us; throwing money at this board I don't think's gonna help it. I think it's going to be developing some standards where you rule out--where someone could look at it and don't see glaring discriminatory practices. And I think that, when you see one case being treated very, very differently than another case, then it has the appearance of being very discriminatory.

STASNEY : I don't disagree with that.

JOHNSON : For someone, for someone to sit and read through a case and see a, a decision arrived at that has goulashes of evidence that would lend itself to another direction, then read another case that has great sanctions that seemed to have nothing there. Now maybe there is something not written that I have not ac--had access to read, but to read that gives me a lot of insecurity about what kind of process and guidelines and review processes that are available that the citizens of this state are having to depend on to provide some measure of security of who is practicing medicine in this state.

STASNEY : You make a good point and, and I want to speak for the consumers of Houston and say that we're deficient by two investigators in Houston. And that means that there's a backlog of cases occurring in Houston because we can't fill these positions. We can't get people to do the investigations that Paul wants done. We had a vacant position, one of them's been vacant how long Paul?

GAVIA : Uh one position \_\_\_\_\_ two years.

STASNEY : Two years, two years we were without an investigator in Houston. And I submit that the consumers are being poorly served uh, when we can't uh, be responsive to them and try to identify problem doctors at an earlier date--

JOHNSON : --And even more poorly once we spent all of the time and pay these people to do it and they come up with these very strange inconsistent uh, outcomes.

GOEHRS : Senator if, if I can pursue that I'm not sure whether you're talking about investigators reports which you have been told already are in files that--(inaudible due to overlapping conversation).

JOHNSON : --Well may--I'm just ta--maybe I'm talking about the review of whatever you release for us to read on cases--

GOEHRS : --That's the hearing examiners report. And that's a, a lawyer that sits as a judge. And we have no way to make inconsistency there, or the vote of the whole board which is going to be all 15 people just like a jury. I'm sure that many of us would say goodness why did that jury do that in the court system. So there's going to be some slight variation but I don't think there's a lot of inconsistency in the investigative files. And that's what you were addressing I believe.

CHAIRMAN : Ms. Jenkins.

JENKINS : I do believe there's an inconsistency going on in the informal settlement conferences. I've questioned it, I think that uh, it's especially in the (prescriber) practices, the \_\_\_\_\_ that we have several board members who tend to dismiss cases, and several board members who tend to be real tough. And there is no written standard on that. And it is all up to the--

JOHNSON : And see that's what concerns me--that's, and you know--

JENKINS : --and it's all up to the board members. And I came to the Senate, your Nominations Committee and said we've got several board members who are, have been dismissing 85 percent of their cases, okay? And, and that, that same doctor if he appeared before one member of the board it's this, and another

member it's this. And it concerns me a lot. And it's, it's there I agree--

JOHNSON : --Well maybe you ought to run for Governor so you can appoint--

JENKINS : --I agree with the Governor. I agree with the Governor that you can't throw money in this situation. And it is the 15 people sitting around the table that make the decisions. And they're inconsistent as hell I will tell you. If you go through them all, I feel real guilty seeing one doctor that was severely disciplined for prescribing practices for one patient and one doctor for prescribing practices similar on 50 patients got his case dismissed by different board members.

JOHNSON : --And what is your responsibility to the public when you see that?

JENKINS : Uh I've talked to the public about it. I've been before the Senate \_\_\_\_\_, Senator Brooks I've talked to about it. I, I am very alarmed about it. And I think that it, it's not fair. I think that it, it hurts the standing of the board in the medical profession when they hear these things. They hear you talk or they read the newsletter and see that somebody's been disciplined for this, and then they \_\_\_\_\_ at so and so \_\_\_\_\_ got his case dismissed--

JOHNSON : Tell me what you think your board can do to tighten this up?

JENKINS : Our board can't do anything.

JOHNSON : You can't?

JENKINS : Our, I can't sit and tell a board member, you've got to be \_\_\_\_\_. And the board members can't tell each other how to vote. And--(inaudible due to overlapping conversation).

JOHNSON : --Okay but, I mean but, do you have any responsibility for helping--

JENKINS : --And I wish I could run for Governor and make some better appointments to this board, thank you, I would have done it.

JOHNSON : Uh huh.

JENKINS : And it'd be in a lot better shape if I had the say in committee. The Senate had a say in committee too, and they didn't do anything about it either. So I don't feel too guilty about it right now. But I'm telling you it's very inconsistent, their disciplinary action, and I'll be glad to show you \_\_\_\_\_.

JOHNSON : What kind of board action has been taken to give attention to these instances?

JENKINS : All \_\_\_\_\_.

JOHNSON : Excuse me?

JENKINS : I have a letter from the Chairman of the DPRC who I've written and told him I'm concerned about it.

JOHNSON : Well I mean did you, have you all considered any rule making--(verbiage lost due to changing of the tape).

END OF SIDE 1

SIDE 2

JENKINS : --if we had a rule that said, if you prescribe three Tylenol number 3 a day to somebody, that's the only--what other standard can you have? You've got to look at the individual patient and, and their history and the doctor and their history. And go with that one patient. And no court in the world's gonna uphold this if we do a written set of guidelines I don't think.

CHAIRMAN : Dr. Hilliard.

HILLIARD : (Inaudible).

CHAIRMAN : Yeah that's a physical impossibility because of the sheer number of cases you have to have.

JOHNSON : Okay now, but when, when, when for example, at this moment, as a member of the legislature has observed these inconsistencies, do you have a process if I would bring a complaint to you?

HILLIARD : (Inaudible).

JOHNSON : If, if I read some cases, and I see what I consider glaring inconsistencies, and I brought this to your attention, do you have any responsibility? Or if someone, if a member of the family who lost a, a loved one or a mother, father or child uh, came and asked you a question about a case, what, what would your process be? How, how would you respond to that?

: \_\_\_\_\_ the doctor was exonerated, I think double jeopardy would prevent us from doing anything about that. But I think we have to, you know, we, we did change our procedures to go from one physician hearing to at least two. Now there are two or three hearings minimum. We have done \_\_\_\_\_ improve that.

JOHNSON : What if additional evidence can be brought before the group that was never uh, brought be--prior?

CHAIRMAN : Well is that the op--do you still have the appeal to the full board?

: Yes.

CHAIRMAN : Okay. So th--additional evidence could be presented at that, that step if they wanted to appeal to the full board.

GOEHRS : I might clarify somewhat Senator. We do have in the process now (we're generating) guidelines for disciplinary procedures for the informal settlement conference. That has nothing to do with investigators you were asking about, but we're setting up guidelines so we do have some standard for the offenses that occur. And that might address what you're speaking of.

JOHNSON : Uhmm.

GOEHRS : This exists \_\_\_\_\_ and in the last two months Mr. Gavia and I have talked about this and we're in the process of creating them, so that might address your concern about it.

JOHNSON : Okay. And one other concern, uh a case was brought to my attention recently, and I have visited with you on that and uh, I--the complaint was brought to me that the family was never notified uh, about this and you insured me that they had been and I asked you for a copy of the correspondence to show me proof, and I've never gotten it. And the family continues to say they have never notified, so - -

GOEHRS : In response to that Senator I'll have to say that case is in litigation is still in process, it's going to the full board in August, and I think to preserve both sides, that should not be discussed in public, I'm sorry--(inaudible due to overlapping conversation).

JOHNSON : --Oh I asked you about correspondence--

GOEHRS : --Yeah--  
JOHNSON : --of notifying that family. The family continues to say they have not been notified. And you told me that you were sure they had been and I asked you to show me a copy of the correspondence.

GOEHRS : I believe I said that the family's attorney had been notified. And that's my understanding. But uh, I'll have to say that uh, I don't we ought to discuss that case in public because it may jeopardize either side, and I don't think that would be correct to do. (Inaudible).

CHAIRMAN : (Lester) if you, I think the, if Senator Johnson uh, wanted to phrase your question about what is your routine procedure for notifying all parties to any of the hearings then that, that would be very appropriate.

JOHNSON : 'Cause that particular case is--

CHAIRMAN : --Yeah and, we don't know want to get into a particular case 'cause that'd be very inappropriate for us. So--

JOHNSON : --Could you answer that question?

GOEHRS : The question of what our routine is in notifying all parties?

CHAIRMAN : Uh huh, right.

GOEHRS : Paul would you mind?

GAVIA : Yes, at the uh, informal settlement conference \_\_\_\_\_ the plaintiff is sent a uh, letter advising of the time taking place and it's sent by certified mail return receipt, uh in this particular case that family nor the attorney complained to us. The complaint came to us from elsewhere. Uh, at the uh, contested hearing we bring our witnesses in and we brought our witnesses in for that case.

JOHNSON : Uh, let me ask you this, without regard to any case, but at, with regard to a process and procedure, when a complaint is brought, you only deal with the source of the complaint and the person they complain about?

GAVIA : (Inaudible).

JOHNSON : And that is standard?

GAVIA : Yes Ma'am. Certified mail return receipt.

JOHNSON : Okay now, if a person gets a complaint brought against them are they aware of the source of the complaint?

GAVIA : No Ma'am. It's confidential. Uh it's--but it, I would say for practical matters--(microphone noise)--is implication or someone who complains to the doctor, to another (society) as filed \_\_\_\_\_ against them and then get a letter from \_\_\_\_\_, they can put two and two together. However, if it's a large hospital say in Houston with hundreds of physicians and nurses and the complaint comes to us from uh, a nurse, we do not disclose the identify of the nurse. In some instances--

JOHNSON : --Uh huh. And that's not important to me that's not the, the crux of where I'm going.

GAVIA : Alright, I'm sorry.

JOHNSON : As to who it is, uh my concern is if a complaint comes from out of mid air on a particular case, you don't \_\_\_\_\_ the parties of the case involved you just deal with the source of the complaint and the person they complained about?

GAVIA : Well it, it depends. If, if we need that first--

JOHNSON : --What, what is your guideline on that?

GAVIA : There are no guidelines. Depends on what the lawyers feel that they're gonna need in the case. Every lawyer has to try their own case and every case is different. In

some cases we may not need the complainant but we may need the person who was injured. In some case we may not need the pe--

JOHNSON : --If the person who was injured was dead who do you get?

GAVIA : If the person is dead? Uh many of our cases are, are made through medical records and review of medical records by consultants who will testify. That is, that is how you try a malpractice case, and that is what we're doing. And in most instances the plaintiff cannot add anything because they are not a physician, by essentially I can say is I went to see Dr. So and So and he did something to me. Exactly what happened and what went wrong is proved through expert testimony. And--

JOHNSON : --You mean to tell me that if I went to a doctor and something happened to me, it would be not really relevant what I had to say--

GAVIA : (No).

JOHNSON : --it would be what the record said?

GAVIA : It would depend on what he did to you Ma'am. That's what I'm saying is, if you came to us and said that he uh, he struck you with his fist then yes we'd want to--

JOHNSON : --No but if, if nobo--if I didn't come to you--

GAVIA : --But it, but it--

JOHNSON : --but it's happened to me.

GAVIA : --If we had indication that a, that a surgical procedure had been performed on you and a uh, sponge had been left in or it was done improperly or something uh, if you were under general anesthesia you wouldn't know it anyway. And we would uh, get the records from the second surgery where they removed the sponge to prove up that there was a sponge left in you, and ask physician testimony that there should have been someone keeping track of sponges, they should have been logging them in, he should have noticed when the patient started complaining of pain the abdomen and so forth. That is--a malpractice case is essentially tried out with, with--

JOHNSON : --But it doesn't matter what ha--what the outcome was with that individual that it happened to, it only matters uh, who sent the complaint is--in, and the physician, is that right?

GAVIA : The, the outcome uh matters uh, but we don't require that patients uh die or, or have a bad

JOHNSON : --I would hope you don't require the patient do anything.

CHAIRMAN : No. (Laughter).

GAVIA : But to prove our case you could have a good outcome from a bad procedure, just because the good Lord looked out for you. Nevertheless we would still want that doctor to explain why he did that. The outcome would matter to--(inaudible due to overlapping conversation).

JOHNSON : --Let me just ask this, if somebody said I did this because I was experimenting, then would you want to ask that parent or that person whether or not they gave permission for that experimentation? Would you want to know that from that person or you just--it doesn't matter?

GAVIA : If, if they were experimenting with the patient they have to get a specific informed consent signed in a

JOHNSON : And if that is not there how can you make a decision?

GAVIA : If it's not there, if it's not there, there is, then, then you have it. He did not obtain informed consent.

JOHNSON : Okay and if he did not obtain informed consent--

CHAIRMAN : --That's a violation \_\_\_\_\_.

JOHNSON : Right.

GAVIA : If, if it's not there \_\_\_\_\_ if it's not in the record they didn't have it. And you may, the physician may say I spoke with them--

JOHNSON : --See I reviewed a case like that. Where there was supposed to be what, that was the, the, the explanation given by this person for doing a procedure. But the family was never notified so--but the recommendation is that no action be taken.

GAVIA : Okay.

JOHNSON : And that troubles me.

GAVIA : The part that troubles you is, is not within my uh, power. That's 15 board members who vote. And, and I did not, all I can do is prepare and present the cases, it's just like trying cases before a jury, some days they'll eat out of your hand, the next day you--

JOHNSON : --But that is a very glaring exception. Was that noticed? I saw no notation whether it was noticed when I read this stuff.

GAVIA : (Inaudible).  
: Dr. Goehrs. Dr. Goehrs, I believe you had some--

GOEHRS : Uh I think uh, we need to respond yes we often do get the complaint \_\_\_\_\_. And \_\_\_\_\_ presiding I can't respond to but I think it must be acceptable because that doesn't sound like one we would (frequently) handle. We do frequently get the complainant in, and they will testify as to what happened.

JOHNSON : I'm not talking about the complainant.

GOEHRS : Yeah--

JOHNSON : --The complainant he said could, would, could be a insurance or somebody in mid air, a nurse--

GOEHRS : -- \_\_\_\_\_ individual is what I'm addressing.

JOHNSON : But I'm talking about the family, next of kin-- \_\_\_\_\_.

GOEHRS : --That's what I'm addressing also. The family, the next of kin, or the complainant themselves. We will get the \_\_\_\_\_.

JOHNSON : But it's no standard--

GOEHRS : --If it's appropriate.

JOHNSON : Yeah.

GOEHRS : It varies as Mr. Gavia said. There is no standard for that.

HILLIARD : I was thinking that generally they agree--the party who was injured if alive would have opportunity to be present and to give input and to testify in the case. Sometime--but this doesn't, doesn't necessarily include that person's family if the person's alive and an adult and can make their own decisions. Sometimes they don't want their families involved, they ask not yeah--

JOHNSON : --Sure.

HILLIARD : But uh, you know, that person would generally have an opportunity to uh, to uh you know speak one way or another if uh, if alive and available. Sometimes they decline the opportunity for various reasons that only we--only they know.

JOHNSON : I understand, but, and, and that is perfectly acceptable, I don't have a question about that. My question is, if there are no guidelines and no standards, I don't know what you follow. You just follow a feeling or a whim or - -

HILLIARD : (Well they haven't been) written down in most cases. Those of us who are physicians--

JOHNSON : --Are they memorized or--

HILLIARD : No those, those who are physicians generally know from experience it gives the experience what uh--

JOHNSON : --That's an assumption.

HILLIARD : Yes.

JOHNSON : You assume that they would know from experience. But there's nothing that generates any level of standards if no one has anything minimal to meet. And I, I have not been able to determine what you follow.

HILLIARD : Yeah, I think it's you're saying I think we probably could uh in some, in some areas have written standards. I happen to be an obstetrician and the American College Obstetrician/Gynecologist does have a book called standards of care. When it's, when the, a new OB patient goes in what should incur in the physical, what level it should be gotten. How many times she should see the doctor which is usually monthly until seven months, she should see him twice a month uh you know, at seven months--

JOHNSON : --And that's secondary to what I'm talking about--

HILLIARD : --But that, that's standards of care.

JOHNSON : --What I'm talking about is the investi--right.

HILLIARD : And we can investigate the follow. If they, if that person followed this then they followed the standards of care. They did not follow this, they probably did not. Although again there could be exceptions with the situation, the patient live out of town and couldn't come every so often. But I, I do think that this could, this could happen very easily in many areas. But in seeing, in uh, lung liver transplants when there is a new, there really aren't any standards of care 'cause they just beginning do them in the state and not enoughs been done elsewhere till there be any standards. We don't, you know--

JOHNSON : Okay let me try to start over and maybe I could, maybe I could make myself more clear. And, and a lung liver transplant is a good example 'cause it doesn't occur often. I am not talking about - - my focus is not on whether or not that is a common occurrence, where there is a standard of care written for the physician or the hospital. What I'm speaking to is when the investigator gets a case, is there a group of questions that must be answered? Or is there a uh, direction as to what bases must be covered? Uh, what are they directed by that would cause every port to have certain information without a doubt? Because the forms have been completed. I mean, what process, what standard process--it's difficult for me to understand how you can arrive at such wide disparities of recommendations using a standard of operation as you go through a process. And that's what I'm trying to find out, what is that and where is it?

GOEHRS : There isn't, it's not written down and you can't write down every one of these details because the cases vary so much. There are standards and guidelines that the investigators go by from experience--

JOHNSON : --But they can't be written?

GOEHRS : It would be almost impossible, it would fill this room or more to write down--

JOHNSON : --If you were reading every little detail. But don't you have a general guideline as to who is, who must be contacted, what facts must be investigated or--

JENKINS : I'll see memos and they'll (file) all the time about where are the medical records on this patient, did you get them from this hospital, did you go to the other doctor

she went to after she left this doctor, you haven't finished this investigation, why haven't you talked to the patient's wife, uh all that kind of stuff. I mean I've never seen a written set of guidelines but I know there's somebody looking over their shoulder because, in every case I've ever looked at they're always numerous memos from the top investigators saying, now that you've done this you need to do this, don't y'all see those--

GOEHRS : --We, we do indeed have another--

JENKINS : --this, this and this. And, and there's direction going on there.

JOHNSON : Okay but where is it generated from?

GOEHRS : There is an investigator's manual in our office which must be \_\_\_\_\_ that guidelines that should be followed.

JOHNSON : Okay so you do have some guidelines--

GOEHRS : --But do not write down every specific detail about every different case. Because it's just impossible to track every case. But there are guidelines--

JOHNSON : --I didn't ask you about (specific) guidelines for every separate case, I'm talking about general operating procedure.

GOEHRS : Yes Ma'am. There is an--there is an investigators guidebook in our office. Yes Ma'am.

JOHNSON : And if there is, my concern is if that is followed. It is difficult for me to understand how you arrive at such wide disparities in the outcome.

GOEHRS : Because of the wide disparities you're speaking of are the results of the hearing examiners and the board votes. And that doesn't--the investigation does not in any way guarantee a given outcome.

JOHNSON : So the documentation has no impact on the minds of people who read them?

GOEHRS : I can't say that because I'm not a hearing examiner. But it will vary, that's why we have 15 board members to get a wide spectrum of opinion about that.

HILLIARD : Senator Johnson sometime a, we get a case where it's a question of who you believe. Uh, the complainant says she did one thing, the doctor say I did not, and we have to take credibility up. We had several cases within this year of where doctors accused of sexual impropriety and witnesses say he did, he says I didn't. And we have witnesses in common and he is \_\_\_\_\_ of them, and boils down to purely a question of who was more believable in this situation. And we have to make a judgement based on that. And of course (making judgement) I mean we could err. And based on that we make a decision--one guy may have accused of three got off, other guy may have accused of one and got, you know, uh punished. But you (believe) we believe of these circumstances the majority of the board believed this witness rather than this doctor. And other times they didn't and I don't know, you know--

JOHNSON : --But you hear both sides?

HILLIARD : I hear both sides yes.

JOHNSON : At all times? 'Cause I was looking at a case where only one side was heard.

JENKINS : We have recently asked in cases of the sexual improprieties, that it not be heard by hearing examiners because there is really no evidence in that case other than testimony. And we've all found it real hard and, you said something while ago about willy nilly and flippant and those are hard, hard cases and all of us are just wrung out by the time we sit there and it's, it's hard to decide who you believe in those cases and that, that's the only thing you have, is a woman sitting here and the doctor sitting here and just, who's telling the truth. Because there is zero--

JOHNSON : --But both of them have an opportunity to bring evidence and witnesses and all that?

JENKINS : --Both--but and the board has requested that we be allowed to see them because if the hearing examiner sees them and then says, well I decided to believe the doctor and not believe the woman then we almost--have to go along with that because we didn't hear either one of them and who are we to read this piece of paper and see which--who was telling the truth.

JOHNSON : Uh huh.

JENKINS : So in--

JOHNSON : And if you'd have a case where the other side is not heard at all, what do you do as a board?

JENKINS : Are you talking about a medical case or the kind of case I was talking--

JOHNSON : --Medical case.

JENKINS : Well the other side a lot of time is not necessarily the patients talking but what the, the medical records--

JOHNSON : --If a patient's dead, dead they can't talk.

JENKINS : Or, or that's right. Or the parents or the grandparents or whatever, it's the records themselves and what the experts say about uh, there is a, and if you're only looking at hearing examiner recommendations and hearing examiner recommendations have not been voted I will tell you that the board frequently reverses what the hearing examiner recommends. We frequently disagree with them. They are not physicians. I mean they're attorneys and they usually are more narrow in looking at specific legal guidelines and not really underst--uh a lot times I don't think they've understood the medical part of it quite like they should have. And we frequently reverse the hearing examiner recommendations. We don't rubber stamp those. I mean I know there's some agencies, hearing examiner comes in and they all sign off and go on. We don't do that. And, and we spend a lot of time on those recommendations and, and I, I would say probably in 20 to 30 percent of them we change at least change their recommendations as to what happens to the physicians. And a lot of the times just turn it around and the, the hearing examiner says I recommend nothing happen and we say we recommend he not practice anymore or the opposite, where the hearing examiner recommended they lose their license and we say no, we, we recommend it be dismissed.

JOHNSON : Okay--

JENKINS : --So that's where the 15 people help. Because then you have 12 medical minds and three people who are hopefully representing the public but, don't be--we're alarmed, and we're not even sure that this hearing, the hearing examiner thing is kind of new and it still kind of bothers me that we do get these wide decisions. But these are people we're hiring by the hour out there, I think they're doing a pretty good job overall. But uh, they, they don't have that much medical, any medical training and, and we do get a wide variety of decisions. But we don't rubber stamp their decisions.

JOHNSON : Okay, that makes me feel a little better. Now let me ask you specifically; when you pick up a case to review it, and you read it and you see a recommendation but as you go down through it you don't see any evidence of the both sides being notified, any evidence of any testimony or a complete record being examined because it's not there because if someone is, is, if that's the only one being asked to bring information they're gonna bring the best information they can bring to defend themselves. I--that's what I would do and that's what everybody else does. Now, and but, no opposite side is ever given an opportunity to present anything. Does that impress you any?

JENKINS : Well uh, I would probably ask a lot of question before I'd vote and there, there's stuff available to the board - -

: (Inaudible).

JENKINS : Well and ther--would those recommendations, there's still stuff that's part of the evidence that the board does elect to look at sometimes, like medical records and the transcript and everything else.

JOHNSON : What about notifying the people so they can come testify. Do you ever do that?

JENKINS : Well - - like they were saying, sometimes that's not essential to the, to the case. It, it's what actually happens to the people as to whether or not, we're not always interested in what the doctor said, it's what he did and, and the records would probably reflect that. Uh it's real important and, and if people can put it in their constituent newsletters or whatever, to let people know if they're unhappy with the doctor they have to complain. That's where they start getting invited to hearings. If they didn't complain--

JOHNSON : --Well if they don't know there's gonna be a hearing.

JENKINS : Well but--who do you notify? Who would you put as a set of standards to notify on a patient? What if you had a, a 16 year old girl that, that uh had an abortion and, and something went wrong and we just routinely sent out a letter to their parents saying, we wanted to invite you (in).

JOHNSON : Who but, who complained? I would certainly invite that 16 year old girl.

JENKINS : What if she died?

JOHNSON : Then you invite whoever's a responsible party.

JENKINS : You would notify them that in fact this medical procedure took place?

JOHNSON : Yes indeed. I think--think the family has a right.

JENKINS : (Inaudible due to overlapping conversation).

JOHNSON : You said what if she died, I'm responding on, on her death. If she's alive she should be invited to come or at least notified and given the opportunity.

JENKINS : I don't know, I'm not a lawyer. But I just don't think we have the right to start telling people about what happened in their, in, in their medical treatment to anybody outside the--

JOHNSON : --That is not--I don't know where you got that conclusion but that's not what I'm talking about. I'm saying notifying persons as it relates to their case.

JENKINS : If they didn't complain it's not their case--

JOHNSON : --When the hearing--Oh it, if it--was not their case, it just has to do with their lives but it's not their case.

JENKINS : No it, it does not have to do with their life. We're not gonna change anything that happened to them. We're now worried about protecting the rest of the public and dealing with that doctor. And it's no--if they are not the complainant, and that's why this board I think has to do more in the mission of telling the public that we in fact exist, and I'd like to talk about that later on but, if they have not complained to us--

JOHNSON : --I don't know if I want anybody to know if I'm getting what I'm think I'm getting.

JENKINS : If, if they've not complained it's not their case. It's not their case.

JOHNSON : Even if it involves their lives it's not their case? And they have no right to be notified they're gonna be discussed--

JENKINS : --It doesn't, it doesn't involve their life. We aren't going to change what happened to them. We're dealing with the physician's aspect of it and protecting anybody that he sees in the future. We're not change the outcome of what happened to that patient. We're not a mal--

JOHNSON : --Right--

JENKINS : --We're trying, we're not seeing how much money they're gonna get, whatever's gonna happen to them, what bills are gonna get paid, we're, we're uh--it's not their case. I, I would really disagree with you that it is their case. I mean I--

JOHNSON : --I don't think I've said it's their case, I'm trying to get information. I'm asking you, do you feel, I'm worn out trying to be understood.

GOEHRS : Senator you apparently have a case in which you feel that one side was not notified--

JOHNSON : --Several, several cases here where it's some glaring inconsistencies.

GOEHRS : Several in which the other, only one side was notified?

JOHNSON : In one case only one side was notified.

GOEHRS : That's what I understood. You have one case in which you feel the one side was not notified. And I'd be glad to review that with you, I think that would be highly unusual in this board. Uh, I would be glad to look at it and see if I could--(Inaudible due to overlapping conversation).

JOHNSON : --Okay that's what I asked the first place. What--

GOEHRS : --But that would be very--

JOHNSON : --What is, what is my recourse. That was my initial question. If I looked at a record as a legislator and I had some concerns about the procedure, where do I go and what would I expect. What--what guideline do I look at to see whether or not it's been violated or, questioned or --

GOEHRS : You could always address the letter to me.

JOHNSON : I've already done that and I didn't--you didn't even respond to me.

GOEHRS : (Inaudible).

JOHNSON : I asked you in person to send me a copy and you said you would.

GOEHRS : But I, I replied I cannot respond on that case. Uh, because it's still before the board. And I replied I cannot respond on that--

JOHNSON : --Well that's not what you told me that just now, but now when I asked you if you could show me evidence of the patient's family being notified fir--you said I'm, I can guarantee you they were. I said could you show me evidence, you said yes I'll send you a copy and I haven't heard from you since.

GOEHRS : Well I probably misspoke because I didn't realize at the time what the legal situation was. And I apologize to you (or if) that's the situation. But right now I have to

JOHNSON : --You didn't, you didn't think you owed me enough courtesy to pick up the telephone and call me and say I cannot tell you, I can't send you a copy because--

GOEHRS : --I apologize to you now for that oversight.

CHAIRMAN : Uh--in uh--I, I don't feel we're really getting anywhere on one specific case here I think we're kind of stalling. Let, let's go on and, and move to the, the big

picture, the overview of, of the operation. The statistical data maybe you have about the numbers of cases you're handling.

GOEHRS : Yes sir.

CHAIRMAN : And uh, and we--it, it is important uh to Senator Johnson that we do get the question answered was the notification handled. And, and let's do that. Uh, it, I would be inclined to agree with what I know about the board's operation, it would be highly unusual for a relevant party not to be notified but, it could happen. I mean uh, we have mistakes happen in our offices too, so. Okay go ahead.

GOEHRS : Uh, we were in the middle of talking about the investigative caseload and I was just uh, going to mention that the caseload for investigator in 1981 was 38 cases and it's jumped to 66 in March of this year. During that same period of time our investigators only increased by 20 percent and as you've heard uh within the last few minutes even that has dropped down because we no longer have 18 full investigators because of resignation. The average investigator time uh, at present is between nine and ten months, uh before the case is investigated sufficiently to bring it forward. Uh, the disciplinary process review committee to which Mr. Gavia referred has set six months as the average time for completing investigations to be achieved uh, within the next year or so. So we hope we can do that, but in face of the shortage of investigators I'm not sure how we're going to do that. In regard to uh, discipline. Uh on Page 7 in your packet and uh, Chart 3 here uh, I have a graph of the informal settlement conferences which is the first uh, level of hearings after the investigation is completed and you can see that these have risen considerably over the last several years. Uh, on Page 8 in your packet, and I don't have a chart for that graph there are figures of the examiner hearings which is the next step after an informal settlement conference when the case is more serious and needs to be heard by an independent hearing examiner and as well as the board hearing uh, figures. I would simply adjust those figures uh, because they in the left column it says to May 31, we uh, anticipate opening something like 800, 1,800 uh cases this year. Uh, up from the 1,200 or so that you see there in May. We have three uh, board hearings scheduled for August so that will increase that. We have six examiner hearings instead of the, in addition to the 20 and the informal settlement uh conferences will reach something like 250 or more by the end of this uh, fiscal year. Uh, in the area of licensure, as of June this year there were 42,640 licensed physicians in this state up 600--or 765 over the last 12 months. Uh--

CHAIRMAN : --Let me get that figure from you again Doctor. Uh, how many lic--

GOEHRS : --42,640. That's uh--

CHAIRMAN : --Last year, or is that current license?

GOEHRS : --That's current license.

CHAIRMAN : Okay.

GOEHRS : 765 over the last year.

CHAIRMAN : Added on \_\_\_\_\_--

GOEHRS : --Added on.

CHAIRMAN : You, you licensed 765 new--

GOEHRS : --During the year and that's included in the 42,640.

CHAIRMAN : And that would include either by examination or reciprocity?

GOEHRS : Right, both.

CHAIRMAN : Or whatever licensure was appropriate.

GOEHRS : Now this June in addition to the 42,640 we examined 1,022 recent graduates so they will be licensed this

fall. Uh, presumably the 98 percent or so who pass the examination. Uh, on the uh, next chart I have shown the reciprocity uh, cases which has increased dramatically this year for some strange reason by 40 percent. So there are a number of people wanting to come from other states here and get licensed by reciprocity. And uh, we don't have a full explanation for that. There is a graph on Page 13 in your packet that explains that. And uh, on the next uh chart, and on pages 10 and 11 in your packet we address the hotline which uh, is now listed in the phone directory as an 800 number in nine cities across the state. Uh, you can see how dramatically the uh, number in the black bars of uh hotline inquiries has gone up. Uh, the hotline was instituted in 88 so our inquiries were going up earlier before that but they took a considerable jump uh, something like 32 to 34 percent increase over the last year or so. The verification uh calls in the green bars are uh mostly written, some uh, uh phone calls where we have to verify the status of licensure and uh, disciplinary procedures for various health agencies and entities. So that's going up. Uh the red bar is simply the licensed physicians in the state and doesn't show quite the dramatic rise as the other uh, procedure. Now to address the next biennium in the 92, 93 needs uh, I think from what we've presented you see that uh overall we have had something like and, predict that we will have 12 to 14 percent projected increase in our case loads. Uh with a current shortage of uh, two investigators and one attorney uh, we're under the gun. We need to get six more investigators to handle this caseload that we've demonstrated to you. For the next biennium we'll need two more attorneys and we'll need to have the support people, the clerks and secretaries uh, to handle that. In the licensure, reciprocity and registration areas uh, have demonstrated I think that the reciprocity increase uh, we'll need to have some increase in personnel in that area as well as someone to handle the hotline as the phone calls increase. To serve all of this with our information services the computer uh, capability uh we'll need to have some expansion. That has uh, been a great tool for us to be able to answer questions quicker, to make uh, reports much more quickly and to keep up with uh where we are with our caseload. Uh, to house all of this we will have to have some increase in space and we're making uh, some reports in that regard and we'll be submitting those to you and to the uh, proper people to anticipate a move in August 91 to bigger quarters when our lease expires. The primary occupant of our building now is the Real Estate Commission and they also are growing and we won't be able to stay there beyond August 91. Uh, the final chart uh, on the right is the objectives we have for the next biennium and uh, that also is the final page in your packet. Uh, would entertain any questions you have and would be glad to have any comments from our board members who are here for questions you may direct at me or them. We appreciate the opportunity of coming.

CHAIRMAN : Also my staff has called to my attention that y'all have produced a, a public information booklet.

GOEHRS : We have.

CHAIRMAN : Uh, which you hope to uh, try to help people, help the general public as well as uh, licensed professionals uh, understand more about the board. Have, have better information about the board.

GOEHRS : Those are available and we distribute them at various uh, group meetings and teachers groups. We distribute them wherever we can so that the public knows what's available to them.

CHAIRMAN : So you, you are trying to actively distribute them through uh, whatever appropriate sources there are like uh, maybe uh--

GOEHRS : We've gone to health fairs, we've gone to various meetings of statewide organizations.

CHAIRMAN : Very good.

GOEHRS : And we make them available to them

CHAIRMAN : And I presume if anyone uh, wanted to write for one that y'all would--

GOEHRS : --If they write we'll be glad to get them.

CHAIRMAN : Very good. Thank you very much. Appreciate that. Any other questions of uh, Dr. Goehrs or our board members or the staff.

TEJEDA : I've got one Mr. Chairman. I was just wondering in the uh, the licensing of physicians, particularly those coming in from another state--

GOEHRS : --Yes--

TEJEDA : --Uh, there is a process I guess for them to get licensed?

GOEHRS : Yes.

TEJEDA : Uh, is there any way of speeding of the process certainly without endangering the public or anyone else, but in turn particularly if they're gonna go serve in under served areas out in the rural part of the state? Questions have been brought to my attention on that.

GOEHRS : Yes. That's a concern we have and uh, we're looking at it but at the present time it's very difficult to speed that up. Uh, it takes two to three months generally unless there's some problems. Beyond that time there would usually be some problem involved of discipline in the previous state where the physician had been, uh inquiries we'd need to make, getting the physician in to talk to them and clarify that. And I don't think it would serve the rural areas well to have uh, a physician there who was under the cloud of some problem.

TEJEDA : No not at all. That's why I prefaced it--

GOEHRS : --Yeah--

TEJEDA : --And I qualified it by saying you, we don't want to endanger the public--

GOEHRS : --Right. But we're looking at that to see what we can do.

TEJEDA : Normally it's two to three months if there's no problem?

GOEHRS : That's correct.

TEJEDA : And that time period is basically checking out or investigating uh--

GOEHRS : --That's writing for reports from the previous state, getting reports from the reporting agencies about mal-practice suits, about any disciplinary procedures that have happened, and previous hospital staff appointments. Those kind of things. And the mail and the response time on the other end of the things that hold us up.

TEJEDA : One individual had uh, brought up the, the suggestion of a temporary license but that wouldn't serve the purpose either if that's what the time is being taken. Or the public wouldn't be served if--

GOEHRS : --Alright temporary license uh, now doesn't have a uh, temp--termination date on it and we'd have to look into that. I think that would be questionable but--yes? Dr. Hilliard.

HILLIARD : I was just gonna say we, we do give temporary license once the application's been--has been filed and

is complete uh, allow them to go into practice if ev--if everything is normal and the application looks okay. (Inaudible).

: Thank you very much.

CHAIRMAN : I understand Dr. Stasney--

STASNEY : One personal comment about that is, is uh, we uh, several years ago got some pressure from uh, a community to approve a doctor by reciprocity and uh, yeah--it, it's one of those things when I disagreed with the majority of the votes on the board on whether this doctor should have a license or not. Uh, and not to say that I wa--I was correct but this is what can happen by short circuiting the system, he went out to this very under served community and uh, did the best uh, parts of medical care and was unwilling to do the worst parts. He would not see the indigent community, he did not want to work in the jail uh and, basically that community was very poorly served by this doctor and uh, so I, I think our process even though sometimes it's cumbersome, the checks and balances there really protect the consumers. And, and I get frustrated with it too as we, gosh, I mean my home town's needed a doctor for years up in North Central Texas. And uh, we're desperately crying out for a doctor but uh, sometimes no doctor's better than the wrong doctor.

HILLIARD : Yes. Understand that we making a real effort to make sure that the under served areas and rural areas, inner-city areas get the same quality of care as those \_\_\_\_\_ River Oaks in Houston. Want to make sure there's no difference in quality of care just because they're rural we don't want to give them a bad doctor.

CHAIRMAN : That's excellent. Any other questions?  
: Go ahead.

CHAIRMAN : Senator Johnson.

JOHNSON : In the legislation that was passed where originally it's presented where the uh, rural physicians would not have liability and it ended up being an indemnification uh, in your opinion would that tend to attract uh, those physicians that uh, that might very well not be the be--best practitioners?

: (Inaudible).

JOHNSON : I mean if they were completely uh, exonerated from liability although the bill was changed some.

HILLIARD : Yeah I don't this would be an exonerated of liability totally, I think that if, if a doctor you know does (create) a, a negligent injury to the patient he ought to, he or she ought to be accountable for that. But you know, what has happened there been so many uh, \_\_\_\_\_ claims, so many frivolous claims, so many other claims and it has driven insurance rates so high which it makes them unable to pay the \_\_\_\_\_ . There are many doctors that don't, who can't make large sums of money in rural areas because the economy is \_\_\_\_\_, if you charge (full) amount of money they could charge the same amount of money for malpractice insurance as a person in, in Dallas and San Antonio perhaps and uh, that discourages from going there you know so - -

JOHNSON : If, according to some of the testimony we've heard it's only about 10 or 15 percent of the physicians that uh, cause the problem in ma--malpractice. And many opinions exist that if there were more actions taken to insure that those were weeded out, you would solve much of your own problem. What is your opinion?

HILLIARD : I think we'd improve it, it would (influence) the problem somewhat.

JOHNSON : Well why don't you do it?  
: Senator Johnson?

JOHNSON : Yes.  
: I think one of the things uh, the  
shoulder should lay on the medical schools. And we visit the  
medical schools and talk to them and encourage them to uh, do  
this sort of uh, role play with their students and teach them  
that can. Some people you can't teach at all--

JOHNSON : --Uh huh--  
: --to uh--

JOHNSON : --And there ought to be a limit, if you  
can't teach--  
: --That's right. So I, I really uh, I  
do think the burden does fall on us after that time that they are  
licensed but, until that time I think part of it should lay in  
the medical schools and they, I'm sure they try but they could  
try harder I think.

JOHNSON : Uh huh.

JENKINS : I, I live in a rural area and I think  
one of the \_\_\_\_\_ that probably--(inaudible). In a small  
town I don't care how bad a doctor is he's--(inaudible). And  
it's kind of hard on us sometimes in the police chief for sheriff  
and everybody. When they're sick, oh we need him bad he's  
\_\_\_\_\_ doctor and everything and--(inaudible).

JOHNSON : But don't you as a board have the  
authority to uh, promulgate some kind of rules and guidelines  
that would govern some standards in those areas.

JENKINS : It's, you know, they see \_\_\_\_\_  
different complications and, and what does--I think we're just as  
tough on them when we get the complaints. We don't go out and  
investigate people that we have not got a complaint on.  
(Inaudible).

JOHNSON : And I'm not talking about individuals,  
I'm talking about standards of practice. For example uh, the  
medical profession is one of the few professions that have no  
requirements for continuing education and yet changes take place  
every day.  
: Well but--

JENKINS : We just finished studying that and, and  
the board has come to the consensus after hearing a lot of  
experts and, and after really looking this issue is that A, it  
would be a very costly thing to keep track of those hours for  
40,000 licensees--

JOHNSON : It's more costly than how many lives  
they might be subjecting to danger.

JENKINS : Well, well now I'll finish--if we,  
we're on a limited budget if, if you were to say \_\_\_\_\_  
we want (C and E) and here's two million dollars to, to  
carry it out and (reap) the fines. But if we get C and E's and  
then we only get fifty thousand funded to take care of it, we're  
gonna be end up pulling that money out of investigative things  
and I think that we are--right now doing uh, just the honor  
system check off on C and E's. And, and all the expert  
testimony, our records, our talks with people that we discipline,  
that is a small problem with a small number of physicians, okay.  
The amount of money--

JOHNSON : --Your problems are with a small number  
of physicians.

JENKINS : Right. But the amount of money it  
takes to do the C and E on those people and what you really need  
to be doing is looking at the medical care they're giving.  
Because that's where--I don't believe Senator Johnson, after  
having been to federal court more than once and district court  
more than once with this board on some of the most horrendous  
patient care cases I've ever seen, and losing, that the courts

will ever uphold us for taking a doctor's license away for lack of C and E. The courts are upholding--

JOHNSON : --No--

JENKINS : --for, for five or six patients. There is not--(inaudible).

JOHNSON : --Right but, you know that is not the reason you would do C and E. The requirement for C and E is not so you can take their license, it is so that they can be more competent and up to date.

JENKINS : And good doctors already do that and the requirement would not change for the good doctors--

JOHNSON : --But we, and I'm not trying to punish anybody and, and the good doctors we're not worried about. We worry about those that's gonna come before you in another fashion. But if they are armed with more information, you might be able to cut some of that.

JENKINS : If they answer no on that form they get a letter from us saying, this you--it's not a requirement however you need to know, and they get the sermon on it--(verbiage lost due to changing of the tape).

END OF TAPE

TEXAS SENATE STAFF SERVICES  
jf07-13-90  
HEALTH AND HUMAN SERVICES  
JUNE 27, 1990  
TAPE 2

1

JOHNSON : -- in certain number.  
JENKINS : and, and you got --  
JOHNSON : -- you still got to send a letter,  
right if they don't --  
JENKINS : You're talking about probably about  
120 to 150 thousand pieces of paper coming in to the agency and  
that's a tremendous --  
JOHNSON : That comes there anyway, doesn't it?  
JENKINS : Don't know.  
JOHNSON : They don't renew their license?  
JENKINS : I mean, if you, I've looked at the  
budgets on different states and, and the state bar on what they  
do and you also have to decided where you're going to make get  
CME, I mean the bar has it, and as far as I'm concern, it's  
window dressing. I mean, my apologizes to legal profession but  
they can be practicing out before our board and if they don't  
have enough hours, they can run down the courthouse and take a  
course on DWI and their license is in good shape. I mean it's  
just window dressing.  
JOHNSON : Well, ah, --  
JENKINS : (Inaudible), the doctors should go  
(inaudible).  
JOHNSON : -- you know I am not all together so,  
it's sure is window dressing. Somebody went to Parkland Hospital  
for example, and did (grand round) and listen to latest  
techniques in something. I think that's better than nothing.  
JENKINS : That's right, and good doctors aren't  
doing that. Bad doctors, we've seen would just go to sign for  
the course and then, step out  
: Play golf ah, --  
JENKINS : -- they'd play golf or whatever. So,  
it wouldn't change the problem and you can spent an, an enormous  
am, amount of money in a limited budget situation on something  
like that, but the states that have adopted that, a lot of them  
have gone back on them. We have heard, or ask the board to  
create a committee because we are not, we're worried about these  
people because their knowledge is not up to par. In working, we,  
we've gotten new examinations for them to take, Hispanics to, to  
check them out if they come before us and, and we can't, there's,  
there needs to be a way to check them out but we don't think  
mandatory CME is the answer, --  
JOHNSON : What?  
JENKINS : -- considering the moment situation.  
JOHNSON : What, what, what would you recommend?  
I mean whatever you could, whatever you recommend if you have the  
power to put it into force.  
JENKINS : (inaudible) I'd if, if I could, if  
you'd give me all the money in the world, I'd say have mandatory  
CME will keep up with that and give everybody a test a every  
seven years --  
JOHNSON : Okay.  
JENKINS : -- in their speciality.  
JOHNSON : I hear you, I hear you --  
JENKINS : But that's not --  
JOHNSON : -- but you said I don't think that is  
the answer, and I'm asking what do you consider to be an  
acceptable approach to it?  
JENKINS : The way we're doing it now.  
JOHNSON : The what?  
: If I might respond ah, I think --

JOHNSON : Sure.  
: -- we have some answers for that.  
Over two-thirds of all of the fields of medicine now require re-certification. That's not CME, in order to do that, they have get CME or continuing medical education.

JOHNSON : Um-hum.  
: Continuing medical education as it is now, as Ms. Jenkins has pointed out with the bar, doesn't always achieve what it's suppose to achieve, but re-certification taking an examination every seven to ten years would --

JOHNSON : Okay.  
: -- and that's in place now for over two-thirds of all of the fields of medicine, that's even better than CME.

JOHNSON : Okay.  
: We do, the Board does have the power to require in our discipline, continuing medical education courses which we can ah, require be specifically design for that person's needs and we do require that now in a number of our disciplinary cases.

JOHNSON : Uh-um.  
: So we do achieve it.  
JOHNSON : Okay, that's in, I like that re-certification now, that is design for whom? The specialties.  
: That's design for the family practitioners all through all the specialties.

JOHNSON : Every specialty, general practitioner  
\_\_\_\_\_.  
: Two-thirds of the specialties that exist, including family practicing.

JOHNSON : So that's every practicing physician, every practicing physician then is required.  
: That's right.

: Alright, listen to this, that's required, of the, the new one, those who have been in, in ah, 65 years of age are going to retire in five years, is not, is not, and it is not, in fact will not be require the exam.

JOHNSON : Even though they're are the ones that need it worst, it's not require of them.  
: Ah, but that varies from board to board, that, that's not across the board. That's in obstetrics, I believe, isn't it?

: Well, some of the others (inaudible), the new persons all have to take it, and the board and that board certified for license was certified for seven years and in seven years you must re-certify to every seven years \_\_\_\_\_ license.

JOHNSON : Okay, and that, that certification process is fairly new, I understand?

: Yes.  
JOHNSON : Okay  
JENKINS : Well a lot of the problems, you'll see a really smart (inaudible), it's not like knowledge that's causing the problem.

JOHNSON : Oh, --  
: You know?  
JOHNSON : -- yeah up --  
JENKINS : And they're a lot more frightening than the ones (inaudible), the ones that really knew what they were doing to begin with.

JOHNSON : Well.  
: CME wouldn't fix that problem, and we're afraid it would take away from out budget in, in areas (inaudible).

: CME is (inaudible)

JOHNSON : Well, maybe the re-certification is just ah, a different approach but it, (Overlapping Voices) but as you say, accomplish the same thing you're, --  
: -- it's apparently different approach and a much more superior approach --

JOHNSON : -- yes.  
: -- than CME.  
: We think it's going to be the new thing, I don't think you'll see many states going to mandatory CME, I think it's just been this \_\_\_\_\_ across the nation.

: That's correct.  
JOHNSON : Well the re-certification sounds superior to that anyway, but I think that the bottom line is it's, it's a review, a requirement of a review of techniques and updating --

: Updating knowledge.  
JOHNSON : -- of knowledge.  
CHAIRMAN : Any further questions Senator Johnson?  
JOHNSON : Not at this time.  
CHAIRMAN : Any other comments or statement from the board?

JOHNSON : Not until the next statement, no.

JENKINS : I've got a little bit more. Ah, I, I think one thing before we leave here that I, y'all should look at it is our rate of dismissals has gone up. Ah, I've been on this board since January 1984, and I don't intend to be re-appointed again if my mother were to be elected Governor next year, so this hopefully my last Health and Human Services meeting. But I've been here a lots, and complained a lots ah, I, I'm appreciative for the help we've gotten. There has been a lot of money thrown at this agency that did a whole heck of a lot of good. I think six years ago, the what was the re-newality, thirty-six dollars when Bob and I came on, it's now over a hundred dollars, agency, it's expanded to four or five attorneys on staff as to compared one part-time attorney when we came on ah, it's a different agency. Ah, if you'll look at numbers though the, the number of dismissals in relation to the number of disciplinary actions has risen drastically in the last couple of years. And I fear that it's more lenient board. I think that, that you all have to realize that in a small licensing agency with just a handful of employees and, and a quasi judicial body that those 15 people that serve on that board are the ones that, they're going to be making the decisions. I've been in this room and out there on the Floor frequently when attorneys brought in, new executives director brought in and everybody yanks their chains and the ah, and everybody is suppose to go home and think it's gonna work, it won't work. It's those 15 people that are accountable and if they aren't making good decisions and if they're not doing the right thing, nothing else works, money's no help, the staff is no help, the Medical Practice Act is no help, it has to be those people doing it and, and, I've got numbers here for you on, on the number of dismissals that another board member worked up not in anticipation of y'all's hearing but because ah, the inspector general recently released some stuff that said medical boards now have more money and are doing their job better but they're still kinda lacks on disciplinary things and I think we see that and we do see a lack of performance of actions by, by the individual board members. I don't think it means a written set of standards, I think it means board members understanding that they have to be fair, that they can't yank one guy around one day and the next day let another walk out the door because --

JOHNSON : And that's what's happening I mean, --

JENKINS : -- they don't like, he was wearing a different color of suit or something.

JOHNSON : -- the records reflexes it, politically.

JENKINS : It has to be some just plain of fairness involve and I'm not sure that's happening. Ah, the number of dismissals in 1980, Fiscal Year 1986 as compared to the disciplinary actions recommended was 19 percent, in 87, it was 13 percent, in 1988, it 44 percent, in 1989 it was 53 percent and this year it's been 41 percent and that concerns me a lot. It concerns me the cases that are being dismiss that ah, probably should not be. It's, it's, we always come over here and we talk about one individual case that, that somebody has and I understand y'all because you hear from your constituents and you want to do that case, but please understand that it's the way that board acts, day in and day out that causes those individual horror stories to come popping out of that agency and, and that's what not changed. The public information that, Dr. Stassney, he's already gone to airport, he started off as ah, Chairman of Public Information and, and was removed. He had some wonderful ideas and we're not doing our job, I still say I can walk all day in my home county except my close friends wouldn't even know that there is a Board of Medical Examiners, and I think it's, it's very important that we get that word out to the public. If, if you see a month-to-month flow chart on the hot-line, every time the Chronicle or the Dallas Morning News or somebody writes a story about us, it goes whooop and it comes back down again because they find out there is a board, and, and they don't know there is one and I think that's one of our missions just as much as licensing and discipline is, is telling people we in fact exist. Ah, --

JOHNSON : And then telling them when they need to be involve.

JENKINS : -- right, but, but there needs to be a continuity out at the board, there needs to be a sense of what's going on all along I think, because there's some of us that remember how bad it was and saw those boxes stacked to the ceiling with cases that hadn't been investigated for the last ten years, and I really fear that can come back again if everybody doesn't understand what happened the first time.

JOHNSON : There is a general feeling that deterioration has setting in since the change came about.

JENKINS : Well, I'm worried about it, I really am and, and it's ah, I, I don't know what can be done. I also have another letter for you from the Chairman of DPRC where three board members questioned dismal and instead of them investigating the doctor further and ah, trying to address the problem in question, they in fact wrote us a letter and told us that we would be liable to harassment suit if we continue to raise questions. That's the first time in seven years of being on the board that I've ever been told that.

JOHNSON : And you were told that by whom?

JENKINS : By the Chairman of Disciplinary Process Review Committee. I brought the letter to you, I have block out patient's name and doctor's name.

CLERK : Cindy can we make copies of those please?

JENKINS : Ah, I, I, really think that board members despite which governor appointed them or which political party they are involve in, walk out that door with the same amount of power they walk in, and just because a new majority walks into the agency, doesn't mean that certain board members have certain, suddenly loss any right to question that they may have and there seems to be a feeling out there that if we question something that we're part of the minority that you just need to shut up and go home, that we're not part of the situation

anymore. That letter is very frightening, I mean I'm not going to put my family and myself under personal liability, I won't be questioning dismissal anymore if I'm going to keep getting letters like that. I don't intend to, to get sued everyday because board members are releasing what's going on out there in investigations. But that's the first time I've seeing anything like that and, and I think it is an alarming situation, I really do, but is the board responsible.

JOHNSON : Do you have a standard of conduct for the board?

JENKINS : No.

JOHNSON : So, even though you have confidential matters otherwise and that sort of thing, you don't have any standards for yourselves.

JENKINS : Well, after I talked to the press one time, they did pass a resolution saying that only the executive director could talk to the press.

: (LAUGHTER)

JOHNSON : Ah, is there ever a time when special investigators or prosecutors whatever are brought in for complicated cases ah, ah, are they just handle routinely any --

JENKINS : A lot of times our, our experts I think that Paul may go into this further, but our expert service as much as is investigators panel will say, well if, if they had this \_\_\_\_\_ complication, we need to go get this blood test and this one and this one and, and they've become like an investigator to us because they know the case a lot better than we do. Like this plastic surgery case or something that, that or if something isn't liver, heart liver transplant, and we would the, the doctor serving as the expert for us would actually serve I think and I think you can probably use that term would be a special investigator, he would steer us in that direction. I think probably the, the cases on ah, sexual abuse that we're eventually going to have to get investigator that's trained ah,

JOHNSON : What is your special, what is the background of the attorneys that you have?

JENKINS : Ah, most of them have worked in other agencies. I believe all of them have worked in other state agencies --

JOHNSON : I mean was any of any speciality in particular areas?

JENKINS : Paul (inaudible)

: Ah, well some administrative law, health law, open records, open meetings was the requirement and litigation. Ah, we have ah, several hearings going on they're essentially a trial before court a bench trial, so they have to have experience in evidence, litigation, administrative law, Medical Practice Act, health law.

JOHNSON : When you have case where it might be a possibility of ah, having to look at ah, tissue and internal changes on a patient to determine the outcome on something ah, do you have that expertise?

: We don't have them as an employee, we have them as consultants either ah, ah, --

JOHNSON : So you can bring in a special --

: -- yes madam ah, medical examiners from different ah, pathologists from, from different areas, either from the medical schools or from universities. We have sixtyish ah, persons we go to a fairly occurring basis but, occasionally, we would need someone who's very, very ah, narrow specialist and we may then have to go find that particular person to tell us ah, for example up until recently, we didn't have an ophthalmologist on the Board, we had an ophthalmologist case and

we had to hire an ophthalmologist to interpret to our board member.

: We also formally had special prosecutor who in my judgement was excellent and, and the Attorney General ruled he could not even serve us in this area because ah, he also served as a lobbyist for another organization and, \_\_\_\_\_ that, that doesn't mean ah, special prosecutor ah, that he, his, his field of expertise is health care law ---

JOHNSON : We don't have but one in the state?  
: No, ah, we can, the others, are here, but they generally represent physicians ah, who come before the board, as they get more lucrative you know than ah, representing the board and, and it, it kinda needs to be somebody in Austin I think that's readily available in for conference and ---.

JOHNSON : How do you go about finding, do you ah, advertise if you ah, need a consultation or ah, or you just hear about somebody?

: Medical, legal or medical consultant?  
JOHNSON : Legal.  
: Ah, we rely upon the adj--, the (inaudible) or the board or Attorney General's office.

: And it's posted at the ah, Texas Employment Commission or the Governor's Office which ever one. They're, they're posted in the routine manner, the job openings.

JOHNSON : Uh-um. I wasn't talking about the, the full-time employees.

: Consultants, yeah.  
: You're talking about consultants?  
JOHNSON : Um-um, when you said one person ah, but you lost and that was so good and, and I just wondered if there's a possibility of having a second one in the state, just as good if they knew that you looking for them.

JENKINS : (Not speaking into mic.)

JOHNSON : Yeah. Ah, in, do you perceive that as being a problem now. I mean is that a handicap, the board is dealing with?

JENKINS : What's that? \_\_\_\_\_ prosecutors like that?

: (Overlapping Voices)  
JENKINS : Ah, I'm not always happy with the job the hearings examiners are, but I don't think the law would allow us to ever give them any guidance. We just have to look at you know, have good judgement \_\_\_\_\_.

JOHNSON : What, what is the basic requirements for that ah, background?

JENKINS : A Hearing Examiner?  
: In experience in administrative law ah, in evidence ah, some litigation, the Medical Practice Act they usually read, they can learn that. Ah, I think now, almost all the ones that we've used went, just completed a recent week long ah, seminar for hearing examiners at the University of Texas ah, I think a couple of three of them are board certified in, in different areas of ah, law and they apply, they're interviewed, we check ah, their resume, check the references, they're brought in and meet with the ah, staff and meet with the board members and then when they're appointed ah, when you assign them ah, fairly straight forward simple cases to begin with and then, and then work them up. Ah, and I think that the ah, full board is fairly satisfied with the five or six that we use, and they, they are independent. Ah, just because the fact that we want to be able to go into court and say that we are not ever tried to influence their ah, decisions.

JOHNSON : Ah, is Mr. Guy (Edena), or whatever?



JOHNSON : But, you're depending on both sides of that question presenting to those people.

: In, in almost every case we have had both sides. The only time we have not had, had both sides --

JOHNSON : In almost every case.

: -- I'm going to tell you, the only exception is when the, the physician was a fugitive from justice. There are only two sides in this case, the Board Medical Examiner, and the, and the subject physician, those are the only two sides. The side you're talking about --

JOHNSON : So a person that's been injured is not a side, they don't have a right?

: -- they're not a party to your, not a party under Administrative Procedure Act, they're not a party.

JOHNSON : So the injured, the victim has no right.

: The injured party has recourse through the courts for malpractice like anybody else does. We do not represent that person, we represent the 18 or 20 million people in the State of Texas, but it's similar to criminal cases brought by the DA, State of Texas, and, and, if you've been, if you've been injured in criminal as a part of a criminal, act then you're free to go seek recourse in the courts, (inaudible).

JOHNSON : Um-um, and if that person has been into court and the court has rendered a judgement, and the judgement is against the person and then that person is having their credentials checked, this is hypothetical ah, does that make a difference in your review?

: We have had physicians in for informal self --

JOHNSON : I mean that's a yes or no question Mr. \_\_\_\_\_.

: If there has been a case settle against a physician?

JOHNSON : Yes.

: \_\_\_\_\_ judgement, and the amount or whether it's, --

: Sure that was --

JOHNSON : It doesn't make any difference what amount, if they found the, the ah, the ah, the practicing physician --

: -- yes --

JOHNSON : -- to be negligence --

: -- yes --

JOHNSON : -- does that have impact on your decisions?

: Yes, but it's not conclusive.

: -- yeah, that would be one piece of evidence, yes. --- Answer is yes.

JOHNSON : But, it doesn't necessarily have to have any effect on it?

: Doesn't automatically makes us decide one way, yeah.

JOHNSON : Sure.

: The answer is yes.

JOHNSON : Okay.

JENKINS : Senator Johnson, on the hearing examiners they've been very helpful as far as the, the first year Bob and I were on board, the legislature did not allow us to use a hearing examiners and they use to, I mean, the first case I heard took 13 days to hear one case and 15 board members. Well, it's real obvious looking at that that we're not going to disciplinary many doctors if we do it that way. So, it's, it's essential that we (leave) it with hearing examiners but the, the

board certainly has to look sharp, real closely at whatever the hearing say and recommend and it help, it's also very important and, and if we had a staff attorney who we didn't think was, was presenting enough evidence for his side of the case, I had the feeling he wouldn't last very long. Ah, you know, we, we were getting, we would know at that hearing that somebody didn't do their job if it wasn't prosecuted properly, we would say well where, where is the medical records on this and the hearing examiner said nobody presented them then I would expect that our executive director needed to talk to that attorney pretty fast. So ---

JOHNSON : Um-um.  
JENKINS : -- it, it works in the end.  
JOHNSON : Um-um.  
JENKINS : And, and the board does have ---.  
JOHNSON : I hope this works in the end because this certainly isn't. Thank you.

: Thank you very much.  
CHAIRMAN : Thank y'all very much. We appreciate y'all's ah, attendance, appearance and certainly your testimony Dr. Goehrs, Dr. Hilliard, Ms. Angelo and Ms. Jenkins, thank you very much. Senator Brooks had a previous commitment, he had to leave. It is the chair's intention to work through the noon hour and perhaps work to about two thirty, three o'clock, if necessary. In the interest of time, if there are people before you have testified and we have perhaps ah, four witnesses ah, those who have testified before you, if they have stated something, please do not repeat it in the interest of time. The chair doesn't, certainly doesn't want to limit anyone's testimony unless it becomes necessary, so we'll work through the noon hour, probably work until about two thirty if necessary and ah, certainly we welcome your testimony. Those of you who have signed your witness registration cards, I'll be calling you perhaps in that order. Those who wish to testify and have not sign your registration card, please do so before you do testify. At this --

JOHNSON : Where are we on the agenda?  
CLERK : Public testimony.  
CHAIRMAN : Public testimony.  
JOHNSON : Oh, I missed the auditor's report.

What did they, what was the outcome of that? Are they going to be --- taking any action on it?

CHAIRMAN : No, any --  
: (Overlapping voices)  
: In the packet that was given to you, the written response to ah, auditor's report. (Inaudible)

JOHNSON : Okay, I just got their packet this morning, so I've been asking questions, I haven't had time to read it but I did read the auditor's report.

: Ah, I think Dr. Goehrs explained earlier that ah, I forget how many recommendations there were but everyone has, had been implemented, some of them were implemented even before the auditors report came out. The only one that's not been implemented is the one that is the legal question that we have to pick up from the Attorney General or the Legislature and it has an interpretation of both the clients. But as far as the security and integrity of, of ah, funds, accounting controls, some of those we did last December.

JOHNSON : Okay.

: And we just recently were re-audited on a regular audit, excuse me, they found no discrepancies - no, no, ah ----.

JOHNSON : What has been the outcome of those persons who were cited in that report?



the ah, case to be this weak that that's going to be dismissed when it comes down to the board. The TOMA feels that there should be more infiltrating investigations done. In other words, undercover investigations, where the investigator has personal knowledge, but yes the doctor is non therapeutically prescribing for a non medical need, -- and that then, the physician brought in the informal settlement conference. These are just suggestions that the TOMA had and ask me to bring ah, to present. With regards to future legislation, last year the TOMA presented to the 71st Legislature a proposed amendment to Article 4495 b, of Section 506, to clarify that an impaired physician's committee has set out in sub part E of that article is a peer review committee. What happen on this is that, there was a case where the records of the committee, of the TOMA, on a impaired physician was subpoena into district court and we went to court to, request a protective order of those records as confidential under Section 506 of the Act. The district judge after hearing the testimony, ruled that because of Section E, making an exception on the impaired physician's committee of a state association reporting to the Board of Medical Examiners, that took them out of being a peer review committee, and therefore their records were not protected under that Act. However, he did rule under old 4447 d, that the records of the committee being records of the association were protected, it did protect the records of the committee. So ah, --

JOHNSON : Sir, now would you repeat that.  
Repeat what you just said now.

SORTORE : The, the judge ruled that, that exception of a physicians, impaired physicians committee in Section E of ah, Section 5.06 among the Medical Practice Act, took the impaired physicians committee out of being defined as a peer review committee.

JOHNSON : Um-um.

SORTORE : And therefore the records did not fall as being confidential records of a peer review committee, however, he turned around and under Article 4447 d, it's been on the books for several years, he did protect the records of the committee as ah, records of the association and kept them confidential under that. Also, the TOMA is going to support legislation that Senator Brooks introduced last year to make ah, complaints where there is no basis of a violation found of the State Board ah, that is made to the State Board of Medical Examiners confidential. Again, presently the law requires that if a health care entity inquires to the Board of Medical Examiners, they've got to report every complaint since the doctor was licensed, regardless if there was a basis or not. And from my experience with the board, many complaints came in that it was just somebody a little upset with the doctor and they're making some type of a complaint. There's really no violation of the Medical Practice Act that no basis for that complaint, and ah, that TMOA will be supporting legislation again to correct that and make ah, dis-- any disciplinary action a public record. But that if it is merely a complaint that has been made to the Board and the Board has investigated it and found no violation of the Medical Practice Act, that that type of complaint would remain confidential and not have to be reported to a hospital where the doctor was applying for staff privileges or whatever. Presently, I understand the Board makes the report with a comment that they've investigated that they found no violation, but that still leaves a little cloud there that should not be against ah, the physician. Also, ah, within the Medical Practice Act in Section 1.02 and 9, it defines that a hospital shall not discriminate based upon acad-- on the academic medical degree. However, several hospitals are requiring AMA Board Certification in a

speciality for hospital staff privileges which the TOMA feels is discriminating against the Osteopathic physician who may be board certified by an AOA Speciality Board. We're going to be asking the Legislature in the next session to amend Article 4437 f and 5547, which is the Hospital Licensing Laws, to eliminate this possible discrimination where it's worded that they'll accept board certification by either the AMA or the AOA. With regards to the subjects that I've discussed with, in behalf of the TOMA, ah, the committee will be furnish a letter expanding on this testimony within the next few days. Now, I have a couple of personal observations as a citizen and as a former member of the staff of the Texas State Board of Medical Examiners, presently retired, that I would like to make. The Healing Arts Identification Act, Article 4590 e, requires a person using the title doctor, to show for what means he is entitle to do so, as specified in the act. The enforcement section states, that if a doctor does not do this, that the licensing board, one of the licensing board specified in Section 3, will ah, contact the county or district attorney, the county where the incident occur and file a complaint. It does not allow anybody but the ah, licensing board to do this. Ah, I feel that this needs to be amended where a citizen could go in and ah, file a complaint with the county attorney where a doctor is not showing and this can be any type of a doctor, a dentist, chiropractor, osteopathic, M.D., if he is not showing by what, it means he's entitle to be called doctor. Now, if the law is not going to be enforced, why do we have, it needs to be taken off the books if it's not going to be enforce and ah, but we're finding more and more doctors and I know several of our osteopathic physicians who are just showing that they're Dr. Joe Jones, they're now showing by what means they're entitle to be call doctor. Ah, when you talk to them about this, why I'm in a medical office building and I'm the only DO, everybody else is an MD. So ah, I just show that I'm a doctor. Ah, to me this is ah, fraud and deceit to the public, it should be corrected. The, the second thing that I feel needs to be directed, is the unlicensed practice of medicine. Years ago when I started with the board in the nineteen sixties, the first and a half I was with the Board, one other investigator and I, made 70 cases of practicing medicine without a license across the state. At that time it was the policy of the board that the investigators because they had the expertise in investigating the practice of medicine without a license and what constituted the practice of medicine. They conducted the investigation, then presented the case to the local county attorney, these types of investigations take maybe three or four hours, to run in undercover on a person that is suposely is practicing medicine. Ah, now is my understanding that the board does not investigate quackery that they merely tell the complainant when they call in or write in that they have to take it to the local county prosecutor. And I, and I feel the board's investigators are the ones that had the expertise to investigate practicing without a license and should conduct the investigation, then present their cases to the local prosecuting attorney under Section 2.09 f of the Medical Practice Act and assist in the ah, prosecution. Recently and I'm sure Mr. Gavia has turned it over to the ah, Attorney General, but recently we had a section in the Fort Worth Star Telegram every Monday that is call Health Talk, every week there is an article in here on medical prevention by a lady up in Decatur, Texas that list herself as an MD, which is a naturopathic doctor. Ah, the Attorney General of the State of Texas in 1956 declared that the statute on naturopathic doctors was unconstitutional. This was upheld in 1958 by the Supreme Court, and many cases since then have been file against people calling themselves naturopathic doctors in the State of Texas,

and I just brought this along as one example of people practicing and stating right in the article that they're practicing medicine. I would like to leave this with you if I may, and then --

JOHNSON : I'm trying, in, in following your testimony ah, you have a point there but you, you're saying that that is under the jurisdiction of this medical board, examiners board, I would not, yours is, is --

SORTORE : Is the medical practitioner --

JOHNSON : -- medical practitioner \_\_\_\_.

SORTORE : -- states that the medical board will assist the local county prosecutors in enforcing the unlawful practice of medicine part of the law.

JOHNSON : Um-um.

SORTORE : Mr. Gavia can probably expand on that.

JOHNSON : And they can verify whether or not they are MDs or DOs or whatever?

SORTORE : That's correct, that's correct.

: We always assist law enforcement agencies when requested to do so.

JOHNSON : But you would not, you would not have the jurisdiction of ah, investigating anyone other than ah, an MD or a DO?

SORTORE : We always did under the ah, prior executive directors and secretaries of the Board, yes.

JOHNSON : Just, the immediate past executive director?

SORTORE : Not the immediately past executive director, but under Doctor M. H. (Crab) and Dr. (A. Bryant Spier). The board investigators investigated all complaints of practicing medicine without a license.

JOHNSON : Well and I, I think probably generally speaking that is, that is ah, is being done now but they determine whether or not, if they're not an MD or a DO, then it moves to another arena, it seems to me, --

SORTORE : That's correct.

JOHNSON : -- okay, so that is, --

SORTORE : But the other, --

JOHNSON : -- that is that responsibility of the board to determine whether they're one or the other. If they're not, then they moves some place else, if they are doing something out of the order, it seems to me.

SORTORE : But, but why is the definition then of the practice, what constitutes the practice of medicine or the unlawful practice of medicine in the Medical Practice Act?

JOHNSON : I hear what you're saying but what I, I'm not sure that I'm making myself clear. You are the, the Board of Medical Examiners, okay. If someone is practicing medicine without a license, that is not this board's responsibility, that becomes the court's responsibility or the Attorney General.

SORTORE : That is correct.

JOHNSON : But if it's an MD or DO that's having difficulty, it seems to me it's in the jurisdiction of this board, but it is not one of those, it is not in that jurisdiction.

SORTORE : Senator I, I cannot agree with you on that from my past experience with the Board because the medical --

JOHNSON : Well, now past experiences are not necessarily law.

SORTORE : -- right.

: (Laughter)

SORTORE : The, the, the ah, Medical Practice Act states if I may in ah, Section L, the Board shall be represented in court proceedings by the Attorney General, this is any appeal of a license fee, that a license fee or MD makes in court, the Attorney General represents them in that. The Board and the employees of the Board shall assist the local prosecuting officers of any county in the enforcement of all laws of the state prohibiting unlawful practice of medicine.

JOHNSON : Yes sir, and, and I'm not disagreeing with you. I think where we are not seeing eye-to-eye is that in my judgement once the Board has verified that they are license or not license then they have cooperated. If they are, if they are license MD, or DO, they might have more to offer than if the person isn't. But because if it's a dentist, there is a Dental Examiner's Board, --

SORTORE : That's correct.

JOHNSON : -- this board would not be examining that dentist --

SORTORE : That's correct.

JOHNSON : -- nor would this board be examining nurses. There is a Nurse Examining Board.

SORTORE : That's, that, I agree with you on that.

JOHNSON : Okay.

SORTORE : There's boards --

JOHNSON : So therefore, they would not be ex-- ah, have jurisdiction over naturopathic and whatever kind of path's they call themselves out there unless they're MDs or DOs.

SORTORE : They would not jurisdiction other than to presenting the case to the county prosecutor.

JOHNSON : And they do that, cause they'll have a record of whether not they are license or not and they all, the only, the only jurisdiction is determine whether --- (Lost verbiage due to changing of tape)

(END OF SIDE 1)

JOHNSON : -- becomes that prosecutors responsibility.

SORTORE : That is true but your prosecutors don't have the investigative staffs with the expertise to investigate.

JOHNSON : Oh, yes they do. They got more than these Medical Examiners Board got. You come to Dallas, we've got 300 and some prosecutors.

: (Laughter)

JENKINS : The problem is, it's Class B, Class C misdemeanors and they don't want to fool with it and the reason we quit investigating those cases was our plate full with our own licensing \_\_\_\_\_ and we were spending enormous amount of time out investigating people, we couldn't take any action against. When we did refer to the prosecutor, he let it lapse because it was like a traffic ticket. So, I think it's, it's, I agree with you, it's not our deal, we'll be glad to find out if they're licensed and tell the prosecutor that this State has got a lot more to worry about than the unlicensed and practicing medicine, as far as what our responsibilities are that that y'all give us, that's what we worry about.

JOHNSON : We might need to tighten up something in terms of ah, a kind of sanctions if someone is doing certain things under the guise of practicing medicine when they're not --

SORTORE : I'm, I'm particularly talking about the ones, not the dentists, the chiropractors and these that there's ah, nurses there's another licensing board, these are ah,

once in a while you find one that gets out of their field. But, I'm talking about the person the --

JOHNSON : The frauds.

SORTORE : -- the frauds that are straight ah, off the street out here or like in the case of this one that I just gave you the newspaper article on, that list themselves as a naturopath when, when there's court cases in the State of Texas declaring that that's unconstitutional, and been declared unconstitutional and upheld by the Supreme Court that there's no such thing in the State of Texas and have them advertising themselves in treating people when they're not qualified.

JOHNSON : Well, we haven't legalize ignorance but its a lot of it out there, so.

SORTORE : Right, I agree. And this concludes my testimony.

CHAIRMAN : Thank you very much. Wellington Smith.

SMITH : My name is Wellington Smith and I'm President of the Texas Doctors Group, which is a physician recruiting organization. We've been recruiting physicians for other physicians, clinics and hospitals since 1975. I'm also a board certified attorney. I'm appearing before this committee today to state what any knowledgeable hospital or clinic administrator or any physician associate, or any physician trying to locate an associate can verify that is, that there's a shortage of primary care physicians in Texas. One only has to read medical publications that are widely available in any library such as the Journal of the American Medicine Association, so call JAMA, and the New England Journal of Medicine, Family Physician or Texas Medicine in the classified section to determine that there's more openings to primary care physicians than there are physicians available. In 1980, ah, GMENAC Committee, Graduate and Medical Education National Advisory Committee came out with a report in 1979 or 1980 and said there was going to be a plethora of physicians in 1990, we're going to have more physicians than we know what we're going to do with. Where do these physicians going to do? Where do those physicians? I want to know because as a physician recruiter, I can't find them. The reasons that there's still a shortage of physicians, including retirement, retirement of existing physicians, the dilemma with malpractice rates that ah, each member of the committee is well aware of, and unanticipated dilemma such as the AIDS epidemic have resulted in this gap not being filled by any new graduates. In the United States, only 11 percent of the nation's physicians are engage to family practice. As members of the Health and Human Services Committee, your conscious should be effective by the paucity of physicians and residency programs choosing family practice. The simple fact is, that the family practice openings are not being filled in the residency programs and for these reasons I support the McKinney Bill, I believe that's House Bill 18, to expose third year medical students to clerkships. This state has a big investment in these medical students, it's a small price for them to pay to serve those clerkships. A notorious bank robber, Willie (Sutton), was asked back in the 1930s, why did he rob banks? He replied, that's where the money is. Recently, I was told that over 50 percent of the major, of a major Texas medical schools graduate class had opted for anesthesiology, radiology, or emergency room medicine because that's where the money is. In addition to that, they know that in those particular specialities they aren't going to work 50 to 70 hours a week. When they're on they're on, and when they're off, there's no calling, there's no night call, so that's an easy choice for them to make. This committee can help the system provide more primary care

physicians through its mandate to the Texas State Board of Medical Examiners. Physicians in other states, Canada or countries, or other countries are reluctant to come to Texas because of the re-- licensing requirement of your own Texas State Board of Medical Examiners. The Texas State Board of Medical Examiners has the reputation compared to other states of having the most extensive licensure requirements of any states. Requirements which can take a season practitioner, I'm talking about a fellow 35 plus, from several months for sometime as long as a year to complete the application. What do you have to do to be a doctor? You have to pass a test. Where does the test come from? The test comes from the National Board of Medical Examiners in Philadelphia, Pennsylvania. Generally speaking, there's two kinds of test for a physician to be license in the United States. One test is the National Board of Medical Examiners examination which is prepared by the National Exam-- Examiners and the other is the (FLEX), whose corporate offices are up in Fort Worth now. The examinations for the MBME Exam and questions for the (FLEX) Exam are prepared by MBME and given to each one of these organizations to examine the physicians. In addition to that, just down the street from the National Board of Medical Examiners, there's another organization call the E-C-F-M-G, the Educational Commission on Foreign Medical Graduates. The Educational Commission on Foreign Medical Graduates makes certain that any foreign tranquisition who comes to the United States, is number one legitimate, is number two, a graduate of a reputable math, medical school and number three, passes an examination so that when they come to the United States for graduate medical education they're competent and they can speak English. Before, that individual can pass his ECFMG credentials, the ECFMG verifies the fact that he is who he is, he's not a criminal or an individual who's been convicted of a crime involving moral turpitude and that the dean of medical school verifies that this in fact that person. One requirement for getting a license in Texas is successful completion of the (FLEX) Examination -- in the last seven years and these are in their regulations right here or alternatively if you took the NBME Examination before 1978, you get a Texas license by reciprocity but if it was after 1978, an individual who has pass the NBME Examination has to pass, successfully complete component two of the (FLEX) Exam or B, the SPEX Exam, S-P-E-X for Special Purposes Examination. Texas is the only state in the United States that does not grant reciprocity for individuals who are applying for a license based upon successful completion of the MBME Examination. Such physicians seeking to practice in Texas, must now complete this SPEX Examination in addition to the MBME Examination or alternatively, if they're board certified board certification works, if it was in the last ten years, or they must be re-certified in order not to have to take the SPEX Exam or components due to the FLEX Exam. Now, Dr. Goehrs mention that two-thirds of the Specialty Examinations have re-certification procedures, but what about that other third. Is it fair when we're looking for doctors in Texas and there's an insatiable demand for them out in rural areas as well as in the ah, certain parts of the ah inter-cities. Say a radiologist where there isn't re-certification, I may be wrong on radiology but in one of, let's, let's assume for discussion purposes that it is radiology, this man is radiologist or this woman is a radiologist, why, why should the Board of Medical Examiners make him go back and take components two of the FLEX which may deal with dermato, everything from A to Z in medicine for alternatively SPEX Exam. As I stated for FLEX application for licensure by, by reciprocity, one must take SPEX if they have not been examine or re-certified in the last ten years. I think it

would be an interesting question for this committee to inquire as to how many physicians on our own Texas State Board of Medical Examiners could meet their own requirements for a Texas license without having to take an additional examination. Perhaps the committee should review the curriculum vita of each board members who is a physician to determine if anyone of these physicians could qualify for a Texas license by a reciprocity without having to take such exam. The need for primary care physicians throughout Texas is too important to be left to the members of the board to promulgate regulation, which they promulgate from time-to-time, which discourage physicians from other states from re-locating to Texas and I suggest a less restricting reciprocity regulation is one of the answers. In my opinion, such regulations as they relate to foreign medical graduates, graduates, or FMG as we call them in the business, discriminate unfairly against such graduates by requiring completion of a three year residency training in one speciality and successful completion of the FLEX Exam, before they can apply for a license by exam or reciprocity. The board should recognize that we now live in a global society and if one can pass the examination all U.S. citizens have to pass for licens-- licenser such as the FLEX Exam or the NBME Examination, that should be adequate for licenser purposes. Let me give you an example of some of the dilemmas that one has in trying to apply for Texas license and said, they, they say I give up. Ah, I have a gentlemen who is ah, a board certified Thoracic Surgeon, Vascular Surgeon in the United Kingdom. He went to the Mayo Clinic and did a two year fellowship, he got a Minnesota license, there's approximately 40 some odd states that this gentlemen can get a license but if he wants to come to Texas, since he is a foreign medical graduate and even though he's been doing Thoracic surgery for the last 12 years, he has to go back into a residency program, it's been difficult to get admission to because of the number of residencies slots that are available. The board in my opinion has a dilatory bureaucratic policy of not promptly processing applications of foreign medical graduates because they don't want any more foreign doctors in Texas. Let me give you another example, this doctor was a graduate of Columbia, he does an internship in Columbia, he does a residency in Columbia and comes to the United States and goes to Chicago. Not being able to get into a residency program immediately in Chicago as an obstetrician gynecologist, he did a six month clerkship in pediatrics and he did a sixth month clerkship in OB gyn. The hospital that he went to for this clerkship, the Norwegian American Hospital, had a certified program in family practice but not in pediatrics and not in the obstetrics, gynecology. This gentlemen then matriculated in the Cook County residency program in obstetrics, after four years there, he finish that, he became board certified, did another fellowship, had an Illinois license, wants to come to Texas. We apply for a Texas license and the Texas State Board Medical Examiners says no. You attended a clerkship that was not an accredited program. Well, after taking three months to get a meeting with the board, and meeting with the members of the board, I asked the board member, I said if he had done nothing and not attended those clerkships, that means that would've gotten a Texas license immediately and they said, that's right. I submit that if one is board certify in a particular speciality, has a license in another state, the board is wasting everybody's time about inquiring into a clerkship that ah, just happen to not be ah, an approve clerkship. What harm can come from that if he subsequently passes the FLEX and becomes board certified. Many physicians who apply for a Texas license are frustrated by the dilatory tactics of the Texas State Board of Medical Examiners and not given them full information as to

when they can take the Jurisprudence Examination. Oh, by the way I forgot to mention the Jurisprudence Examination, after, in connection with FLEX Exam or the MBME or the SPEX Exam, one also has to pass the Medical Jurisprudence Examination. The actual policy of the board is, that any time except the week of or the week before the FLEX Exam, one can come to the offices of the Texas State Board of Medical Examiners and sit for the Medical Jurisprudence Exam but they tell all of the physicians well, now you're going to have to wait until we have our regular licensor examination, which is in June, and then those results won't be, be out until September. Just another dilatory ah, tactic by the Texas State Board of Medical Examiners in discouraging doctors from coming to Texas. The requirements for licensor are outdated that are being used by the Texas State Board of Medical Examiners. There's a network through this flux and malpractice ah, networks where they can easily check on the credentials of doctors to make sure, number one, that they are who they are, and have (dropped mic) never been arrested for crime involving moral turpitude and that they have legitimate credentials. I mention earlier that the ECFMG checks these cren--, credentials one time and for any foreign medical graduate, not only do they have to have the dean of the medical school sign the ah, application for licensor as does every applicant, but the signature of the consul or embassy official in that country has to verify that, that signature. I've had a number of situations where that is not possible because of the absence of diplomatic relations with that country, and the Board of Medical Examiners will make one come back and explain this before they'll finally, reluctantly grant the, grant the license. I think this committee should make certain that anybody that's on the board, wants to be on the board. As an attorney who represents people who go before the board, you have a person's life and future sitting next to you, the board especially in cases involving foreign medical graduates, leave the room and you're sitting there talking to two or three people when a full committee has to vote on the future of this individual. They ought to be more accountable for their actions. Texas medicine in 1990, in a profile of Texas family practice ah, residency program, recognizes a primary care physician shortage, 93 counties for health manpower shortage areas in the state and 21 counties have partial shortages. The New York Times, in February of this year did a survey, and 40 percent of the doctors that they interviewed said, they wouldn't go back to medical school again, ladies and gentlemen we have a crisis on our hand. Nobody wants to become a doctor because number one, it's so hard to get into medical school and complete the curriculum but you haven't seen anything yes, yet because the rural shortage has continue. I've been recruiting doctors since 1975 and I can tell you right now without exception that the situation is worst now then it was in the late seventies. Your constituents want physicians to serve their needs, but these restricted regulations discourage physicians from re-locating to Texas to serve in these shortage areas. Instead of Black and White rules and regulations, the Board should its job to ascertain that any competent and knowledgeable specialist physician who has pass the FLEX Exam, can obtain a Texas license by reciprocity through a special panel that the board ought to set-up to evaluate his competence or if there's any questions regarding his competence. I'll give you another example, a gentlemen who is a world renown international orthopedics, number of patents that have been published and so on, appeared in New Orleans at the orthopedics surgery Conference ah, a few months back, wants to come to Texas, he has 12 years experience as an orthopedic surgeon, research and a, and a researcher. He wants to affiliate with somebody in, in ah, in San Antonio, he just,

who was also connected with the medical school. Again, this gentlemen who was board certified in England in order to get a Texas license will have to matriculate in a three year or four year residency training program in orthopedic and then pass the FLEX Exam. I think anybody that applies for a Texas license should be competent and should be examined. But for an individual of national and international renown, who is not going to be practicing obstetrics, he's not going to be in family practice, he's going to be in orthopedics. If he can pass the FLEX Exam, why shouldn't he have the ability to go through, go to a special panel, such it should be set-up by the Board of Medical Examiners and obtain a license in Texas, it'll take him several years to do that. This committee should address how their constituents are going to receive health care in smaller size towns throughout Texas. We all know, there's been 200 hospitals closed in the state in the last few years. Additional doctors in smaller towns are the only way to prevent additional hospitals from closing. Granted that there's a mal-distribution of physicians in the United States and as a recruiter, as I've told you, I think it's worst now then it was in the seventies. The board should re-- this committee should recognize that they can alleviate this problem by changing, by having the Texas State Board of Medical Examiners change their rules and regulations to provide avenues through which these well trained physicians who've pass the examination, and who have a license in other state can come to Texas and get a license and serve the needs of our, of our people. I submit the board should not permit unqualified physicians to practice medicine in Texas, however, through renewed peer review hearings more medical and graduates and older physicians from other states who are specialist should be permitted to obtained licensor under the new regulations the board could devise that are less restrictive. The free market system should dictate the availability of physicians, not the Texas State Board of Medical Examiners. I submit to you that the board should have regulations and encourage family practice, that's why your House Bill 18, should be successful. Perhaps the board should encourage programs where they could re-train specialist to go into family practice to solve this dilemma out in the country and in the inner cities. This crisis will get worst and I predicate ration health care will be in the United States within the next ten years. In absence of a user fee in any medical system that we have in the United States, such a system will be a disaster as it has been in the United Kingdom and in Canada. Texas has just experience an education dilemma in the Legislature as you're well aware of, and the board should recognize other industries in Texas rely on out-of-state graduates because Texas ranks 42nd in the country in granting of bachelor degrees, 29th in the county in doctoral degrees and 45th in the number of colleges and universities, -- we're going to have to get them more money. The University is going to be battling for more money next year to give their teachers raises. You get what you paid for, we gotta give the educators raises, you gotta give the teachers raises, you're going to give the Texas State Board of Medical Examiners more money for their examinations, for their examiners. I'm not questioning any of that, but we ought to have some type of vehicle that can take advantage of these physicians that are willing to come to Texas to serve the needs of Texans. It's doubtful that you will in the Legislature grant the money to change these embarrassing numbers or enlarge the medical schools, but these numbers are significant since Texas has one of the highest percentage of population under the age of 24 of any state. To find the needed positions Texas in my opinion will have to go out of the state if the problem is to have any chance of being resolve. The Board of Medical

Examiners and this committee should recognize that revised regulations to permit such physicians licensure in Texas would help in restructuring the health care system and provide primary health care to areas where doctors are needed. You members of the committee have any other questions, I'll be glad to answer those or work with their, their aids. Their wish is my command.

JOHNSON : I do have a question. Ah, I was trying to delineate whether you were speaking ah, just foreign graduates or any graduates outside the state?

SMITH : I'm speaking to any graduate outside of this state. If you passed and completed the National Board of Medical Examiners, examination after January 1978, and why did they do that? We weren't given any explanation on that in 1978. The board says, well wait a minute, the FLEX Exam is more comprehensive than the National Board of Medical Examiners examination. The National Board of Medical Examiners wrote the FLEX Exam, they also administered the MBME Examination, the National Board of Medical Examiners also administered the examinations for all the foreign medical graduates. Any foreign medical graduate coming to United States with graduate medical education, here we go on alphabetic again, must first complete the FM GEMS Examination, the Foreign Medical Graduate Examination of the Medical Sciences. Since 1983, there is no longer an ECFMG Certificate, they ascertain number one in this two day examination that they have the didactic work in medical school to be competent to come here for training, that they can speak English, and they're given that certificate ah, from the ECFMG stating that they pass that examination. For the first time this last year, foreign medical graduates can take MBME Examination but even, remember this, even if one, say in England or South Africa or Ireland passes the MB Exam, MBME Examination there, if they want to come to Texas, well, they can take component two of the FLEX or the SPEX. Texas is the only state that does not recognize the MBME Examination by reciprocity.

JOHNSON : Ah, ah, I'm looking at the statute here and ah, under Section 3.03, and ah, it says the board is the sole descretion upon payment by an applicant of a fee prescribe by the board on his acts may grant a license to practice medicine to any reputable physician with a graduate of a reputable medical college who is a licensee of another state or Canadian committee province having requirements for physician registration and practice substantially equivalent to those establish by the laws of this state, or is qualified by examination for certificate to practice medicine under a condition and, and former services of the United States. Then as I skip down, this is in addition to the requirements of this section, the board may require applicants to comply with other requirements that the board considers appropriate and I guess that's where the (inaudible).

SMITH : Those are the regulations that I was trying to explain through the alphabet.

JOHNSON : Yeah.

SMITH : Numbers or those alphabet letters.

JOHNSON : So it is within the discretion of ah the Board that the Examiners Board now --

SMITH : Yes madam.

JOHNSON : -- to promulgate rules to submit.

SMITH : They're Gods, they can promulgate whatever they want, they feel that it's justified.

JOHNSON : Have you been before the Board to ask them questions?

SMITH : Yes.

JOHNSON : What is the response?

SMITH : Mr. Smith, we have rules and regulations. you have to meet those rules and regulations. The

incidences that I've had before the board re-- involve some of these regulations that ah, that they don't need to have, for a example a physician from war torn country who is unable to get the application from the Board of Medical Examiners execute by the dean of the medical school and thereafter, the dean's signature verified by the consul embassy official. In addition to that, this gentlemen was a ah, ah, a license physician in another state and the, the board representatives would not take the same statement from those records, no they had to have them for their own. -- I'm not trying to do away with any licensor examination but I think that there's situations for specialist, or for other individuals who are not going to be any danger to the Texas public that as specialist they can provide a very good medical service to Texas. Another dilemma is the, the universities, surely you've heard some complaints from the universities on how the, the visiting professor permits expire.

JOHNSON : Well, I guess my response to you is that according to the way the law is written, it is possible for that to happen, now it is left to the board.

SMITH : Well, Senator Johnson what I'm telling you is, if you want to try to help get more doctors out in the country, the board could change their rules and regulations and give us an avenue of where those, those needs could be serviced, and people that are willing --

JOHNSON : Yeah.

SMITH : -- to do it.

JOHNSON : Well, yes, I, I hear you and they can do that, they have the discretion to permit that right now because there's nothing in this law that prohibits them from doing that.

SMITH : Well Senator as a practical matter, you try to address the board under the statutory provisions of that, they refer you to the regulations and they say I'm sorry, we won't even take your money for a license application. -- Now then, you can sue them, but you're talking about a minimum of twenty thousand dollars to sue them in district court and I've discuss this with clients and they say, it's not that important to me even if I got a license. If I have to spent that much money to sue them, I don't want to go there anyway and I can't blame them for having that opinion.

CHAIRMAN : Any other question? Thank you very much Mr. Smith. Deborah Thorpe.

THORPE : Ah, if it's alright I'd like to defer my testimony until after Dr. Hill has present his prepared statement but I can still

CHAIRMAN : Alright, Dr. Hill.

HILL : My name is C. Stratton Hill, Jr. and I'm the Director, I've also got laryngitis, ah --

CLERK : Do you need some water?

HILL : -- yeah. Ah, Pain Service at M. D. Anderson Hospital in Houston, however, I guess I'm here to represent more of a ah, ah, people in pain than I am, I'm not an official representative of a University of Texas or M.D. Anderson Hospital. But some of my remarks certain to fit in with what you were talking about earlier on today, Senator Johnson, in regard to ah, the application of standard practices ah, to physicians and other. But, I'd like to bring to attention to this committee the massive evidence that a significant number of patients with cancer and other types of chronicle pain and, and cancer is about roughly 80 percent of all patients who have cancer, who are under treated for it and suffer needlessly. This is true in Texas as well as nationally and worldwide. Dr. Charles Schuster, Director of the National Institute on Drug Abuse has stated that the way we treat Cancer pain in this country borders on a national

disgrace. Unfortunately, it is the patient who requires narcotics for pain relief who is likely to be under treated. Nobody has to beg an anesthesiologist to do a nerve block or ah, a physiologist to do hypnosis or other of these alternatives methods of treatment but when a patient becomes to the point that they have defuse pain all over and require narcotics for relief, chances are they're not going to get them. And ah, we ah, that was one of the reasons why we push to get the Intractable Pain Treatment Act pass during the ah, past legislative ah, 71st Legislature. But, for reasons that they're likely to be under treated, number one, their cultural and societal attitudes towards narcotics which become varies to the appropriate and adequate use of narcotics. Their knowledge deficits about the pharmacology of narcotics in patients with pain. All the information that's in narc-- in pharmacology textbooks are based on studies done in post operative pain patients and in patients who didn't even have, they were individuals who didn't even have pain. It be similar to ah, someone if they would study the pharmacology of insulin to some body who is not a diabetic and this ah, would not be applicable, and thirdly, the influence of regulatory agencies both state and federal, and it is the latter reason that is as important to this committee. As I understand it, this committee has as its responsibility assuring that health care providers, provide the best health care for the citizens of Texas. Certainly, the relief of pain and suffering would be a high priority on the list of assuring good health care. Unfortunately, it is not so much a matter of what the regulatory boards actually do, as it is a perception in the minds of the physicians and other health care professions of what they do. Let me give you an example, I had a physician call me from San Antonio, that he himself had primary carcinoma of duodenum which is a very rare cancer. He was operated on and found to be inoperable and I had written a booklet about ah, the treatment of cancer pain and the problems that people have getting adequate treatment, and he wanted to thank me for writing this, and he expressed to me, that his concern was not so much, that he was going to accept the fact that he was going to die, but he was fearful of the process of dying. This is a physician, who is fearful of the process of dying, and the reason that he was fearful of it, because he did not feel like his colleagues would treat his pain adequately. He was already having pain and he was getting ah, Tylenol with Codeine and this was giving him good relief. However, he was taking so much of it that he was getting toxic on the Tylenol. So he asked his doctor to write the prescription for the Codeine separate from the Tylenol. In Texas, you have to put Codeine on triplicate prescription. You don't have to write a Tylenol with Codeine on a triplicate. The doctor did that but after ten days, he told the, his patient physician, I'm sorry I can't do that anymore, Austin will be down on me. And I, that was his perception and he acted on that perception, so this made whatever a person thinks the board does, that is actually what it does. There's little doubt in my mind that the physician could of written prescriptions for Codeine or for that matter stronger narcotics in definitely without any repercussions from the Board of Med-- Medical Examiners or any other regulatory agent, agency. But his perception was that continued or chronic prescribe would put him in jeopardy with the regulatory agency, in this case one that had authority to take his license away from him. The Board of Medical Examiners is charge with investigating complaints and allegations as practitioners are not performing to acceptable standards of medical practice and to be on the alert to detect illegal activities of practitioners. Both of these responsibilities apply to the use of narcotics. The basic problem about regulatory

agencies as far as physicians are concerned is, what are the standards of medical practice that are used to determine the proper use of narcotics. Well, the Medical Practice Act of Texas provides these standards, however, the language in this act is often ambiguous and imprecise. As witness by the ambiguous phrase, habitual user, in regard to prescribing narcotics. This is street talk that has been incorporated into the law. Habitual users are people who are drug abusers and our society has a, a great deal of difficulty distinguishing between the person who is using narcotics legitimately and those that are abusing them. Additionally, in Section 3.08 e, f and f 18, the sections which apply to a high percentage of cases of misconduct investigated by the board, the language is very vague, and this has to do with prescribing or administering a drug or treatment that is not non-therapeutic in nature or non-therapeutic in a manner the drug or treatment is administered or prescribed. Prescribing, administering or dispensing in a manner not consistent with public health and welfare and professional failure to practice medicine in an acceptable manner consistent with public health and welfare. Now, these are the standards that are often used. Ah, there is justification for this vagueness if it allows for flexibility in applying the law to meet varying circumstances in medical practice. However, if cultural biases and misinformation influence the standards applied, there is need to better define the standards of medical practices applied. Evidence suggests that the standards applied the use of narcotics need to be better defined to provide for the adequate relief of pain. As my interpretation that the Inter, Intractable Pain Treatment Act in Texas does set a standard for the treatment of intractable pain. It is likely that this standard is in conflict with certain of our culturally derived concepts of narcotics use. Number one, anyone who takes narcotics chronically is a drug addict, this is simply not true. That is not the definition of a drug addict that the American Medical Association uses, it's not the definition that ah, the World Health Organization uses. We don't distinguish between the person living out here on the street that is taking and abusing drugs for physiological reasons and those persons who are taking these drugs for legitimate medical reasons. And I had a call yesterday from a physician who had been apparently ah, through the first informal hearing in which he was asked to give his ah, narcotics license up, simply because he was relieving pain in a person who had intractable chronic pain because he was prescribing to a habitual user. These were one patient, I didn't know the details of the cases, but he told me one patient had seventeen operations on his back. These patients are in excruciation, horrible pain. Our society says, that we had rather see these patients be non-participants in the society, non-contributors and dependent on the society rather than for them to take narcotics that would put them back into a functional capacity in that they would contribute something to society. I don't mean to minimize the problem of drug addiction, but these people are not drug addicts. So, what the other aspect of this problem is, that we are now moving patients out of hospitals much quicker than we were before, because we're able to apply techniques for pain relief that don't have to be done in hospitals. We're having people ah, use ah, epidural catheters with pumps and ah, there's no standards to go by on the basis of what an equal analgesic doses of narcotics when it's applied that way as oppose to narcotics that are taken orally. However, a practitioner who prescribes a dose of narcotics orally that's outside of the usual for the recommended doses or the ah, ah, person being treated for post-operative pain, you see those recommendations came from studies done in patients with post-operative pain. Chronic pain for medical reasons, whether

it's benign or malignant is much more severe. You're infested with osteoporosis, that's horrible pain, nothing to compare with post operative pain. Physicians are not trained to handle the patients like this. The standards that the Medical Board uses ah, come from places like the PDR and pharmacology text books and these are ah, not in error, they just don't go far enough. The most used standard of ah, the pharmacology text book is Goodman and Gilman's textbooks of Pharmacology and Doctor Jerry Jaffey wrote the section on narcotics in that text, in that textbook and in we have ah, a conference in Houston in 1988 and this book came out from that conference and it's called the Drug Treatment of Cancer Pain in a Drug Oriented Society, it's volume 11 in the series of advances in pain research and therapy, and we asked Dr. Jaffey to address the issue of relationship between euphoria and addiction, and he did that but in the, in this he, he said before I discuss this relationship, I would like to offer three short stories about the consequences of physicians' opophobia, the fear of using narcotics. The hospitals make rules and regulations out of this inordinate, irrational fear of making people drug addicts. He relates three stories in time, one in 1964, 1977, and 1988. The first story was about his father who died in horrible pain because his physician wouldn't give adequate doses of pain relievers in 1964, and his sister said to him, considering his pain, it was a blessing because he was wishing for death because he couldn't get pain relief. And he even goes on to say that, at that time he was preparing a chapter on opioid analgesics for Goodman and Gilman's textbook of pharmacology. I made an extra insert into the final draft of the chapter on narcotics analgesic as a last but inadequate gesture of atonement on behalf of a profession that too often has left too many patients to suffer needlessly in their final days. Almost 25 years later in several additions later still in italics, the statement remains no patient should ever wish for death because of his physician's reluctances ----

END OF SIDE 2

HILL : --bleeding from the gastral intestine tract. His physician ordered no pain medication, he ordered (Benzodiazipan), and he went to see his father-in-law, and he said the attending physician, a family friend of many years, prescribes a long-acting (Benzodiazipan) for anx--anxiety. After some persuasion, the physician reluctantly orders a few doses of 75 milligrams of Demerol, patient gets better, sometime after my departure, his physician discontinued the order for Demerol, stating that the patient does not have severe pain, and he does not want to addict him, this is a person who's paralyzed and dying. He says, the order (Benzodiazipan) was reinstituted on a PRN basis, the obvious distress returns. My father-in-law died a few days later in severe pain. And then he tells the story of his sister, who fell down the steps, fractured her leg in three or four places, was given three aspirin for those, that, fric--fracture, that was the order for the pain, she called her brother, he gave her the credentials, his credentials, and said that he wanted her treated properly, she was, said uh, uh, the relief was immediate and dramatic. My sister was transferred to a medical school affiliated hospital for surgery. She was reasonably comfortable during the transfer, but she wondered what happens to people who do not have relatives, who write pharmacology textbooks, and he says how can it be, that after 25 years, we've made so little progress in teaching our students and colleagues about the management of pain. Now the physician who, in San Antonio, that I told you about, subsequently died, and I asked, I said, if he can't give you anymore Codine because Austin would be down on it, on it, what was he gonna give you, and he said (Tagamet). (Tagamet) is an anti-ulcer drug. Now to me, that is uh, non-therapeutic prescriber, if, but I guarantee that nothing ever happened to that doctor, not giving him narcotics, he giving him (Tagamet). So my, I think that we, because of the need to meet the requirement of people who are in severe pain, be it benign pain, or malignant pain, who must be relieved, that we're gonna have to look at the standards. And I agree with you, Senator Johnson, that something has got to be done to uh, add to, what I read there, I think something that we, a requirement, that humane care, now that would be just as difficult to interpret, because non-therapeutic prescribe, but it seems almost incredible to me to say that you would not prescribe a analgesic to someone in pain, and charge a physician with non-therapeutic prescribe, it's non-therapeutic because our culture doesn't accept it, it confuses this with a drug abuser. It is perfectly therapeutic from a pharmacological standpoint. Analgesics, their prime purpose, is to relieve pain, and the second purpose is to relieve diarrhea. So, I think we're gonna have to do something to address these standards that would allow a physician to be humane in his treatment, in some of the uh, non-malignancies such as (osteoporosis), where it can be terrible pain, rheumatoid arthritis, it is not socially acceptable to give these patients narcotics, I've also heard it said that it even makes the disease worse, which I, there is no data to support anything like that. So what happens is, that non-treatment of pain becomes a standard. You can't treat the pain, you can't relieve the disease, but you can treat the symptoms from it, and this is strictly on the basis on biases and misinformation about what addictions, addiction is a lifestyle, it's where someone is uh, totally caught up in obtaining a drug and taking it, for illegal purposes, they sacrifice everything to this drug. Our patients don't do that, nor do patients who have chronic pain for any

reasons. I have a lawyer that functions perfectly well, who has vascular headaches. He's a trial lawyer, a patient, who takes three Tylenol with Codine every day, and works every day. Without that, he's a basket case. Now the board will probably say well, we'd accept that, maybe they will, maybe they won't. Here's a letter I got from a patient who says I'm completely off of morphine, although I kept a supply just in case, I accomplished this by gradually reducing the intake over a eight week period that ended February 13 without the slightest withdrawal syndrome, as you know, I dislike taking medications, especially habit-forming ones, although at my young age, and he's approaching 80, what could it hurt. That's another misconception, we can use narcotics, as long as we don't use them very long, and cancer patients are put off to almost their (aginal) stage before narcotics are used, and then they'll say, what difference does it make if he doesn't become an addict at this point. And he goes on to say, actually I'm completely free of all medication whatsoever. You don't get a letter like this from a drug addict. This is a patient who had cancer, but the data supports the fact that all patients who are introduced to narcotics through medical means, almost none of 'em become addicts, in a study of over 12,000 people in the Greater Boston area, only four people were considered to be drug addicts, after they quit taking their drug, three of them had dr--, had been drug abusers before, out of a study of 10,000 patients, with severe burns, requiring narcotics for treatment, none of 'em, and where the literature says that you see a lot of people who take drugs, that comes from the psychiatric literature, so, the world is topsy-turvy in this regard, we've got this to the point, and, and the board could perfectly well to say, that all of those, these cases that I've admitted, I, I've talked about, we would have no trouble, but the perception out there is that the doctor will, because there's enough cases where the doctors do get into trouble, that they uh, and, and the physicians here, and therefore, they will not prescribe. The State of California, there's only nine states that have triplicate prescription laws, and they're designed to prevent diversion, there's not any studies, in any of these studies that show that this has accomplished what it was supposed to accomplish, if it would of done with things that were already in place, then, the State of California, they're so tough on doctors, that only 25 percent of the physicians even buy triplicate prescription. So I think that if we do something, to look at the medical standards, and how they're apply, and, and we gonna have to do this for people in hospice, and homecare, where we're gonna have to rely on other people that are less well trained, to administer these medicines, adjust the dosage, change the dosage, because if you don't, you're going to see these patients unnecessarily suffering. And uh, we see this right now, uh, hospice nurses can tell you stories that'll make the hair stand up on your head, about the inadequate treatment of, of patients with pain, thank you very much.

CHAIRMAN : Thank you, Senator.

JOHNSON : What is the answer? I agree with you, I have uh, witnessed uh, that degree of pain, especially in hospice, but also with uh, the elderly, and we're getting more and more of a population of elderly--

HILL : Right.

JOHNSON : --that have chronic uh, arthritis or--

HILL : Absolutely.

JOHNSON : --and uh, I think it is a matter of, a lot of it is public education, as well as educating the professionals, because they're in the same mind set, many of them.

HILL : That's right. Uh, well, education is a big problem, as I said there are three factors, cultural and societal attitude towards narcotics that are barriers to their adequate use. I think if there is legitimate reason to give uh, narcotics to people who are in pain, who have these chronic long term, de--, they don't become addicts, we're able to study pharmacology of the opiates in a population now that has pain, and that's the cancer patients, and we're seeing this all the time, we're seeing that, number one, the myth that uh, that there's respiratory depression, pain is a natural antagonist, through respiratory depression, physicians don't give uh, adequate narcotics because they're afraid they're gonna get respiratory depression. I was just at the 6th World Congress on Pain, in Adelaide, Australia, and we were in a room with uh, a group of people that just take care of pain patients, cancer patients, and we, everybody was asking, have you ever seen a case of respiratory depression in your patients, and not a soul said that they had. So we got new information, but physicians don't know that, pain is a natural antagonist to the analgesic effect, so, you've got to give a big enough dose to get over the severity of the pain. You see, if, and then, all these studies a--, in pharmacology books, about the respiratory depression were done in patients who didn't have pain. Well, obviously, narcotics have a different action, if they don't have anything to antagonize, it's just like a, a diabetic, a person who doesn't have Diabetes is exquisitely sensitive to Insulin, and if we used, if, if, if dosages of Insulin had been based on what these normal people did, you'd probably see dosages in the range of point five to six units, and anybody getting 15 units would have been, thought they were just getting something horrible. Well, this is what happened to, with post-operative pain, they were, that's how the doses got in there, so the usual, and the recommended doses are only for post-operative pain, just like Insulin, just like the Diabetes determines the dose of Insulin, the pain ought to determine the dose of, of the analgesic. Now, this is being recognized all over, here's a report from the International Narcotics Control Board for 1989, Demand and Supply of Opiates for Medical and Scientific Needs, and they recognized the fact that more narcotics have to be made available uh, for the patients in, in pain, and you might be interested, uh, Senator Johnson, on this paper that I'm just submitting to the, uh, Texas Medical for pub-publication on the uh, it's entitled uh, Medical Practice Standards, the Use of Narcotics, and the Intractable Pain Treatment Act of Texas. In other words, uh, this act, this Intractable Pain Treatment Act, should be a standard, and in there, we say that, intractable pain is any pain that cannot be uh, removed or otherwise relieved, and it's interesting that the Federal--, Code of Federal Regulation, which uh, has to do with the use of narcotics, states in their Use of Narcotics, this section is not intended to impose any limitations on a physician, or authorize hospital staff to administer or dispense narcotic drugs in a hospital, to maintain or de-toxify a person as an incidental, adjunct to medical or surgical treatment of conditions other than addiction, or to administer or dispense narcotic drugs to persons with intractable pain in which no relief or cure is possible, or none has been found after reasonable efforts, in other words, they, the federal uh, law, specifically s--states that the, that these drugs can be used, and most physicians feel like that they get into trouble with the DEA, which is the federal, but they don't, they get in trouble more with the uh, uh, with the state board, than they do with the uh, with the federal authorities, 'cause, if you get in trouble with one, you're in trouble with all, let's face it, but uh, they all get in there, and this is a special issue of the uh,

supplement to the journal, Pain, the Symptom Management, February 1990. Relieving Patient Pain in a Regulated Environment, a Medical Dilemma for the 1990's. And uh, in here, there are contributions by people from the National Institute on Drug Abuse, uh, I gave a presentation on the relationship among cultural, educational regulatory agency influences on optimum cancer pain treatment, and so forth, this is what this whole issue is devoted to, it is the perception of physicians as to what these regulations are, and how they act on these perceptions, not to treat pain. And I think that when we get into the, I think that because of the biases, and the misconception, and the cultural, societal uh, fixation of these notions, that what influences the board more than pharmacological action. So I, I, I would say, be, we must make some attempt to clarify these uh, standards, the doctor right now doesn't have a clue when he's gonna get in trouble, when he's using narcotics. The uh, the uh, the board may simply say, well, you're just using too much; compared to what, you know, and he has no guidelines whatsoever, to go on, and this is always determined after the fact, and the, the board comes in, says, in this case, you used too much, or this is not an indication, it's non-therapeutic, not that it's non-therapeutic as far as the drug per se is concerned, it's non-therapeutic from our cultural acceptance of the use of that drug. So hopefully, I would hope that, whether it's in the next legislative session, or whether it's in Sunset, which comes up in 1993, that these issues are addressed so that we can assure physicians, that when they use narcotics for humane relief of pain, that they're not gonna get into trouble, and we're gonna have to define addiction, because the chronic taking of narcotic is not synonymous with addiction.

CHAIRMAN : Thank you very much, Dr. Hill, appreciate your testimony. Ms. Thorpe, did you have anything to add to that?

: (unclear)

CHAIRMAN : All right, thank you. The Chair at this time calls Debra Thorpe.

THORPE : My name is Debra Thorpe, and I'm the Clinical Nurse Specialist uh, for the Pain Service, working with uh, Dr. Hill, at M.D. Anderson Cancer Center, I'm here primarily uh, representing my own concerns as a, as a sit-in--citizen, as a professional nurse, ah, my one of my fundamental roles is that of patient advocate, and those are, that's really who I would like to believe I'm speaking for today. I could, ah, spend several hours uh, telling you horror stories that Dr. Hill referred to, as a nurse, I'm very frequently caught uh, in between the, the patient need for pain relief and the physician's difficulty in providing that pain relief, for the precise reasons that Dr. Hill has already outlined uh, and a lot of 'em have to do with perceived notions of what regulatory agent, uh regulations are all about, rather than what the actual uh, regulations are about. However, as, as also been pointed out many times, uh, there are not uh, adequate standards for people to follow, that it is certainly a very difficult uh, thing to establish, standards, uh, uh, the nursing profession is struggling with it, but there uh, certainly is a need I think to address those, and, a way to urge people to, in establishing standards, uh, to look at the outcome of care, uh, as a more important focus of the appropriateness of care than necessarily the process, and this is uh, very well illustrated by the uh, treatment of pain, in that, I would, uh, hate to see regulations, and, and guidelines about the number of narcotics that can safely be prescribed, because that is so variable, that the attention needs to be turned to, how does a patient function, does the treatment provide pain relief, is the patient able to function in their most able capacity, and so what

is the outcome of that treatment uh, in establishing standards. Uh, it is not an easy task, because every situation is individual, but there should be some way to identify minimum standards of, of care, uh, that are not based on uh, our cultural and societal notions of what is appropriate, particularly when we have so much evidence that, uh, use of narcotics to treat pain is very different from what, what those cultural notions are. Uh, I would like to point out that it's somewhat disappointing that uh, the uh, impact of the, Intractable Pain Treatment Act, which was passed nearly a year ago, is not reflected in the current publication which was published this, this year, of the Medical Practice Act, and I think one of the most crucial things is uh, the need for education of physicians that this act is available and does protect them in the process of treating patients with pain. I've been on the phone several times, uh, trying to encourage patients to allow their physician to be aware that this, patients will call me from uh, outside the institution, I get re--, uh, referrals for consulta--, phone consultations quite frequently, and recently had the experience of working with a patient who was in terrible pain from chronic vascular headaches, whose physician had cared for her for a period of several years, and then very precipitously decided he did not wish to provide her with the necessary narcotics to uh, relieve her any further and gave her three months notice to find another physician, and she lives in a small town where there are very few physicians, and all of the other remaining physicians had already been influenced not to care for her by uh, the physicians in that area, and we uh, have sent her copies of the Pain Treatment Act, and provided information to her to try to relay to her physicians, and still, the perception is overriding, that if they prescribe narcotics to this person, that they will get in trouble for it, and they are ad--, quite adamantly refusing to, to do it, so this person has to travel, at great expense, uh, and with great difficulty to other areas of the state in order to uh, achieve care. So there are uh, many other situations that I could relate to you on that same theme, uh, it is a significant problem I think, and would encourage uh, action that can assure uh, patients better treatment of pain, and to assure that pain can be relieved, not just in the big medical centers, but throughout the state. Thank you.

CHAIRMAN : Thank you very much, any questions?

JOHNSON : Uh, I, I have one, and maybe I should have asked it to the physician but I think anyone of you can probably answer, do you think that it would help any if there was a designation to have a specialist, uh, a physician who specializes in uh, pain control, on the board? On the Medical Examiner's Board? Is that where most of the lack of knowledge seems to occur, uh?

THORPE : Well, I can't speak to the knowledge level of the board because I am not--

JOHNSON : --well I don't mean in the lack of knowledge--

THORPE : --familiar with actions they may or may (overlapping dialogue)

JOHNSON : --based upon what is happening, does it appear that they have no knowledge?

THORPE : I, I certainly feel that a, a physician uh, that has a, expertise needs to be in the area of pain management with-- good credentials in that area, needs to be consulted whenever that is uh, an issue before the board, the problem goes beyond the actual board actions, and in, into the perceptions of the uh, physicians in the state, many of whom will never uh, come in contact with the Board of Medical Examiners, but whose practice is directly affected by how uh, they perceive

a regulatory agency to influence their care, and this extends also to nursing practice, because many nurses are reluctant to administer drugs even when physicians prescribe them, and they are there, and the, but the nurse has a decision uh, particularly in, in instances where the uh, medications are ordered on a as needed basis, then the nurse has to make a decision, as to whether it's needed or not, has, has to enact that order, and, there are, have been studies that have been done that show that uh, that's another area in which uh, patients are denied adequate treatment, when, and even if they have adequate uh, medication, prescribed and available to them, what is actually administered, particularly in a controlled situation, such as a hospital, that, that the amount of pain relief they get still is, is lacking, so it's not just a physician issue, it's uh, and the same occurs with uh, patients themselves, and, and families, again, because of the perception that narcotics are bad, and they, they hold off on taking them, as much as a nurse or a physician may hold off on administering.

JOHNSON : Uh, yeah, I think you're right, because I have to admit that before I had some orientation to hospice, uh, I had some questions about the amount of drugs that were being ordered for patients who are chronically and terminally ill with pain, but, and uh, and while I have not worked at the bedside, I have been a position to uh, uh, observe and people who are having that kind of pain can tolerate very large doses, and uh, there is a way to document the need, I mean, so, so it's-- I think it is a matter of education, and probably changing our, a long term, maybe indelible uh, especially in the drug culture today, I mean the environment, drug culture, people are very fearful.

THORPE : And, it is a, a significant problem, and as Dr. Hill reiterated, we do not wish to minimize the problem of drug abuse, the, the point that we need to make is that it absolutely has to be, dis--, uh, the, distinguished between the abuse of those drugs and the legitimate use of them, I, I use an analogy frequently in teaching uh, nurses about narcotics that uh, if you look at uh, the element of fire, fire is a, potentially very destructive force that can destroy everything in its path, if not contained and used appropriately, yet how would we be able to live without the element of fire, to heat, to provide warmth and comfort and uh, to cook, and things, all of those things that, that element is so very useful for, so, it sometimes is helpful if they can apply an analogy that they may already understand to a concept such as narcotic use, which has uh, those same properties, the ability to be very positive, life-restoring, life, ah, transforming life, and uh, also destroying life.

JOHNSON : Yes. You can say that about water. So, we do have an education problem in the state, maybe we'll get there one day, we're still trying.

CHAIRMAN : Thank you very much, Ms. Thorpe, appreciate your testimony. Chair at this time will call Les (Wisebroad). Please state your name and whom you represent, proceed with your testimony, please.

WISEBROAD : My name is Les Wisebroad, I represent my law firm in Dallas, Morgan & Wisebroad, and myself. I am a plaintiffs medical malpractice trial lawyer. I am here because uh, I am very concerned about what I consider to be uh, incompetence on the part of some staff attorneys uh, with the Board of Medical Examiners in prosecuting uh, the worst disciplinary cases in front of the board. Uh, there are obviously some uh, vast differences between pursuing a civil medical malpractice case and some differences of interest, uh, but there are, uh, a, as opposed to pursuing a Board of Medical

Examiner's case, but there are also some areas of similarity, and the problem, uh, one of the problems I see is, that the board is not taking advantage of a vast resource out there, and that is plaintiffs trial lawyers, to gather information and help uh, to prosecute the worst cases. It appears from a review of the board's statistics that there are only eight or nine cases in fiscal 1989 that went in front of a hearing examiner, in those cases, there are resources which I think are available, uh, that could of been used that are not. Let me go to the specific case, and I'm here about--

CHAIRMAN : --sir, you know, with all due respect, uh, we cannot refer to any specific case if it's pending before the board or whatever, we will deal with processes or procedures, or--

WISEBROAD : --I understand that--

CHAIRMAN : --criticisms, but if you can, if you keep from any specific case, we'd appreciate that.

WISEBROAD : --and I, and I do not, I do not intend to use any names or any specifics, I'm going to use some illustrations to get to a broader process and to the complaint uh, that, that I think needs to be addressed, perhaps legislatively. Uh, in the case I am referring to, uh, there was uh, a physician involved, who a civil malpractice case is being pursued against. It's a very, very serious case. A deposition of this physician was taken, and in that deposition it came out that the Board of Medical Examiners was conducting investigation and that a hearing, uh, open hearing, in front of a trial examiner had been conducted, I might add, that those cases, uh, those kinds of hearings and the results are public information, Senator. Uh, when we found out that the public hearing had been uh, uh conducted, and we found out, in the course of deposing this doctor, uh, that it was his belief the complaint against him had been filed by the Dallas County Medical Examiners office, not by a plaintiff in a medical malpractice case, and I think uh, there's a different set of circumstances if a plaintiff in an ongoing malpractice case is the complainant and that that can be dealt with differently. But in a case in which someone other than uh, the complaint, the, the patient who was the victim has filed the complaint, uh, the patient who is the victim has no way of finding about it, nor do the attorneys representing him, after this deposition of this physician was taken, and we found out there had been an open hearing that we didn't know anything about, we contacted the Board of Medical Examiners office, particularly the staff attorney, who presented the case to the Hearing Examiner. We told the staff attorney that we had discovered information uh, that was not presented based on the transcript that we had read, and information uh, that should have been presented, uh, we were told that a conscious decision was made, on the part of the staff attorney and the Board of Medical Examiners not to contact the plaintiff's attorneys in the malpractice case to investigate or share any information they had because the staff attorney did not want to overdramatize the case in front of the Board of Medical Examiners. We told the staff attorney the information we had, which was information that uh, involved incomplete records being given to the board, it involved uh, lack of expert testimony being presented to the board and being chosen so that there was a lack of a full presentation of the case. We asked if the record could be reopened so that this information could be submitted, we were told by the staff attorney from the Board of Medical Examiners, the Board of Medical Examiners was not interested in this information and that the record would not be reopened. The concern then is, if the staff attorneys are not fully investigating their cases, if they're not contacting in a situation where there's a civil

malpractice case, the plaintiffs' attorneys in getting that information, if they're not getting assistance in choosing the expert witnesses and consultants that are on the list that the agency is using, or getting additional expert testimony, and they're not getting assistance in presenting a case to a hearing examiner in the best possible way, the board never gets that information. When the hearing examiner's opinion goes to the board, and when the transcript goes to the board, the information that's not in the transcript that could have been attained by engaging in cooperative ventures with plaintiffs' attorneys having parallel civil cases, does not get put in front of the board, that can result, in this case, the hearing examiners recommendation is that no discipline be taken against uh, this particular physician. I think that that presents a grave travesty in this particular case, and I am concerned that there should be either legislative action or a change in the board's rules and regulations to require that when there is information that there is an ongoing civil malpractice action that as a minimum step, that the investigators or at least when you are at hearing examiners stage, staff attorney be required to contact the plaintiffs' attorneys in the medical malpractice case to gather whatever information they have. Obviously, if that information is uh, one-sided or not credible, it can be discarded, and not continued on, but not to even make the inquiry to find out what information is out there, is not proper investigation, and not proper prosecution of complaints that are serious with regard to medical licenses. Uh, in addition, in a situation where a claint--, a complaint is made uh, by a third party, a, a county medical examiner, another physician, and the patient is not involved, or the patient's family is not involved, the Board of Medical Examiners must have some mechanism to where they contact and get the information from the patient or from the family member, I heard Ms. Jenkins say, what difference does it make, it doesn't affect the life of the patient anymore, the incident's already over for them, what we're after is protecting the public. Well, how can you get the proper information to carry through the disciplinary action to present to the board, to protect the public, if you don't find out what information the patient, or the patient's family might have with regard to the conduct that's being investigated. In the case that I'm concerned with, there is an issue of consent to experimental procedures, the patient's family must be contacted to find out if consent uh, was requested or given when there's no written record of that in particular, uh, that type of investigation was not undertaken, and I don't think that type of investigation is routinely undertaken. I think part of the problem as to why that sort of investigation, the sort of detail, that we investigate cases for, malpractice cases civilly, is not undertaken is because of a lack of funding of the agency, the agency has attorneys who are, uh, civil servants, uh, who are not making as much as private practitioners, uh, we were told uh, by I believe the, the president of the Board, or the Chairman's Board, that uh, there was one special prosecutor who was lost, 'cause he represented uh, uh, physicians I believe, and, and because uh, you make more money representing physicians. Understand all this, uh, but, I have never been asked with the experience that I have, and I've handled well in excess of a hundred medical malpractice cases, by the Board of Medical Examiners to be a special prosecutor, and I can tell you, uh, that I would volunteer my time in an appropriate case in one of the eight cases that are serious enough to go in front of a hearing examiner in a year, I would volunteer my time to be a special prosecutor. I have a partner who is a MDJD, I have three lawyers on my firm who are RNJD's, who would volunteer their time to

either be a hearing examiner or a special prosecutor, I believe that there is no cooperative program going on, and no attempt made for a cooperative program where the Board of Medical Examiners is approached uh, the Texas Trial Lawyers Association, uh, the Texas uh, Medical Association, and ask those two associations, can you get together and provide us with the technical assistance uh, on a voluntary basis from uh, your members who are expert in these situations, uh, to where we don't have to expend state funds, but we can do the most thorough possible investigation and we can be prepared in a case where we know in front of a hearing examiner, a physician is going to bring in a very highly paid, very experienced uh, attorney to defend him, and that happened in this case, in, uh, where the presentation of the hearing examiner was made by what I considered to be a very inexperienced attorney, and I don't know the attorney, but I can tell from reading the transcript uh, that the attorney did not prepare well, did not do a good job of cross-examination, did not go out and recruit appropriate experts, did not have rebuttal witnesses, so that some of the fact finding that was done by the hearing examiner is done on the base of un-rebutted testimony from the physician who the complaint's against, uh, these are the kinds of things that if we're serious about uh, discipline, and we're serious about discipline in the most serious cases, the eight cases a year that make their way to a hearing examiner, or if it's 15, uh, that shouldn't happen, there's no reason or excuse for it to happen, particularly when there are untapped resources th--that can be used for free. You know, when the Senate goes out to investigate the Watergate Hearings, or the Irangate Hearings, they get a special prosecutor, in a case, that is a case involving a death of a child, that's a serious case, I venture to say that if Joe Jamel were asked to volunteer his time, to help the board and prosecute that case, he'd do it, without any request for a fee, I know that Tommy Jacks, who's the current president of the Texas Trial Lawyer's Association would do it, I know I would do it, and I know there are several other attorneys uh, that would do that. The, the problem extends when there is a lack of an appropriate record presented to the hearing examiner, and the hearing examiner doesn't have enough medical, legal experience to even know that there is a lack of a record being presented, to know the right questions to ask when the hearing examiner's time comes to ask questions, and when the hearing examiner has to weigh the evidence and make the recommendations to the board, it doesn't have uh, that experience. Uh, Mr. (Gabia) said that they'd love to have MDJD's or RNJD's but they can't afford 'em, they don't have to afford 'em, all they have to do is ask, and they'll get that service for free, and the other point is, although the board has the ability not to accept a recommendation from a hearing examiner, why should the process be done in a fashion that's not appropriate or in, in a manner to which it's going to be thrown out, if you're going to go through a hearing examiner, and a hearing examiner's process in a hearing, why not do it right? Why not get the people uh, who can make good decisions, who can do better than what there is, so that the board doesn't have, in, too, and as many cases uh, do something different than what the hearing examiner recommends, throw it out, or put even more scrutiny into it because a good enough job wasn't done. So, in short, what I am recommending is, number one, if, if a mechanism needs to be had, legislatively it be done to enable the Board of Medical Examiners to call upon voluntary help and to encourage the Board of Medical Examiners to seek out voluntary expertise from trial lawyers and medical association in the way of special prosecutors, in the way of qualified hearing examiners, that the board be required, either regulatory or legislatively, to contact

and investigate the files of plaintiffs attorneys involved in parallel civil medical malpractice cases where disciplinary proceedings are being undertaken, and finally, that where there is a complaint not made by a patient, but affecting, made by a third party, but affecting a patient, or a family member, where the patient is deceased, uh, that those people be contacted and have some input into the process. Thank you.

CHAIRMAN : Thank you very much. Let me ask just one question, uh, has this been brought up before the board of uh, TTLA, or any other organization of which you spoke or--,

WISEBROAD : --well,

CHAIRMAN : --you know, before TMA, or--

WISEBROAD : --I, I am a uh--

CHAIRMAN : --has this, has this been discussed uh, publicly or officially or--

WISEBROAD : No, I don't believe it's been discussed publicly or officially, uh, I am an officer of the Dallas Trial Lawyers Association, I am a member of the Board of Directors for the Texas Trial Lawyers, I'm not here on behalf of either of those organizations, but I can tell you from my experience within those organizations, and my informal discussions with members of those organizations uh, that this is something that those organizations would be uh, very happy uh, to provide the Board of Medical Examiners with.

CHAIRMAN : In, in, in following your, your testimony, and I heard earlier by one of the uh, BME members, I'm not sure who are the attorneys, somebody mentioned that uh, most of the time the patient uh, is not a party to the action, before (Verbiage lost due to changing of the tape).

END OF SIDE 1

SIDE 2

CHAIRMAN : --did that also--

WISEBROAD : --well,

CHAIRMAN : --in many cases, particularly where it's brought by a third party, they said, we don't need, we can follow, or we can follow the tracks through the medical evidence through the records etcetera. I'm just wondering, if, let's say in a case, you're representing an individual who was hurt, a plaintiff, and if the Board of Medical Examiners, their attorney or counsel were to go to you, well you have a vested interest, and I'm just concerned that uh, oftentimes the complaint will be handled by the board, perhaps years or months before it gets to trial, in which case, I can see the, the trial attorney uh, using the action of the board, whatever it may be, to try to bolster or help the case in which you and the plaintiff certainly have a vested interest, and I'm not going on the merits, whether it's justified or not, but you see what I'm saying--,

WISEBROAD : --that's a legitimate concern,

CHAIRMAN : --so we wouldn't want that to be tainted, I'm, this is just something that came up.

WISEBROAD : --that's a legitimate concern, but there are a number of ways to safeguard against that, and, and first of all, I'm not suggesting that in a case, that where I represent an injured party, that I be a special prosecutor, I'm suggesting that in cases that I don't have absolutely anything to do with, that I am a resource, and there are others like me who can be a resource and be used in those cases, and--

CHAIRMAN : --in no way, excuse me, was I suggesting that the uh, the plaintiffs attorney in a particular action, be a special prosecutor, I wasn't even thinking a special

prosecutor, that's a separate issue, I was thinking of, perhaps, seeking uh, advice or expertise, because you've been on the case, and perhaps invested uh, tens of thousands of dollars through experts, through consultants, through you know, re--restructuring, re--, you know, re-enacting, the, the whole bit, that was one--

WISEBROAD : --here, here's, here's what I think, I think that the merits of the Board of Medical Examiner's case uh, should not be detracted from or there should not be a concern if there is a civil malpractice case going on, that by contacting the plaintiff's attorneys that somehow they're gonna further the civil malpractice case at the expense of the Board of Medical Examiner's case, what I'm suggesting is that the contact is made, the Board of Medical Examiners can get whatever information they want, if they think the information's tainted, if they think the information or the attorney's only trying to further his own case, they don't have to use the information, they can throw it away, but not to even get the information, that's the complaint that I have, because if you get that information, let's say, and you don't even use that information, it can lead you to other information, in other words, if they get an expert report from a witness that I'm going to use in my civil case, and that expert report has a lot of detail in it, they may not want to use my expert, but they will get the gem of the idea that this is the line they should be following in presenting this case to the Board of Medical Examiners, they can then go out and get their own expert, but be educated, with regard to the medical issues that are involved in the case, and with regard to the areas that they ought to be going, to get more information, and without that contact, and without uh, me or some other plaintiffs attorney giving them that input, uh, they're dealing with more limited resources and more limited expertise than we have, and have a greater likelihood of not thoroughly presenting the case for disciplinary action in front of the board. So, uh, the other part of that is, that the Board of Medical Examiners results in the action are not admissible in the civil trial, so to the extent that, let's say the case is prosecuted somewhere down the line, unless there is some particular special exception that comes up in most cases, uh, the two are not gonna be related, the only way it's gonna feather my case, my civil plaintiff's case, is only because perhaps, uh, everybody that's involved with it knows that maybe some discipline went on and the doctor may be more anxious to settle the case or something of that nature, but it's not gonna go on in front of the jury, and the findings should no go in front of the jury. Now, if there's a hearing examiner's hearing, it's public information, and I can have the transcript, uh, typed up at my request and my payment, and I can get the testimony of the experts before the medical examiner went out and recruited on their own, and I can contact those experts and ask those experts to come testify for me, in my civil malpractice case, so, I already have the ability to take advantage of whatever the Board of Medical Examiners is doing if they get to the hearing examiners level, but they're not using the ability to take advantage of me.

CHAIRMAN : And you're saying at all levels they can, they can use your resources or whatever, even at the confidential level, 'cause once it gets to the hearing examiner, then that's public?

WISEBROAD : Cert--, I'm saying certainly at the hearing examiners, and I'm saying those are the worst cases, uh, I think, that, that if they get to that stage, it's the most difficult case, obviously, if, if the doctor has surrendered his license, they don't need to go through all this, they, they had it easy. Uh, it, and if the investigation uh, determines that

it's not a particularly meritorious case at a very early stage, uh, maybe they don't need to pursue that, although I think that if they don't think it's a meritorious case at an early stage, but yet there's a civil malpractice case pending, that they could at least, you know, find out what information the lawyer has to see if the lawyer has a serious case and they've missed something, I, I don't see a problem with that, I, I think that uh, there are some confidentiality uh, clauses uh, in the earlier investigative stages, and uh, I think that, that, you know, to the extent, that those have to be respected and that those may present contact in the early stage of an investigation, then you, you can't have that interface at that stage, but what I'm particularly focusing on is a stage to where you're gonna go in front of a hearing examiner, and you're gonna have a public hearing and a public transcript, that before you go into that hearing, there's no excuse for not getting together with the plaintiff's attorney in a pending case, and getting all the information that's, that's there to help with the presentation.

CHAIRMAN : --see if they have found anything that you or your investigators may not have?

WISEBROAD : Exactly.

CHAIRMAN : That is interesting. One, just one other thing, and I'd like to hear your response to this, I know that there's a close comraderie among plaintiffs lawyers, particularly some of the more successful ones, and you mentioned Joe Jamel and some of the others, who then would the board or someone else go to if in fact there's this close comraderie, and oftentimes we see that even though it may not be tainted, but the appearance of, of taint sometimes uh, can detract from the merits of the case.

WISEBROAD : Well, anybody who would uh, sign on as a special prosecutor, just as you've got some uh, very high profile people that have done this in Watergate and Irangate, uh, anybody who signs on to that, has to uh, undertake confidentiality in that process and cannot share the information and I don't think any reputable lawyer would have a problem with uh, doing that, I mean w--we're almost to the point where somebody who's in practice with a firm and becomes a judge, uh, and has matters come before me has a close comraderie with others uh, but i--in most cases that doesn't taint the ability to act as a judge and the ability to do what they're charged to do and that thing--

CHAIRMAN : --in most cases I would think that the judge would have to recuse himself, number one. I mean if he's been there, and--

WISEBROAD : --and, and, and if that--

CHAIRMAN : --and knows of those matters or has discussed those matters--

WISEBROAD : --and that would be--

CHAIRMAN : --I know of many judges who recuse themselves simply because of the friendship or the closeness--

WISEBROAD : --that would, that would be proper, if that was the case uh, in this instance too, but what I'm saying is, that there are enough cases that are coming up, enough disciplinary actions, to where, I, I believe an attorney can be found who doesn't have an interest in the case, who can be used as a resource person, and who would be willing to do that, and certainly, you know, the trial lawyers have taken their share of shots at being greedy and not uh, doing public service, and not doing uh, uh things to put back in to society, and this creates certainly a, a wonderful opportunity, an ample opportunity uh, for trial lawyers to do some work for the benefit of the public without being paid for it.

CHAIRMAN : So you're talking two things, one is the staff of BME investigators avail themselves of whatever resources or expertise or work product already done by plaintiff lawyers. Another, you're talking about a special prosecutor being brought on by the agency to prosecute some of these worse cases?

WISEBROAD : Exactly.

JOHNSON : Let, let me ask a question. In view of that, what kind of insurance is practiced on the medical examiners board, because the doctors do have, those decisions have to be ultimately decided by that board, and, they could be just as good as friends.

CHAIRMAN : I don't, I don't have the answer to that, but, but that certainly is interesting.

: Excuse me, may I stand, we recuse ourselves from cases where we are, do have a relationship with the persons involved.

JOHNSON : So the process is the same?

: (Inaudible)

JOHNSON : So, it's no different, or should not be any different from lawyers as physicians?

: I, I didn't (Inaudible)

JOHNSON : --oh, I thought that's what he did say.

: (unclear) (not speaking into

microphone)

JOHNSON : Oh, he said he didn't know, yeah--

CHAIRMAN : --no, oh, no, on the Board of Medical Examiners I don't know. In a court setting, if a judge has a close relationship with an attorney, or a vested interest, or has some knowledge of the case, uh, he should, he or she should recuse themselves to avoid even the appearance of impropriety, and that's in the uh, the Code of uh, Ethics.

JOHNSON : Sure. That's what I had to say.

CHAIRMAN : Thank you very much. That's an interesting proposal, perhaps it should be followed, thank you.

WISEBROAD : Thank you.

CHAIRMAN : Anyone else, we've got a few minutes before we're gonna recess. Anyone else uh, to provide any testimony, again, thank you very much, if anyone didn't get to testify, uh, Senator Brooks did say that he would make opportunity for those to be heard, perhaps some had to leave a little early. Thank you very much, this committee stands in recess.

END OF SIDE 2



# *Texas State Board of Medical Examiners*

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SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES

PUBLIC HEARING  
TEXAS STATE BOARD OF MEDICAL EXAMINERS  
Wednesday, June 27, 1990  
10:00 a.m.  
Lt. Governor's Committee Room

RECOMMENDATIONS FROM THE INVESTIGATION  
OF CERTAIN ALLEGED FINANCIAL ERRORS OR IRREGULARITIES  
AT THE TEXAS STATE BOARD OF MEDICAL EXAMINERS  
AND BOARD RESPONSE

1. We recommend that the Board of Medical Examiners institute procedures which will ensure that all contracts for services, including calligraphy, are regularly awarded on a competitive bid basis.

**Response:** All contracts for services now follow State Purchasing and General Services Commission guidelines.

2. We recommend that the Board of Medical Examiners establish uniform standards for evaluating bids from service providers in advance of the solicitation of bids.

*we want to c them* **Response:** The Board now establishes uniform standards for evaluating all bids in advance.

3. Due to the improper exclusion of a qualified candidate from bidding on the calligraphy services needed by the Board of Medical Examiners, we recommend the Board of Medical Examiners repeat the bid process to ensure that all qualified calligraphers have an opportunity to submit bids to the Board of Medical Examiners.

*when* **Response:** All qualified calligraphers will have an opportunity to submit bids.

4. We recommend that the Board of Medical Examiners establish criteria for selecting future test sites. After the selection criteria is established, we recommend the Board of Medical Examiners solicit proposals from eligible facilities.

**Response:** The Board now uses the State Purchasing Commissions' meeting planning services.

5. We recommend that the Board of Medical Examiners implement formal procedures to protect blank examinations from unauthorized duplication during the test administration.

*what are they* **Response: Procedures are now established to protect blank examinations from unauthorized duplication.**

6. We recommend that Chief Proctor duties be assigned to a regular full-time Board of Medical Examiners exploit, subject to regular performance evaluations.

*who* **Response: A regular full-time Board employee is the Chief Proctor.**

7. We recommend that the Board of Medical Examiners establish uniform procedures for selecting, recording, and verifying the identity of proctors.

*we want to c them* **Response: Uniform procedures for selecting recording and verifying the identity of proctors have been established.**

8. We recommend that the Board of Medical Examiners establish a policy discouraging the use of relatives of the Board of Medical Examiners employees as proctors.

**Response: It is now Board policy that no board employees' relatives serve as proctors.**

9. We recommend that the Board of Medical Examiners require better supporting documentation of payments made to proctors.

**Response: A time sheet for each proctor is now being used.**

10. We recommend that payments to proctors be prepared and mail to proctors after the examination has be concluded.

**Response: Payments to proctors are prepared and mailed to proctors after the**

examination.

11. We recommend the Board of Medical Examiners adopt procedures which will ensure the receipt of adequate information from independent contractors prior to the issuance of payments.

**Response: All independent contractors must furnish their taxpayer identification number or Social Security number prior to payment.**

12. We recommend the Board of Medical Examiners adopt procedures which will ensure compliance with IRS regulations.

**Response: The Board is now in compliance with IRS regulations.**

13. We recommend that the Board of Medical Examiners revise its internal timekeeping procedures to facilitate proper recording of all employee leave.

**Response: A monthly timekeeping form is now used by all employees.**

14. We recommend that duties associated with payroll and personnel be separated.

**Response: Payroll and personnel duties are now separated.**

15. We recommend that the balance of current Board of Medical Examiners accounts and all future Board of Medical Examiners funds be deposited in the State Treasury into a special fund established for that purpose in accordance with the State Funds Reform Act.

**Response: The Board disagrees with this recommendation, as the Legislature acknowledges the Board's non-treasury funds in the Appropriation Bill.**

16. We recommend that the Board of Medical Examiners establish procedures segregating the functions of check writing, voucher approval, and bank statement reconciliation.

**Response: Check writing, voucher approval and bank statement reconciliation**

**functions are now segregated.**

17. We recommend the Board of Medical Examiners adopt procedures segregating the bank reconciliation duties from the purchasing function.

**Response: Bank reconciliation duties and the purchasing functions are now segregated.**

18. We recommend that the Board of Medical Examiners adopt procedures which will ensure that the travel reimbursement limits established in the Appropriations Act are observed.

**Response: Travel reimbursements now comply with the Appropriations Act.**

19. We recommend that the Board of Medical Examiners adopt standards for documentation of travel expenses reimbursed from the Board of Medical Examiners local funds.

**Response: Local fund expenditures are now documented the same as treasury fund expenditures.**

20. We recommend that the Board of Medical Examiners establish procedures requiring the regular reconciliations of:

test fees deposited to examinations ordered (which will ensure that all fees are deposited)

examinations passed to licenses issued (which will ensure that licenses are only issued to persons who have passed the exam)

**Response: The Board will develop automated procedures reconciling test fees to examinations ordered and examinations passed to licenses issued.**

21. We recommend that Board re-evaluate the need to review examination questions in advance of the test. In the event the Board determines that such an advance review is necessary, we recommend the Board implement procedures which will safeguard examination booklets from unauthorized duplication.

**Response: Procedures now safeguard examination booklets from authorized duplication.**

22. We recommend that the Board of Medical Examiners establish procedures which will ensure that blank examination booklets are secured against loss or unauthorized use.

**Response: Procedures now safeguard examination booklets from authorized duplication.**

23. We recommend that the Board of Medical Examiners develop procedures for controlling blank certificate stock. We suggest that the Board of Medical Examiners consider modifying the form slightly to include a consecutive preprinted control number on the reverse side of the certificate.

**Response: Blank certificate stock is now safeguarded and form include printed control numbers.**

24. We also recommend that physical access to the blank certificates be strictly controlled.

**Response: Physical access to blank certificates is now limited.**

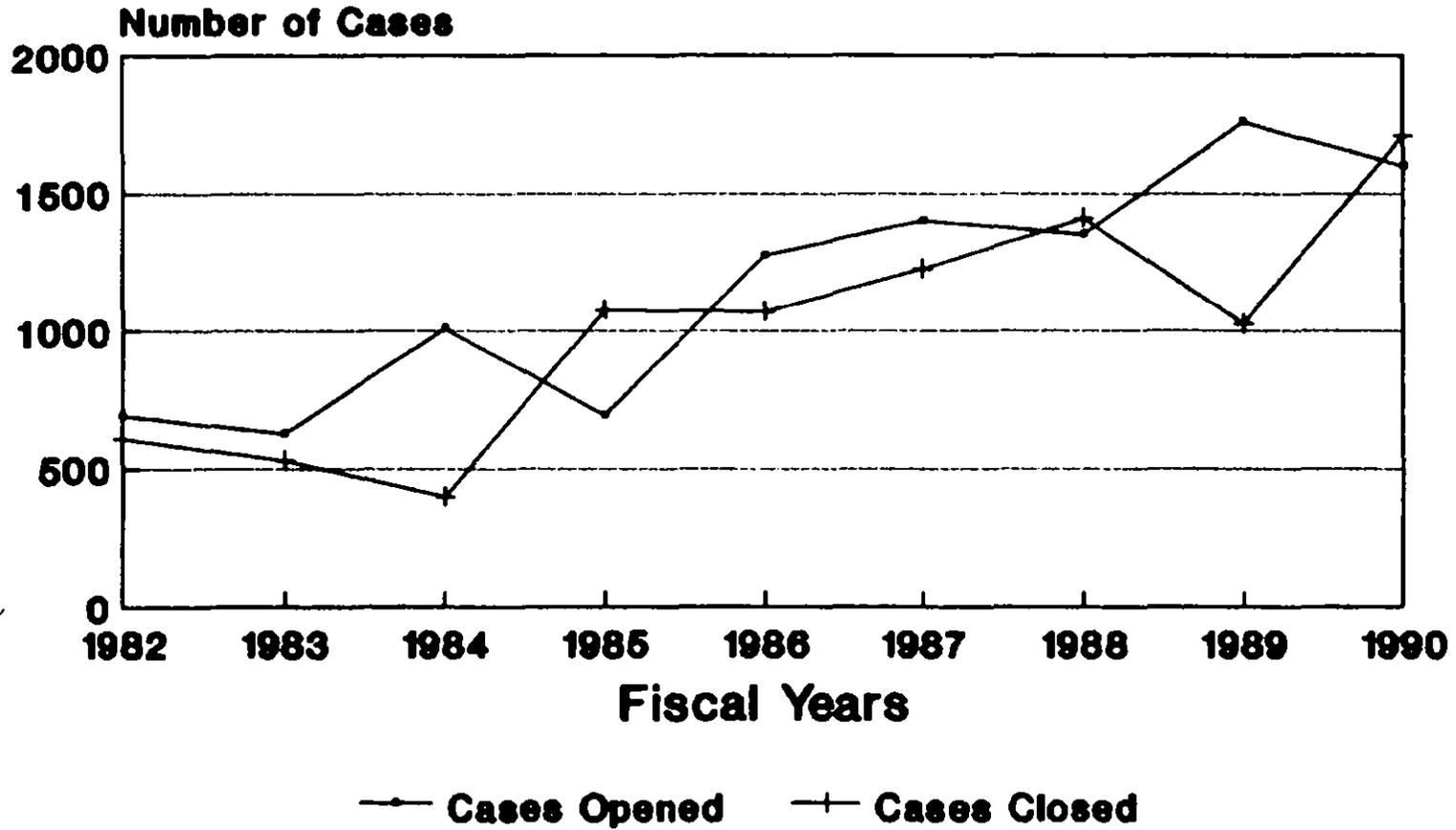
25. We recommend that the Board of Medical Examiners establish procedures which would ensure compliance with the telephone usage provisions of the Appropriations Act.

**Response: All employees are made aware of the telephone usage provisions of the Appropriations Act and procedures now test compliance.**

26. We recommend that the Board of Medical Examiners adopt appropriate mail opening procedures which protect the contents of correspondence required to be kept confidential under the Medical Practice Act.

**Response: Mail opening procedures were changed to protect the confidentiality of the contents of correspondence.**

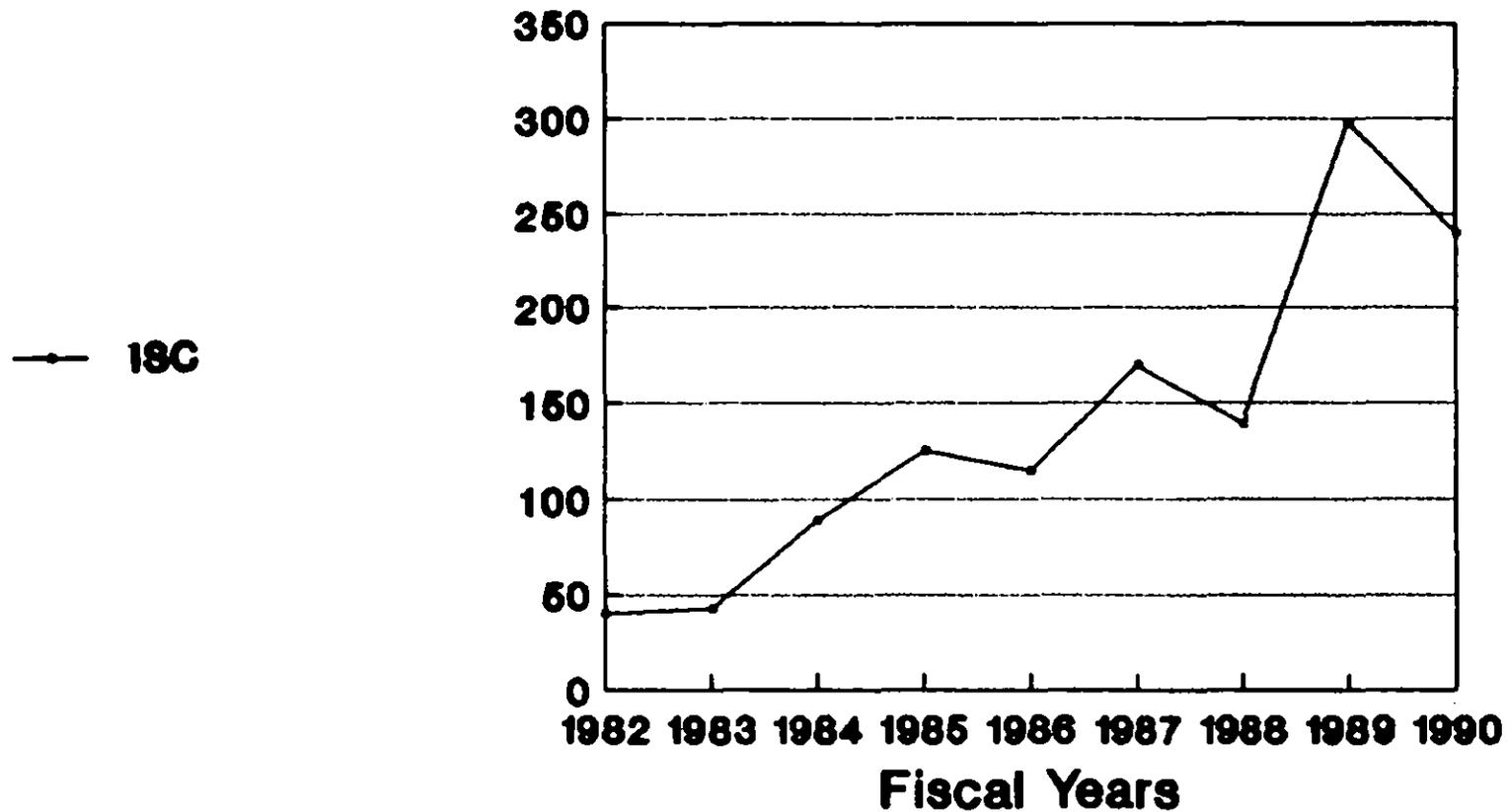
# Texas State Board of Medical Examiners Cases Opened and Closed



*23-25% =  
Multiple  
Liability  
Cases*

1990 figures are projected

# Texas State Board of Medical Examiners Informal Settlement Conferences



1990 figures are projected

	To 5/31/90 1990	FY 1989	FY 1988	FY 1987	FY 1986
<b>Investigations:</b>					
Opened	1189	1767	1350	1401	1275
Completed	1283	1016	1411	1222	1075
Pending yr. end	1147	1252	1017	1083	1099
Within a year	69%	69.3%	65.9%	62%	N/A
<b>Hearings:</b>					
Board	4	5	4	7	12
Examiner	20	8	13	43	26
ISC <i>Informal Settlement Conf'ce</i>	163	296	139	170	116
TOTAL	187	309	156	220	159
<b>Actions:</b>				(26A)	
Revoke-Surrender	4	11	7	29	19
Suspension	2	3	3	5	3
Restrict	72	87	53	149	91
Reprimand	8	1	8	83	1
Dismissed	66	114	55	39 (41)	26
TOTAL	166	216	126	305	140

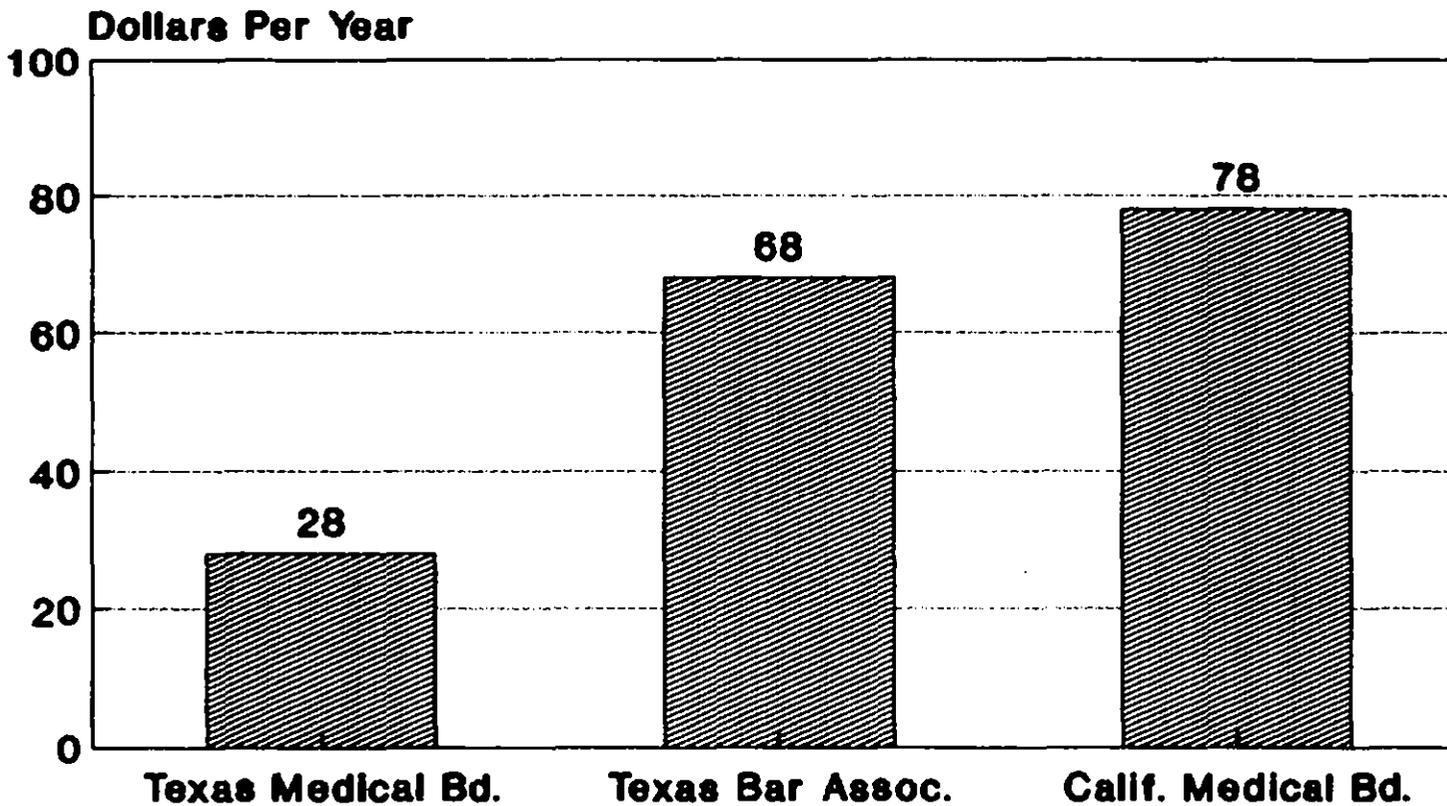
*3 Bk hearings scheduled for Aug.*

*(26A)*

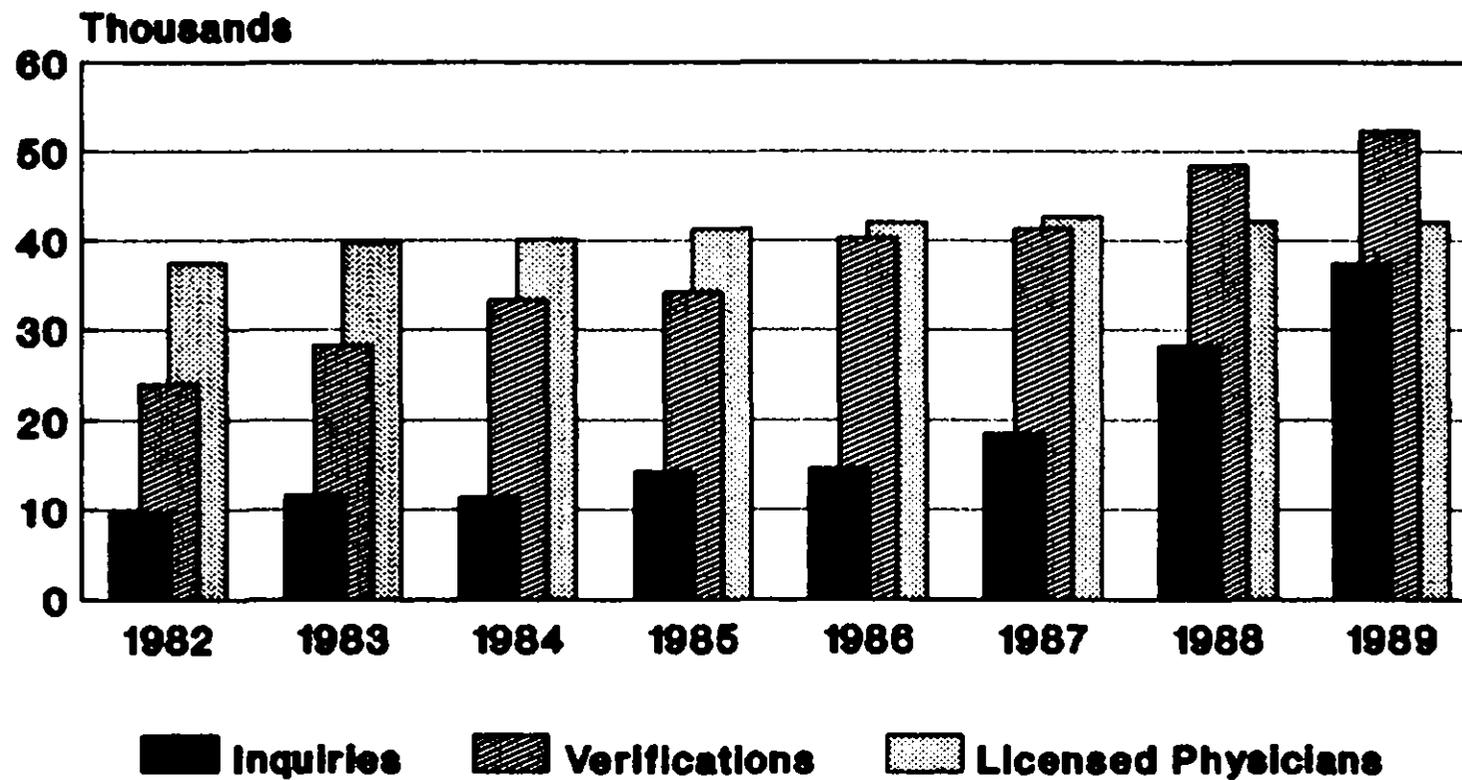
*114*

# Comparative Budgets

## Amount Spent Per Licensed Physician (or Attorney) Per Year for Enforcement



# Texas State Board of Medical Examiners Inquiries and Verifications



Hot Line Added in 1988

## **HOTLINE TOTALS**

Sept. '89 - Aug. '90

**Sep.   Oct.   Nov.   Dec.   Jan.   Feb.   Mar.   Apr.   May   Jun.   Jul.   Aug.   TOTAL**

<b>A</b>	152	204	175	158	270	273	244	230	260				1966
<b>B</b>	31	18	16	27	32	32	37	41	44				278
<b>C</b>	200	132	98	85	156	172	159	125	127				1254
<b>TOTAL</b>	383	354	289	270	458	477	440	396	431				3498
<b>'88 - '89</b>	156	142	261	142	153	205	243	246	238	261	265	378	2690
<b>'87 - '88</b>	152	45	45	55	53	136	78	66	131	60	67	79	967

**A - Actual number of calls requesting disciplinary info**

**B - Number of calls wanting to lodge a complaint**

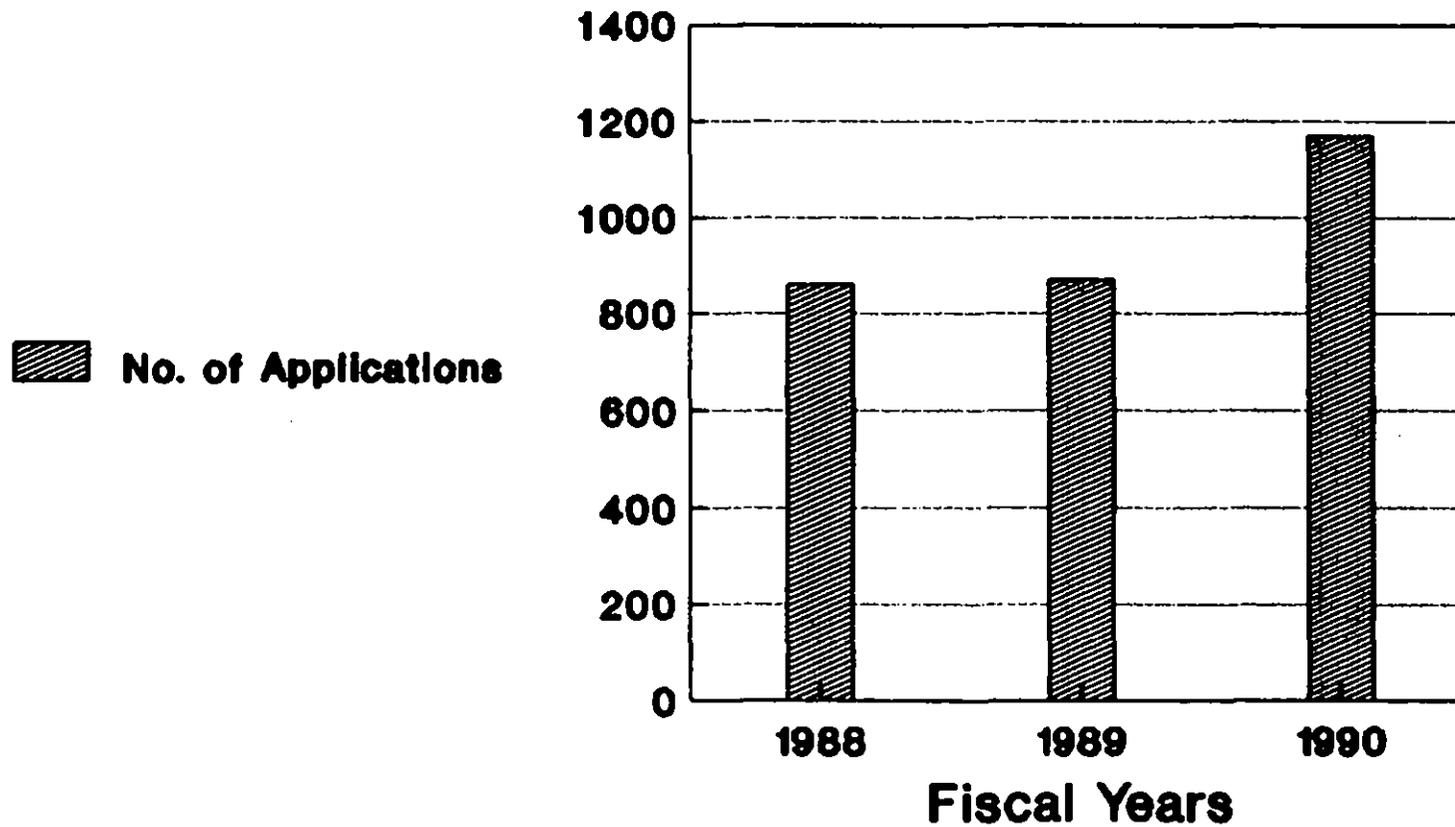
**C - Miscellaneous info not given on Hotline**

**INQUIRIES AND VERIFICATIONS**

	1982	1983	1984	1985	1986	1987	1988	1989
<b>Verifications</b>	24,006	28,183	33,255	34,096	40,239	41,352	48,389	52,294
<b>Inquiries (included Hotline)</b>	9,767	11,669	11,477	14,259	14,623	18,516	28,189*	37,444
<b>Number of Licensed Physicians</b>	37,480	39,798	40,136	41,346	42,001	42,652	42,199	42,124
<b>Number of Employees</b>	4	4	4	4	4	5	5	6

**\*Hot Line Added**

# Texas State Board of Medical Examiners Reciprocity Applications Received



800 #  
 Listed in the phone bk  
 of 9 cities

FLEX SUMMARY  
 NUMBER OF EXAMINEES AND PASS RATE PERCENTAGE

	DEC 85		JUNE 86		DEC 86		JUNE 87		DEC 87		JUNE 88		DEC 88		JUNE 89		DEC 89	
	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
<b><u>FLEX I</u></b>																		
TEXAS	67	82%	882	98%	73	83%	953	97%	71	88%	896	97%	68	89%	875	98%	71	85%
US/CANADA	96	90%	146	96%	102	92%	145	94%	101	93%	107	93%	104	90%	129	96%	68	82%
FOREIGN	24	54%	20	75%	19	63%	11	54%	24	83%	17	82%	14	78%	23	91%	21	76%
TOTAL	187	82%	1048	97%	194	86%	1109	96%	196	90%	1020	96%	186	89%	1027	97%	160	83%
<b><u>FLEX II</u></b>																		
TEXAS	61	95%	877	98%	73	87%	950	98%	61	98%	895	96%	72	90%	873	99%	61	98%
US/CANADA	95	96%	142	99%	96	94%	141	96%	94	96%	104	97%	99	93%	125	100%	65	91%
FOREIGN	22	72%	17	88%	13	76%	10	80%	20	95%	15	100%	12	83%	22	100%	21	95%
TOTAL	178	93%	1036	98%	182	90%	1106	98%	175	97%	1014	96%	183	91%	1020	99%	147	95%

SPEX SUMMARY

	<u>SCHEDULED</u>	<u>EXAMINED</u>	<u>PASSED</u>	<u>FAILED</u>
MARCH 88	13	13	13	0
JUNE 88	75	53	52	1
SEPTEMBER 88	63	39	36	3
DECEMBER 88	46	43	36	7
MARCH 89	53	38	36	2
JUNE 89	70	46	45	1
SEPTEMBER 89	60	45	43	2
DECEMBER 89	57	40	37	3
MARCH 90	71	44	42	2
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TOTAL	508	361	340	21

PASS RATE

TEXAS	21	21	100	%
UNITED STATES/CANADA	323	309	96	
FOREIGN MEDICAL GRADUATES	<u>17</u>	<u>10</u>	<u>58</u>	
TOTAL		361	340	94
10 YEAR RULE		88	73	82
NATIONAL BOARD RULE		263	261	99
DISCIPLINARY ACTION		<u>10</u>	<u>6</u>	<u>57</u>
TOTAL		361	340	94
M.D.		330	312	95
D.O.		<u>31</u>	<u>28</u>	<u>86</u>
TOTAL		361	340	94

MAIN OBJECTIVES IN NEXT BIENNIUM

1. To reduce the time to investigate complaints against physicians.
2. To reduce the time to process applications for new physicians.
3. To raise the public's awareness of the board's functions.
4. To inform licensees of their responsibilities to the public.
5. To increase employee productivity.

*need expansion of  
info services  
Will need ↑ in space - will  
have to move by 8/91*