SUBJECT: Regulation of physicians by the Texas State Board of Medical Examiners

COMMITTEE: Public Health — committee substitute recommended

VOTE: 9 ayes — Capelo, Laubenberg, Truitt, Coleman, Dawson, McReynolds, Naishtat, Taylor, Zedler

0 nays

WITNESSES: *(On original version:)*
For — Richard Gray, Laurie Grover, and Tom Weber; *(Registered, but did not testify:)* Luke Bellsnyder, Texas Association of Business.

Against — *(Registered, but did not testify:)* Dan Lambe, Texas Watch.

On — David Durden, Texas Department of Insurance; Lisa McGiffert, Consumers Union; George Parker Young, Texas Trial Lawyers Association; Donald Patrick, Jamie Garanflo, and Mari Robinsion, Texas State Board of Medical Examiners; Susan Strate, M.D., Texas Medical Association; Howard Fletcher; Craig Franklin; Dan Franklin; Kim Marth; and Shannon O'Keefe-Hetter; *(Registered, but did not testify:)* Jose Montemayor, Texas Department of Insurance; Cathleen Parsley, State Office of Administrative Hearings; Matt Wall, Texas Hospital Association; and Laura Castleberry; (*On committee substitute*:) Tom Smith, Public Citizen.

BACKGROUND: Title 3, Subchaper B, Physicians, of the Occupations Code regulates the licensure and oversight of physicians in Texas. It establishes the Texas State Board of Medical Examiners (BME) as the regulatory body; sets requirements and fees for physician licensure; procedures for resolving complaints against licensees; and disciplinary actions, including suspension or revocation of a license.

BME's key functions are licensing, enforcement, and public awareness. It receives complaints against a licensee and makes an initial determination of jurisdiction. Complaints of someone impersonating a doctor or other allegations that are not against a licensee are not investigated by the board, but referred to the appropriate authority. Once jurisdiction is established,

BME will initiate an investigation and also may suspend a license temporarily if the doctor's practice constitutes "a continuing threat." This suspension is in force until the investigation is complete and a final action can be taken.

BME next determines if the allegation is a matter of fact, such as impairment or sexual misconduct, or a matter of standard of care, such as failing to properly treat a patient. If the matter is a possible breach of standard of care, BME refers the case to an expert, a peer physician who makes that determination. If the finding of fact or the expert's opinion supports investigation of the complaint, BME's staff proceeds and when enough information is gathered, meets with the licensee in an informal settlement conference. This is an opportunity for the licensee to prove compliance or to negotiate a settlement with the board.

If no settlement can be reached, the case is taken to the State Office of Administrative Hearings (SOAH), where a recommended action is decided. BME receives SOAH's recommendation and may follow it or choose some other form of enforcement. The five enforcement tools BME has concerning a physician's license are: revocation; suspension; restriction, such as required rehabilitation or continuing medical education; administrative fine; and reprimand.

As a part of its public awareness function, BME's web site includes a "physician profile" for each licensee that includes information about the doctor's practice, specialties, and licensing.

DIGEST:

CSHB 6 would amend the Occupations Code to change the requirements for licensure, direct BME to prioritize complaints and adopt a schedule of sanctions, establish an expert panel to assist in investigation of complaints, change the complaint resolution and enforcement process, and change the fee structure for physician licensure.

Requirements for licensure. CSHB 6 would require physicians to comply with continuing medical education requirements and submit a physician profile for their license to remain in effect. It also would permit BME to deny licensure when the applicant was under a deferred adjudication for a felony or certain misdemeanors.

In addition to a felony conviction leading to license suspension, BME would be directed to suspend the license of a physician convicted of misdemeanors under Chapter 22 of the Penal Code (assaultive offenses) that are not punishable by fine alone. This would apply to initial convictions on or after the effective date of the bill.

The bill would change the definition for acts that may lead to license suspension or restriction from "a person licensed to practice medicine would, by the person's continuation in practice, constitute a continuing threat to the public welfare" to "a person licensed to practice medicine would, by the person's continuation in unrestricted practice, constitute a real danger to the health or safety of the person's patients."

The bill would require BME to revoke a license if the physician's license were revoked in another state. This would apply to licenses revoked before, on, or after the date CSHB 6 became effective.

Prioritize complaints and schedule of sanctions. The bill would direct BME to give priority to complaints that allege sexual misconduct, substandard quality of care, and impaired physicians. The board would be required to immediately investigate complaints against a physician who was being monitored as part of a previous disciplinary action. It also would direct the board to adopt a schedule of disciplinary sanctions by January 1, 2004.

Expert panel. CSHB 6 would direct BME to adopt rules for convening an expert physician panel to assist in complaints and investigations when standard of care was at issue. The panel members would be practitioners in the same or similar specialty as the licensee. Following review of the complaint, the panel would determine how the complaint pertained to the standard of care and report its findings to BME. The panel would be funded through a surcharge on registration and renewal.

Complaint resolution and enforcement process. If BME dismissed a complaint, CSHB 6 would require the board to send a letter advising the physician, as well as the patient, of the dismissal.

If BME did not dismiss a complaint, it would be required to schedule an informal meeting within 180 days following the filing of the complaint, unless the board could show good cause for a delay. If the licensee had been a subject of a disciplinary action by BME in the past, the board could not delay the informal meeting, even with good cause. If at any time before the informal meeting BME determined that a complaint was baseless, the complaint would be dismissed at that time. The complaint report would reflect the fact that the claim was dismissed as baseless or unfounded.

BME would have to give notice to the licensee at least 30 days before the informal meeting. The notice would include any exculpatory information the board might have. At least 10 days before the hearing, the licensee would receive all information the board had, including the expert panel's report. The only exceptions would be:

- a board investigative report, unless it included exculpatory information;
- the identity of a non-testifying complainant; and
- attorney-client communications.

If the board failed to provide the required information, any disciplinary action other than suspension would not be effective.

CSHB 6 would permit BME to restrict a physician's practice in addition to suspending a license, but would require BME to provide immediate notice to the physician of such action. The physician would have to be notified of a disciplinary panel hearing on the restriction or suspension at least 10 days before the hearing, which would be held not less than 14 days after the initial notice of restriction or suspension. If the board did not uphold the restriction or suspension, then the same facts could not be the sole basis for subsequent action. If the disciplinary panel hearing affirmed the BME's action, the board would schedule an informal hearing, unless the physician waived it. If the physician were unable to show compliance at the informal meeting, BME would be required to file a formal complaint. The changes in the complaint resolution and enforcement process would apply to complaints filed with the board on or after the effective date of the bill.

The bill would add violation of federal law and workers' compensation laws to the list of acts the board must report to a prosecuting authority if discovered during an investigation of a complaint.

Fee structure. CSHB 6 would change the payment of fees for registration and renewal from an annual to a biennial schedule and increase penalties assigned to late renewals. In addition, it would establish a surcharge of $30 for each registration and renewal, which would be credited to an account dedicated to BME's enforcement activities, including the establishment of the expert panel. The changes in the fee structure would begin January 1, 2004, and BME could adopt a staggered registration system on or after September 1, 2004.

BME would be required to adopt all rules, other than the ones designated for 2004, by December 1, 2003. The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2003.

SUPPORTERS SAY:

CSHB 6 would give BME the tools it needs to ensure that bad doctors do not practice medicine in Texas. The board could deny or revoke a license for a broader range of reasons: deferred adjudication, assaultive crimes, and license revocation in another state. The expert panel would give BME a broader range of expertise in evaluating standard of care cases. These tools would help make sure that bad doctors do not get or keep their licenses in Texas.

A stronger BME could help reduce medical malpractice insurance premiums in the state. A very small proportion of physicians account for the majority of malpractice cases, which drives up the rates for all. If BME could target those few physicians, the risk for insurers would be reduced, and the savings would be passed on to Texas' doctors. This is an integral part of fixing the state's medical malpractice insurance crisis.

The bill would throw the weight of legislative intent behind current board activities. Prioritizing complaints, notification of dismissal, additional disclosure of complaint information, establishing a schedule of sanctions, investigation of licensees under disciplinary order, and timely scheduling of informal settlement conferences all would support recent efforts the board has made to better perform its duties.

BME has made great strides over the past year to investigate more complaints more quickly, but it needs additional authority to do its job. Contrary to reports that the board has not revoked a license for medical error in the last five years, 27 Texas physicians' licenses have been surrendered, revoked or indefinitely suspended since 1998. The confusion is because the reports focus on "medical error," a term of art for which BME does not have specific statistics. In addition to enforcement actions resulting in removal of a license, the board has launched a public information campaign to make patients aware of the right to file a complaint against a physician, and BME has reduced the amount of time it takes to investigate a complaint.

BME is underfunded for the important work it must perform, and CSHB 6 would generate additional money for enforcement. In 2003, the BME received a $200,000 grant from the Governor's Office because it did not have sufficient funding to investigate a backlog of about 40 cases, some of which were more than five years old. The bill would secure funding through fees for ongoing enforcement so that the board could investigate and resolve complaints in a timely manner. It also would free up administrative resources by changing licensing from an annual to a biennial requirement.

The bill would help prevent sexual predators from preying on patients. It would authorize BME to suspend the license of a physician convicted of misdemeanors under Chapter 22, which includes assault. This means, for example, that if a physician inappropriately touched a patient (normally a felony) but pled guilty to a lesser misdemeanor charge of assault, BME still would suspend the doctor’s license.

CSHB 6 would help ensure that board decisions to suspend a license do not get overturned. The recent case of a Houston physician who was involved in murder for hire, yet could continue practicing medicine, illustrates the need for a better definition of the grounds for suspension. The physician was convicted of a felony after paying a uniformed police officer to have a former patient killed. BME suspended the doctor's license, but the physician obtained a temporary restraining order against the suspension because the doctor's practice did not constitute "a continuing threat," as required under current law. By changing the wording to "a real danger," the board's suspension orders would not be overturned in such cases.

The bill would target repeat offenders by requiring BME to investigate complaints against doctors who are under a disciplinary order and expediting informal hearings involving physicians who have been disciplined before. This would be a better way to focus on repeat offenders than just reviewing insurance claims because it would prompt immediate action against doctors who have been through the process before, but would filter out the claims that did not result in a complaint to BME.

It is not necessary to require that rehabilitation orders, which are confidential agreements under which an impaired physician is required to obtain treatment, automatically trigger an investigation of a repeat offender. Another complaint would trigger immediate investigation of a physician under a rehabilitation order anyway because the terms of an order include adherence to the law.

The bill would accelerate the complaint resolution process as much as is feasible by scheduling the informal settlement conference within 180 days. If the informal settlement conference did not resolve the complaint, then the board would have to take the complaint to the State Office of Administrative Hearings, which cannot be compelled to act according to any time line set by BME.

The complaint resolution function at BME should not be moved to the Attorney General's Office. The state should give BME the tools it needs to fix the problem, not take away its enforcement arm. If the board’s lawyers are not paid enough, they should be paid more, but the state should not gut BME’s enforcement authority.

OPPONENTS SAY:

This bill would offer consumers too few protections, while expanding the protections that BME now offers physicians. The only provision in the bill that would expand patients' protections would be to require physicians to keep their profiles current at BME. This information is similar to what a patient can receive from an insurer or managed care organization: the physician's name, address, specialty, registration status, degree, license number, date of licensure, and expiration date. Any information about past board actions is written in overly broad language. Consumers should have the information they need to decide whether they should choose a particular physician.

The bill also would expand protection of physicians by requiring notification and adding new rights for physicians during the complaint process, requiring more extensive research of standard of care cases, and dismissing complaints if BME did not act by certain deadlines. These protections far outweigh consumer benefits from CSHB 6.

A lax BME is a primary cause of the state's medical malpractice crisis, and this bill would not do enough to fix the problem. According to a report by Public Citizen, there are 272 physicians who have lost or settled four or more malpractice complaints in Texas, but have not been disciplined in the last 12 years. Further, as of June 2002, BME had not revoked a single medical license due to substandard care in the preceding five years. This bill would not direct BME to be more aggressive in its investigation of complaints against doctors.

This bill would not hasten BME's action in any way because it would not alter the current system. Under current law, BME meets with an accused physician in an informal settlement conference, then goes to the State Office of Administrative Hearings if no agreement is reached. The bill only would require that BME schedule the informal settlement conference within 180 days, unless the board could show good cause for delay. BME can do this now, yet actions come so late that they are ineffective, such as the case of an El Paso doctor who was found to have performed questionable treatments in 1993 and 1994, but whose license was not revoked until 1998, two years after it expired.

CSHB 6 would not crack down on repeat offenders. According to a report by Public Citizen, the bulk of medical malpractice is at the hands of physicians who have settled two or more medical malpractice claims in the past. The state should require BME to investigate any physician against whom an expert report was filed in multiple malpractice cases, rather than requiring it to investigate all claims, as current law does. Claims, identified by 4590i letters, are the first contact a claimant makes to a physician and often result in no action. Most insurers do not report all 4590i letters, and there are too many for BME to investigate anyway. Plaintiff's attorneys could be required to send the board copies of the expert report. Because an expert report requires a higher level of investigation than the claim letter sent to defendants as an initial notification, it would focus the board's attention on more legitimate claims.

The bill should require immediate action in cases of complaints against physicians who have been subjects of past rehabilitation orders, not just disciplinary orders. Rehabilitation orders are confidential and only known to BME and the physician. The public should be assured that a repeat offender who has received a rehabilitation order as a settlement with the board will be investigated promptly. Because no citizen group can verify that this is done, it should be in statute.

BME should be required to check the National Practitioner's Data Bank for reports of suspension or revocation of clinical privileges at a hospital or in a managed care organization. Those actions are some of the best indicators that something is wrong, yet the board is not required to access this information.

This bill would not resolve BME's inherent conflict of interest. The majority of board members are physicians, and all standard of care issues are determined by physicians, which makes the board's actions biased toward protecting physicians' interests, not the safety of the public. There are many examples of BME's protecting physicians, including a physician on probation for sexual misconduct who had sex with two patients and was placed on probation by the board again. The bill should include a public member on the expert panel to dispel the shroud of mystery surrounding the board's actions and to ensure that the public is represented.

This bill would fail to give patients access to the information they need. Under current law, the formal complaint and final order are public information, but patients must request them from BME. All information about previous medical malpractice cases that resulted in a judgment also is public, though the public must sort through files at the courthouse. The board should compile public information, so that patients can make real decisions about which doctor to see.

BME should publish aggregate information annually about the complaints it receives. This information, which should be categorized by the type of complaint such as billing or quality of care, would give the public a way to assess the board's performance.

The complaint resolution function should be moved to the Attorney General's Office, where the state has more experienced attorneys. BME's attorneys are underpaid and inexperienced and do not represent the state's interests well. The Attorney General's Office has very experienced attorneys who can stand up to doctor's well-paid private sector defense lawyers and win.

The move of the complaint resolution function to the Attorney General's Office also would create a check and balance on BME's decisions. It would be better to remove the portion of the agency that is investigating the physician from the part of the agency that determines that physician's fate. Instead, the attorney general's lawyers would bring the case before the board, and BME would take action.

The bill should create a patient advocate office, similar to those at the Public Utility Commission, Department of Insurance, and Texas Commission of Environmental Quality. This independent advocate should be a non-physician whose mission is to represent consumers in evaluating the board's actions. It could be funded with a small fee on physician licenses.

NOTES:

The author intends to offer two floor amendments. The first would change the registration and renewal surcharge from $30 to $80. The second would add a threat of real danger "to the public" to the criteria for license suspension.

The fiscal note for the committee substitute anticipates the bill would generate $12.3 million in revenue in fiscal 2004-05, but this was based on the $30 surcharge in CSHB 6.

The committee substitute does not include a physician education and assistance program to identify physicians at risk of committing acts of malpractice or medical error and to ensure all physicians are current in their medical knowledge, which was part of the bill as filed. The committee substitute identifies offenses in Chapter 22 of the Penal Code as a basis for suspension, while the bill as filed identified violent crimes and directed BME to define that term. The language regarding acts that may lead to license suspension is "real danger" in the committee substitute, while it is "threat to the public welfare" in the bill as filed. Both versions of the bill would require the board to revoke a license when the physician's license is revoked in another state. All other changes to the requirements for licensure, the

prioritization of complaints and development of a schedule of sanctions, establishment of an expert panel, other changes to the complaint resolution and enforcement process, and changes to the fee structure are only in the committee substitute.

The companion bill, SB 104 by Nelson, passed the Senate by 31-0 on March 10. The bill as amended and passed by the Senate is identical to CSHB 6 except that it would not require a 14-day lag between an initial notice of restriction or suspension of a license and the disciplinary hearing. The House Public Health Committee reported SB 104 favorably, as substituted, on March 12, making it eligible to be considered in lieu of HB 6. The House committee substitute for SB 104 is identical to CSHB 6.