Public Citizen's Report On Dangerous Texas Medical Board Enforcement Deficiencies: Their Causes and Solutions

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About Public Citizen

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BACKGROUND

The Texas Medical Board regulates the licensing and enforcement of about 69,000 physicians (including doctors of osteopathic medicine), 5,000 physician assistants, 940 acupuncturists, and 270 surgical assistants. The medical board has four organizational components that make up the enforcement division: Enforcement Support, Investigations, Litigation, and Compliance. Given the fact that 92 percent of the more than 75,000 health professionals regulated by the Texas Medical Board are physicians, it follows that the largest proportion of board funding and work involves doctors.

SUNSET ADVISORY COMMISSION REVIEWS

Under Texas law, the state medical board is required to undergo a "sunset review" every 12 years. The most recent review was in 2005.[1] A more limited performance review was conducted in 2009.[2] As a result of the 2005 sunset review, the 79th Legislature passed Senate Bill 419, which implemented most of the Sunset Advisory Commission recommendations involving the medical board.[3]

Despite the statutory and policy changes undertaken following the 2005 Sunset Advisory Commission review, and the more limited 2009 Sunset Advisory Commission performance review, Public Citizen's analysis of medical board enforcement activities — as well as data from the National Practitioner Data Bank (NPDB) — indicates that in order to protect Texas patients, further steps should be taken to strengthen the Texas Medical Board. These actions should be executed as soon as possible, rather than waiting for the 2017 sunset review.

EVIDENCE OF DANGEROUSLY INADEQUATE DISCIPLINE BY THE TEXAS MEDICAL BOARD

Physicians with Texas clinical privilege sanctions — 75 percent by hospitals — but not disciplined by the Texas Medical Board

Public Citizen's March 14, 2011, letter to the Texas Medical Board (see Addendum A) notes that there were over 438 physicians in Texas who have had one or more clinical privilege reports in the NPDB but did not have any medical board action against them as of December 30, 2009.

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[1] Report to 79th Legislature. Austin, TX: Sunset Advisory Commission; February 2005. http://www.sunset.state.tx.us/79threports/final79th/final.pdf. (Also see Implementation of 2005 Sunset Legislation. Austin, TX: Sunset Advisory Commission; January 2007. http://www.sunset.state.tx.us/80threports/implementation.pdf.)

[2] Texas Medical Board Performance Study: Report to the 81st Legislature. Austin, TX: Sunset Advisory Commission; February 2009. http://www.sunset.state.tx.us/81streports/final81st/255.pdf.

[3] Implementation of 2005 Sunset Legislation, Austin, TX: Sunset Advisory Commission; January 2007, p. 3. http://www.sunset.state.tx.us/80threports/implementation.pdf.

Based on Public Citizen's most recent analysis of the NPDB Public Use Data File, for over 21 years (September 1990 through the end of 2011), Texas health care organizations have taken disciplinary action against 793 Texas physicians.[4] Although just over 42 percent (334) of these physicians have also had a disciplinary action by the Texas Medical Board, almost 58 percent (459) have never had any medical board disciplinary action, despite the seriousness of what they were found to have done and the usually serious actions meted out against them by Texas hospitals and other health care organizations. These clinical privilege actions were mainly (75 percent) taken by hospitals but also by other health care organizations such as health maintenance organizations (HMOs) and ambulatory surgical centers.[5]

Of an estimated 900,000 or more physicians who have practiced in the U.S. from 1990 to 2012, only 11, 669 — barely more than one percent — have ever had a clinical privilege disciplinary action reported to the NPDB, a repository of all state disciplinary actions and medical malpractice payouts as well as clinical privilege actions against physicians.[6] Thus, when hospitals or other organizations finally do take such actions against a physician, the reason for the action and the type of action are usually quite serious, as indicated in the following sections.

Seriousness of the reasons for clinical privilege actions

These 459 Texas practitioners who have been disciplined by health care organizations but not by the Texas Medical Board were responsible for 641 clinical privilege reports to the NPDB. Of these 641 reports, 144 peer reviewer actions were taken for the most serious offenses, including:

- Immediate threat to health or safety of patients — 8 physicians
- Incompetence/negligence/malpractice — 93 physicians
- Substandard care — 33 physicians
- Sexual misconduct — 2 physicians
- Insurance fraud/filing of false reports — 3 physicians
- Inability to practice safely/alcohol/substance abuse/physical impairment — 14 physicians
- Diversion of controlled substances – 1 physician

[4] Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2009-2011: Public Citizen's Health Research Group. Washington, DC: 2012.

[5] As of December 2011.

[6] According to data from the federal NPDB, as of three years ago, barely one-half of American hospitals had taken even a single action against physicians with admitting privileges at that hospital at any time during the almost 20 years that the NPDB had been in operation (since September 1990). Hospitals are required to report clinical privilege actions to the NPDB when they restrict or revoke clinical privileges for more than 30 days for reasons involving performance or conduct.

Peer review findings against the remaining physicians included such offenses as unprofessional conduct, misrepresentation of credentials, and disruptive behavior.

Seriousness of types of actions

The seriousness of the peer review actions is also demonstrated by the specific disciplinary actions taken by the health care organizations:

- Summary/emergency suspension of clinical privileges — 34 physicians
- Summary/emergency limitation/restriction/reduction of clinical privileges — 3 physicians
- Revocation of clinical privileges — 96 physicians
- Suspension of clinical privileges — 93 physicians
- Denial of clinical privileges — 81 physicians
- Voluntary surrender of clinical privileges while under investigation — 131 physicians

The length of these sanctions varied:

- Indefinite penalty — 222 reports
- Permanent penalty — 327 reports
- Four years — one report
- 1.5 years — seven reports

Public Citizen found that while 339 (74 percent) of these 459 Texas physicians had one clinical privilege action reported to the NPDB, 120 had multiple sanctions reported, including 79 physicians with two reports, 28 physicians with three reports, and 13 physicians with four or more reports (including one practitioner with seven clinical privilege sanctions in the NPDB). None of these sanctions, however, have ever been matched with any Texas Medical Board licensure action.

Physicians with clinical privilege sanctions and medical malpractice payouts but no disciplinary action from the Texas Medical Board

Public Citizen also examined the number of medical malpractice reports in the NPDB for these 459 physicians with Texas clinical privilege sanctions but no Texas Medical Board actions against them. We found that 47.1 percent had one or more medical malpractice reports, including one practitioner with 22 payouts.

Table 1: Number of medical malpractice payments for Texas physicians with clinical privilege sanction by a Texas health care organization but no licensure action by the Texas Medical Board

Malpractice payments overall		
Number of medical malpractice payments	**Number of physicians**	**Percent**
0	243	52.9%
One or more payments	216	47.1%
Total	**459**	**100%**
Malpractice payments among physicians with one or more payments		
1	110	24
2	50	10.9
3	27	5.9
4	10	2.2
5	5	1.1
6	7	1.5
7	3	.7
8	1	.2
11	1	.2
13	1	.2
22	1	.2
Total	**216**	**47.1**

There were thus 216 Texas physicians who had one or more malpractice payments (see Table 1) and at least one clinical privilege sanction in the NPDB. The Texas Medical Board did not take any action against any of these 216 practitioners. The total number of malpractice payouts against these 216 doctors was 473, an average of more than two payouts per physician.

Specific examples of Texas physicians with hospital or other clinical privilege actions but no Texas Medical Board disciplinary actions of any kind meted against them include the following (identities of the physicians and hospitals have been deleted in the NPDB Public Use Data File; we can use only their coded identification numbers).

- Physician #91019[7] — This practitioner had clinical privileges revoked indefinitely by a peer review committee in 2006 and had 22 medical malpractice payments for

[7] Practitioner identification numbers used in this report come from the NPDB Public Use Data File for the period September 1, 1990, through September 30, 2011. This is important to keep in mind because practitioner numbers in the NPDB Public Use Data File are changed every quarter to help maintain the

the period 1996 through 2008. The total payout was $2.4 million, and all apparently were surgery related. Reasons for the medical malpractice payments included delay in diagnosis (four cases), improper performance (three cases), failure to recognize a complication (two cases), failure to treat (two cases), wrong body part removed (one case), failure to order appropriate medication (one case), wrong dosage administered (one case), unnecessary procedure (one case), and contraindicated procedure (one case).[8] Three of the medical malpractice cases involved significant permanent injury. In 2009, the practitioner was expelled from a professional medical society for unprofessional conduct. Fortunately for the public, the physician retired in June 2009. Unfortunately, the Texas Medical Board allowed this physician to practice while committing 22 cases of medical malpractice.

- Physician #35684 — This practitioner had clinical privileges restricted by a peer review committee in 2010 for substandard and/or inadequate care. The physician had 11 medical malpractice payments for the period 1993 through 2011. Total payout was $2.1 million, and all were apparently surgery related. Reasons for the medical malpractice payments included failure to diagnose (four cases), improper performance (two cases), improper management (two cases), failure to treat (one case), improper technique (one case), and unnecessary procedure (one case). One surgery related death was noted in the NPDB Public Use Data File.

- Physician #23292 — In 2002, this physician was permanently denied clinical privileges by a hospital. The practitioner had eight medical malpractice payments for the period 1992 through 2005. Total payout was $1.2 million. All medical malpractice cases were apparently surgery related and involved improper performance (three cases), wrong body part removed (one case), unnecessary procedure (one case), failure to order appropriate drug (one case), and failure to recognize complication (one case).

- Physician #36859 — This practitioner had clinical privileges revoked in 1998 and in 1999 for incompetence. His privileges were reinstated in 1999 and 2001. The physician had 13 medical malpractice payments for the period 1994 through 2008. Total payout was $1.7 million. Reasons for the medical malpractice included improper performance (three cases), improper management (two cases), wrong body part removed (two cases), wrong procedure (one case), and unnecessary treatment (one case). There was one case of significant permanent injury and one death.

- Physician #98284 — In 2010, this doctor voluntarily surrendered clinical privileges while under investigation for "disruptive behavior." The practitioner had six medical malpractice payouts totaling $1.3 million. All were surgery related. Three cases

confidentiality of practitioners. Thus, accessing the Public Use Data File for a different time period will not provide information on the providers identified in this document.

[8] Total cases do not add up to 22 because the NPDB Public Use Data File does not always show the reason or basis for medical malpractice payments.

involved improper performance, and two cases involved improper technique. The NPDB file did not have information on the reason for the sixth payout.

Recent worsening of the rate of serious state medical board disciplinary actions in Texas compared to that of other states

Using the Federation of State Medical Boards annual data on the number of disciplinary actions taken against doctors, Public Citizen annually calculates the rate of serious disciplinary actions (revocations, surrenders, suspensions, and probations/restrictions per 1,000 doctors) in each state and compiles a national report ranking each state medical board for the average of the three most recent years.[9]

Texas had initially, in the 1995 and 1996 rankings, stood among the top one-half of states, at numbers 25 and 23, respectively. However, starting in 1997 and continuing through the most recent ranking (2011), the rate of disciplinary actions has been lower, in some years much lower. For example, Texas ranked 28th in 1997, 33rd in 2002, 38th in 2009, and 30th in 2011.[10] Since 1997, Texas has consistently been among the bottom one-half of states in the rate of seriously disciplining doctors.

Lax enforcement

Even when the Texas Medical Board does take disciplinary action, such action is not always commensurate with the seriousness of the offense.

In a July 2, 2002, Public Citizen report, we highlighted the Texas Medical Board's poor record of disciplining Texas doctors. The report offered examples of doctors with dangerous records who were disciplined but nevertheless allowed to continue to practice:

- A doctor who admitted to and was convicted for four drive-by shootings of garages and automobiles belonging to a former business partner
- A doctor who was arrested and pleaded guilty on charges stemming from writing prescriptions in exchange for sexual favors
- A doctor whose surgical outpatient died after the doctor administered an overdose of Ketalar and Valium, placing her under general anesthesia rather than the conscious sedation intended
- A doctor who settled a lawsuit alleging fusing the wrong level of a patient's neck

[9] Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2009-2011: Public Citizen's Health Research Group. Washington, DC: 2012. http://www.citizen.org/documents/2034.pdf. Our calculation of rates uses the American Medical Association data on doctors.

[10] Ranking of the Rate of State Medical Boards' Serious Disciplinary Actions, 2009-2011: Public Citizen's Health Research Group. Washington, DC: 2012, Table 2. http://www.citizen.org/documents/2034.pdf. Also see, Ranking of the State Medical Boards' Serious Disciplinary Actions in 2003: Public Citizen's Health Research Group. Washington, DC: 2004, Table 2. http://www.citizen.org/Page.aspx?pid=2395.

- A doctor who had sexual relations with four patients and admitted to a history of alcoholism[11]

A more recent example of lax enforcement and its impact on patient safety — in this case, the death of two patients: Patient A and Patient B — was brought to the attention of Public Citizen by the mother of Patient B. Patient B died under the care of Dr. X while the physician was under a 2008 Texas Medical Board disciplinary order.

In 1999, Dr. X had signed an "Agreed Order" — that is, a consent order. The 1999 consent order outlined a multitude of violations of the Texas Medical Practice Act, including intemperate use of alcohol and drugs, writing fictitious prescriptions, nontherapeutic prescribing, and unprofessional conduct.

As punishment, the Texas Medical Board 1999 consent order suspended the practitioner's license but stayed the suspension and placed Dr. X on five years' probation. The medical board required the doctor to agree to enter an impaired physician program and placed limits on the physician's privilege to prescribe controlled drugs.

In January 2008, Patient A died from a mixed-drug overdose with a lethal level of Tramadol and therapeutic levels of other drugs in her system.

In October 2008, the medical board entered into another consent order with the physician because of prescribing violations. The punishment was a fine of $1,000.

In December 2008, Patient B died from a mixed-drug overdose. Dr. X had prescribed 2,400 tablets of controlled substances in a 120-day period.

In an October 2009 formal complaint against Dr. X, the medical board noted the following:

> "This case involves patient harm, severe harm to a patient, increased potential for harm to the public, knowing or grossly negligent acts, prior similar violations of the Act and Board rules and multiple violations of the Act ... Additionally, a previous Board order for Respondent included violations similar to the allegations of this complaint. On October 10, 2008, the Board entered an Agreed Order ('2008 Order') due to Respondent's failure to follow the Board's guidelines for the use of pain medicines and to his use of pre-signed prescription pads for controlled substances in 2007."[12]

In April 2011, Dr. X signed a new consent order. As punishment, the physician was allowed to continue practicing medicine under a Texas Medical Board monitoring program that

[11] Public Citizen. Public Citizen Releases Database With names of 1,111 "Questionable Doctors" in Texas — Most Still Practicing. Washington, DC: 2002. http://www.citizen.org/pressroom/print_release.cfm?ID=1142.

[12] Texas Medical Board Formal Complaint. Austin, TX: Texas State Office of Administrative Hearings; October 23, 2009, Exhibit 1, p. 4.

included a periodic review of medical records. The physician was also required to take a course in medical record keeping, as well as a course in diagnosing and treating chronic pain. At the end of a year, the physician could ask the medical board to amend the order.

It should be noted that the 1999 consent order included the following:

> Respondent's cooperation, through consent to this Agreed Order, will save money and resources for the State of Texas and is indicative of rehabilitative potential.[13]

The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) noted in an August 1990 report that because of increasing numbers of cases and staff shortages, medical boards are using consent orders more frequently. However, the OIG stated that "as the proportion of cases so settled exceeds 50 percent and, indeed, nears 100 percent in some places, one wonders if the 'appropriate' board action is always being taken — if the pressure to settle might not be leading some boards in some cases to act more leniently than the violation would warrant."[14]

CAUSES OF DANGEROUSLY INADEQUATE DISCIPLINE BY THE TEXAS MEDICAL BOARD

Serious funding and staffing issues

One obvious problem is inadequate funding of medical boards. The funding problem was foreshadowed by the Sunset Advisory Commission 2009 performance review, which noted:

> "Within the agency's enforcement division, increasing numbers of complaints, quality of care cases, and active cases could contribute to higher enforcement costs, heavier staff workload, and ultimately more time to resolve complaints."[15]

Also, the Texas Medical Board's own strategic plan for the fiscal years between 2011 and 2015 has noted the following:

> "The continued growth in complaints filed makes it impossible for enforcement staff to meet statutory deadlines for case closure. Furthermore, the investigations workload affects litigation staff and board members who must serve on disciplinary panels. The time demands upon board members are severe since there are a limited

[13] Agreed Order. Austin, TX: Texas State Board of Medical Examiners; 1999.

[14] Kusserow, RP. State Medical Boards and Medical Discipline, OEI-01-89-00560. Office of Inspector, Department of Health and Human Services;, August 1990, p. 14.

[15] Texas Medical Board Performance Study: Report to the 81st Legislature. Austin, TX: Sunset Advisory Commission; February 2009. http://www.sunset.state.tx.us/81streports/final81st/255.pdf.

> number of appointed members. Also, licensees will experience longer waits for case closure."[16]

Furthermore, the Medical Board's strategic plan for the fiscal years between 2013 and 2017 notes:

> "In terms of comparing revenue collections to agency annual appropriations, for the past few years the TMB [Texas Medical Board] has, on average, collected in excess of $30 million per year (including the state's $200 physician professional fee/surcharge) that goes to the state's general revenue fund. The TMB is appropriated approximately 1/3 of this revenue each year."[17]

The $30 million annual revenue generated by the Texas Medical Board comes from license fees (initial and biennial renewal), professional fees (occupation tax), and fines/penalties. The initial two-year registration cost to a physician, which includes the license and professional fees, is currently $826.

The impact of the funding problem can be clearly seen through the amount of complaints and budget totals (see Table 2). In fiscal year 2011, the Texas Medical Board received 8,182 complaints, an increase of 57 percent from 2006, when it received 5,210 complaints. However, the medical board budget for fiscal year 2011 was $10.9 million, an increase of only 12 percent from 2006, when it was $8.7 million (or $9.7 million, adjusted to 2011 dollars for inflation).[18] Furthermore, the number of FTE's (full-time equivalents) increased by only 16 percent, from 133 in 2006 to 153 in 2011.[19]

[16] Texas Medical Board: Agency Strategic Plan, Fiscal Years 2011- 2015. Austin, TX: Texas Medical Board; p. 24.

[17] Texas Medical Board: Agency Strategic Plan, Fiscal Years 2013-2017. Austin, TX: Texas Medical Board; p. 15. http://www.tmb.state.tx.us/TMB_Strategic_Plan_2013-2017.pdf.

[18] Using the U.S. Department of Labor Inflation Calculator. http://www.bls.gov/data/inflation_calculator.htm/.

[19] Texas Medical Board Statistics, Fiscal Years 2002-2011. Austin, TX: Texas Medical Board. http://www.tmb.state.tx.us/TMBstats-FY02-11.pdf. Note that this budget data covers both licensure and enforcement activities.

Table 2: Comparing board complaints and funding, fiscal years 2006 and 2011

Fiscal year	Number of complaints to board	Budget	FTE Staff
2006	5,210	$9.7 million adjusted for inflation	133
2011	8,182	$10.9 million	152
% increase ('06-'11)	57%	12% (adjusted for inflation)	16%

For fiscal year 2012, the medical board budget increased only very slightly to $11.3 million ($11.1 million in 2011 dollars), and the FTE cap was 165. This still represents only 14.4 percent more funding than in 2006, one-fourth as great an increase as the 57 percent increase in complaints to the board.[20]

Furthermore, the actual portion of the medical board budget devoted exclusively to enforcement (that is, does not include the impaired physician program or public education) shows signs of a decline. In fiscal year 2009, the medical board spent $6,234,361 on enforcement.[21] The fiscal year 2011 enforcement budget was $7,053,047. However, the fiscal year 2012 enforcement budget is $6,975,235, while the fiscal year 2013 request shows a decrease to $6,971,389.[22]

According to the Texas Medical Board strategic plan for fiscal years 2011 to 2015:

> "Due to the budget reductions that were mandated in FY 10-11, TMB … has not been able to hire all the additional staff granted by the 81st Legislature to address the current backlog of investigations. Consequently, the agency will continue to be unable to meet the statutory guideline that investigations be completed within 180 days. In addition, the number of complaints the agency receives is likely to continue to increase in the future which will further add to the agency's existing investigation backlog."[23]

[20] General Appropriations Act for the 2012-13 Biennium. Austin, TX: 82nd Texas State Legislature; 2011, VIII-35. http://www.lbb.state.tx.us/Bill_82/GAA.pdf. Also, Texas Medical Board email to Public Citizen. May 17, 2012.

[21] Legislative Appropriations Request for Fiscal Years 2012 and 2013. Austin, TX: Texas Medical Board; 2010, p. 8. http://www.tmb.state.tx.us/agency/TMB_LAR_FY_2012-13.pdf.

[22] General Appropriations Act for the 2012-13 Biennium. Austin, TX: 82nd Texas State Legislature; 2011, VIII-35. http://www.lbb.state.tx.us/Bill_82/GAA.pdf. Also see Legislative Appropriations Request for Fiscal Years 2012 and 2013. Austin, TX: Texas Medical Board; 2010, p. 8. http://www.tmb.state.tx.us/agency/TMB_LAR_FY_2012-13.pdf.

[23] Texas Medical Board: Agency Strategic Plan, Fiscal Years 2011- 2015. Austin, TX: Texas Medical Board; p. 72.

The board faces ongoing staffing issues, and the board itself notes that "increases in workload, constrained resources and an environment of continuous process improvement create stress for staff at all levels. The agency continues to experience a higher turnover rate than the state's average.[24]

Predictable backlog of complaints because of staffing shortages

According to the Texas Medical Board, "[w]hile the number of complaints has increased, the sources of the complaints have been relatively constant during fiscal years 2002 to 2008."[25] A review of medical board data shows the following for fiscal year 2008:

- Complaints by a patient — 44 percent
- Complaints by friends/family of a patient — 24 percent
- Complaints by the Texas Medical Board — 14 percent
- Complaints by health professionals — 8 percent
- Complaints by other parties (insurance companies, government, etc.) — 10 percent[26]

The Texas Medical Board operating budget for fiscal year 2012 outlines outcome measures for the Medical Board's enforcement activities. For the category "Percent of Documented Complaints Resolved Within Six Months," the document shows the following:[27]

- For FY 2010 — 28 percent
- For FY 2011 — 34 percent
- For FY 2012 — 35 percent (projected)

Thus, considering the fiscal year 2012 projection, the medical board hopes to resolve only about one-third of documented complaints within the 180-day statutory time frame for resolving complaints.

State law also requires the medical board to report investigations extending beyond one year to the state legislature.[28] The most recent Texas Medical Board report to the state legislature indicated that as of August 31, 2011, "454 investigations in the agency … had

[24] Ibid. p. 13.

[25] Texas Medical Board Performance Study: Report to the 81st Legislature. Austin, TX: Sunset Advisory Commission, February 2009, p. 262. http://www.sunset.state.tx.us/81streports/final81st/255.pdf.

[26] Ibid.

[27] FY 12 Operating Budget. Austin, TX: Texas Medical Board. http://www.tmb.state.tx.us/TMB-FY12-Operating-Budget.pdf.

[28] Senate Bill 104, passed by the legislature in 2003.

been open for at least one year." (See Addendum B, p. 1.) The period covered by the report includes cases from as far back as 2005. The report also includes progress notes on cases that had been resolved by November 2011.

Impact of backlog and staffing deficiencies on board actions and Texas patients' risks

The 14 percent of complaints that originate with the medical board itself include the statutory requirement to review the medical competency of a physician against whom three or more malpractice suits have been filed within five years.[29] According to the Texas Medical Board, cases are also generated based on other methods, such as "results of CME audits, responses to physician registration questions … [and] newspaper items."[30]

Public Citizen asked the Texas Medical Board if it had the authority to take an interim action when patient safety is at risk (for example, in a criminal case or standard of care investigation). We also asked if the medical board had taken such action against any practitioner in these two categories. The board advised us that it has such authority, but it would have to research whether such action has been taken in the cases we referenced.

Given the length of time it is taking to complete complaint investigations, many Texans should be concerned that they may be at risk for substandard care in cases involving quality concerns about doctors who should have been but were not disciplined by the board.

In 2007, the state Legislature asked the Sunset Advisory Commission to do a special, more limited review of the Texas Medical Board to determine if the board was complying with legislative direction and performance goals. The 2009 Sunset Advisory Commission performance report noted that "[w]hile quality of care complaints make up the large majority of the total complaints received, a much smaller percentage has resulted in disciplinary action."[31]

Further, the 2009 report found, for example, that "[i]n fiscal year 2008, the Medical Board did not meet its target performance for the percentage of jurisdictional complaints resulting in disciplinary action, disciplining 14 percent of physicians, as compared to the 18 percent target."[32]

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[29] Ibid.

[30] Texas Medical Board email to Public Citizen. April 30, 2012.

[31] Texas Medical Board Performance Study: Report to the 81st Legislature. Austin, TX: Sunset Advisory Commission; February 2009, p. 266. http://www.sunset.state.tx.us/81streports/final81st/255.pdf.

[32] Ibid., p. 267.

In December 2010, the Texas Medical Board obtained, on its own initiative, a list from NPDB staff of 147 names believed to be Texas physicians who had clinical privilege reports in the Public Use Data File for the period 2005 to 2009. In a March 22, 2012 email to Public Citizen, the Texas Medical Board advised us that it had completed an initial review of 60 of these physicians but, inexplicably, was unable to provide us with the status or outcome of any investigation. This March 2012 email further noted: "For the remaining 59% (87) of cases in which the hospital had reported to NPDB, but not to TMB, we completed an initial review of our records and did not find that a review/investigation had occurred for any of these cases. We have not had the resources to do a more comprehensive review."

What the board has essentially told us is that it does not have the resources to follow up on many doctors believed to be Texas physicians who have already had a credentialing action to see if they also merit a medical board disciplinary action. This certainly speaks to the critical issue of inadequate funding and staffing that is central the demonstrable lack of protection for Texas patients from many doctors who should arguably be disciplined.

RECOMMENDATIONS FOR A MORE EFFECTIVE TEXAS MEDICAL BOARD

1. Allow the Texas Medical Board to keep a greater share, ideally all, of the revenue it generates. Currently, the medical board brings in about $60 million from licensing and renewal fees over a two-year budget period. Because of a state legislature policy decision, the medical board gets to keep only one-third, $20 million, of the licensing and renewal fees over the two-year period, while two thirds, or $ 40 million, is turned over to the state general revenue fund.

   Also, according to a Texas Medical Board statistical analysis, from fiscal year 2002 through fiscal year 2011, the medical board obtained about $5.5 million in administrative penalties through enforcement activities. However, such recoveries by the medical board currently go to the state general revenue fund. Such recoveries should revert to the medical board for enforcement activities.

   This increased funding would have an important impact on the board's staffing deficiencies and the adverse impact the latter have on board functions as discussed in this report. Increased funding is particularly important given the recent decreases in the board's enforcement budget.

2. Appoint an independent medical board enforcement monitor, similar to that used to address problems involving the Medical Board of California's performance. The California legislature, as a result of findings from the 2001-2002 sunset review of its medical board, provided for the appointment of an independent monitor charged with "evaluating 'the disciplinary system and procedures … of the board's enforcement program."[33] This monitor could (a) advocate for the medical board; (b)

[33] Fellmeth, JD and Papageorge, TA. Final Report: Medical Board of California Enforcement Program Monitor. Medical Board of California; November 2005, Executive Summary, p. 1. http://www.mbc.ca.gov/publications/enforcement_report.html.

review the impaired physician program to ensure that impaired practitioners are properly monitored, tested, and counseled, etc.; (c) monitor enforcement policies and practices to ensure that disciplinary actions and consent orders are commensurate with violations of the Texas Medical Practice Act; (d) and oversee investigation caseloads to ensure that investigations lasting for long periods of time do not compromise the safety of Texas patients.

3. Consider instituting random practice audits of physicians as a proactive quality assurance mechanism. The HHS OIG has highlighted the use of random practice audits.[34] The OIG has also noted the College of Physicians and Surgeons of Ontario experience in making the most extensive use of random practice audits. The Ontario institution reviews the practices of about 400 physicians. Of this total, about three-quarters is randomly selected, with the rest coming from a target group of practitioners over 70 years old. The College has found this effort to be quite effective in identifying practice deficiencies.

SUMMARY

This report provides evidence concerning the inadequate capacity of the Texas Medical Board to protect Texas patients from medical harm. The evidence includes:

1. The apparent failure to sanction hundreds of physicians who have been disciplined by Texas hospitals, many of whom have multiple medical practice payments and including some practitioners who have been considered an immediate threat to the health or safety of patients;

2. The backlog of hundreds of complaints (including cases going back seven years); and

3. The drop in the rate of serious disciplinary actions, as noted in Public Citizen's annual ranking of state medical board performance.

Public Citizen's annual ranking of state medical boards' performance notes that boards are likely to do a better job of disciplining physicians if the following conditions are met:

- Adequate funding (all money from license fees going to fund board activities instead of going into the state treasury for general purposes)
- Adequate staffing
- Proactive investigations rather than only reacting to complaints

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[34] Kusserow, RP. Quality Assurance Activities of Medical Licensure Authorities in the United States and Canada, OEI-01-89-00561. Washington, DC: Department of Health and Human Services, Office of Inspector General, p. 4. http://oig.hhs.gov/oei/reports/oei-01-89-00561.pdf.

- The use of all available/reliable data from other sources, such as Medicare and Medicaid sanctions, hospital sanctions, malpractice payouts, and the criminal justice system
- Excellent leadership
- Independence from state medical societies
- Independence from other parts of the state government so that the board has the ability to develop its own budgets and regulations
- A reasonable legal standard for disciplining doctors ("preponderance of the evidence" rather than "beyond a reasonable doubt" or "clear and convincing evidence")[35]

We therefore recommend, as discussed in recommendation number 1, that a greater portion of license and renewal fees, as well as all administrative penalties, are returned to the Texas Medical Board to enhance activities relating to enforcement and patient safety. With this increased funding must come the responsibility to decrease the dangerous backlog of unresolved cases and to discipline a large proportion of the 459 Texas physicians found to have committed offenses serious enough to result in the severe credentialing actions against them by Texas hospitals and other health care entities.

Thank you for your consideration of our recommendations.

We look forward to hearing from you.

Sincerely,

Sidney Wolfe
Director
Public Citizen's Health Research Group

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