



# Understanding the Texas Medical Board — a resource for physicians

A publication of Texas Medical Liability Trust

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The only health care liability claim trust created and endorsed by the Texas Medical Association.

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## **Preface**

This manual has been developed as a guide for physicians who may be facing an investigation by the Texas Medical Board (the TMB or the Board) or who want to know more about the disciplinary and regulatory functions of the TMB. The first section provides information on TMLT's Medefense coverage, which is a policy endorsement that provides legal expense reimbursement for disciplinary proceedings, including actions by the TMB. The second section will introduce the TMB and briefly discuss its history and functions. The next section takes a detailed look at the complaint process from the pre-investigation stage to the State Office of Administrative Hearings. The following three sections will address regulatory areas that affect Texas physicians' every day practice —TMB documentation requirements, TMB CME requirements, and TMB rules related to physician advertising.

The information in this publication is intended to enhance your knowledge of the Texas Medical Board, reduce your exposure to disciplinary actions by the Board, and assist in your defense should an action occur. This information is not intended to serve as legal advice, but as a resource for physicians.

We would like to acknowledge the contribution of Jon Porter and Jill Wiggins. Material for this publication was taken from content previously written by these individuals and published by TMLT.

For questions related to TMLT's Medefense coverage, please call 800-580-8658 and ask for the Claim Department. For all other questions, please contact the Risk Management Department at 800-580-8658.

## **You've been notified of a TMB complaint — take advantage of Medefense coverage**

All TMLT policies that cover *individual physicians* include a Medefense Endorsement, which provides reimbursement for legal expenses for disciplinary proceedings and tax audits. According to the endorsement, disciplinary proceeding(s) means and is limited to the following:

- “1. any professional review action against the Named Insured by professional review body of a hospital, health maintenance organization, preferred provider organization, or managed care organization with which such insured has clinical privileges or membership, which action is taken for the purpose of adversely affecting said clinical privileges or membership;
2. proceedings instituted by a state medical licensing authority against the Named Insured for unprofessional conduct;
3. proceedings instituted against the Named Insured by a professional review organization pursuant to part 1004 and 1005 of title 42, Chapter V, Code of Federal Regulations to impose sanctions on the Named Insured; [these regulations deal with compliance issues under Medicare rules];
4. proceedings instituted against the Named Insured by a state department of insurance, state worker's compensation commission, state department of health or the federal department of health and human services alleging that the Named Insured has performed medical services in excess of or in violation of guidelines for appropriate utilization of said services; and
5. except as excluded by paragraph V(3) of this endorsement, proceedings by a state or federal government or an agency thereof against the Named Insured involving allegations of non-compliance with Medicare/Medicaid regulations or procedures.” (1)

The Medefense Endorsement also provides reimbursement for audit expenses associated with an individual physician's U.S. income tax return under examination by the Internal Revenue Service.

### **Physicians are strongly urged to do the following as soon as they are notified of any disciplinary action by the TMB:**

**1. Notify TMLT** as soon as you receive written notice from the TMB or other disciplinary authority. The policy states that a policyholder has 60 days to report an insured event to receive reimbursement for covered expenses. “In order to preserve coverage it's very important that policyholders pay attention to that 60-day window in which to report knowledge of a proceeding,” says John Southrey, a claim supervisor who handles Medefense claims for TMLT policyholders.

Please call the claim department at 800-580-8658 to report a Medefense claim.

**2. Consider retaining an attorney** to help draft your initial response to the TMB. Upon request, TMLT can provide policyholders with the contact information of attorneys who have experience handling disciplinary proceedings.

“Retaining an experienced attorney as early as possible in this process can help to shape the case,” says Southrey. “It provides the attorney with the opportunity for early interaction with the Board’s investigator, hopefully before the investigator has formed his or her impressions. It can also facilitate a clear, concise, and objective response to the Board’s complaint without subjective overtones.”

Working with an attorney who is knowledgeable of TMB proceedings can be advantageous because sometimes this can result in an early dismissal of the complaint. “I do not think that you can over emphasize the need to timely and thoroughly respond to the initial investigation letter from the Board,” says Gregory Myers, an attorney with Kroger, Myers, Frisby & Hirsch in Houston. “I have seen too many examples of cases where the physician responds on his own, or forwards a copy of the medical records without a response. Often the physician’s response does not contain what it should and can actually make matters worse.”

**3. To expedite the reimbursement process** under Meddefense, promptly send the following information to TMLT:

- a copy of the initial written notice/letter informing the policyholder that a disciplinary proceeding has been instituted;
- copies of all legal expense invoices pertaining to the defense of the claim — the legal or audit expenses should be itemized on an hourly basis showing the services provided, the time incurred, and the hourly rate;
- copies of all payments made to the attorney or law firm representing the policyholder in the matter; and
- a copy of the dispositive letter describing the final outcome so the claim can be closed.

To learn more about Meddefense, please contact the claim department at 800-580-8658.

#### **Source**

1. TMLT policy Meddefense Endorsement. Coverage agreement, paragraph 1.

## **Introduction to the Texas Medical Board**

The Texas Medical Board (“TMB” or “the Board”) was one of the first agencies created by the Republic of Texas in 1837, known then as the Board of Medical Censors. Since that time, there have been numerous variations of the role, composition, and purpose of the Board. TMB as we know it today takes on multiple roles, with its chief missions being to protect the public and ensure a sufficiently trained physician workforce.

As a regulatory agency, the Board licenses, investigates, disciplines, and informs the public about physicians licensed in Texas. Currently, it also does the same for physician assistants through the Texas Physician Assistant Board; for acupuncturists through the Texas State Board of Acupuncture Examiners; and for Surgical Assistants through the Texas State Board of Surgical Assistant Examiners. The Board also regulates nonprofit health corporations, the practice of telemedicine, and anesthesia in outpatient settings; and it establishes core credentialing, among many other duties. In recent times, more responsibilities and obligations have been given to the Board, often with limited funding and caps on the number of employees it can hire.

You will recall from high school government class that the legislature passes a law or statute. Then, the executive branch — with the governor as chief executive officer — reviews the law and enforces it. More often than not, an agency will formulate rules or regulations to define what the law means and how the agency intends to enforce it.

There are roughly 150 pages of statute (law) that govern how you are supposed to act as a physician and these are found in the Texas Medical Practice Act, which is in the Texas Occupations Code, Sections 151 to 165.

Then there are the rules. All the regulations created by the TMB are found in Title 22 of the Texas Administrative Code, Sections 160 to 200. There are roughly 1,000 pages of regulations about the Board and its authority over physicians and the other professions it regulates.

Of course, there are plenty of other statutes and regulations that affect the practice of medicine —both state and federal. A violation of those laws and regulations can, and often does, lead to problems with the TMB. It is important for all physicians to stay informed about the various changes that come through the Board. There have been plenty of changes in recent years that have placed a variety of limitations on the practice of medicine, which, if overlooked, can result in serious harm to a physician’s ability to practice medicine in Texas. For better or for worse, the practice of medicine is a highly regulated profession. It is your duty to know what is considered appropriate and what is not.



**Sidebar: Violations for which the TMB can act**

“Sections 164.051 and 164.052 of the Occupations Code spell out the violations for which TMB may deny licensure or discipline a licensee. Here they are paraphrased; the full statutory language is at <http://tlo2.tlc.state.tx.us/statutes/oc.toc.htm>:

- Conviction or deferred adjudication, community supervision, or deferred disposition for a felony or a misdemeanor involving moral turpitude.
- Commits or attempts to commit a violation of the Board Rules (complete Board Rules are at <http://www.tmb.state.tx.us/rules/rules/bdrules.php> ).
- Is unable to practice medicine with reasonable skill and safety because of illness, drunkenness; excessive use of drugs, narcotics, or other substances, or a mental or physical condition, or is found by a court to be of unsound mind, or uses alcohol or drugs in an intemperate manner that could endanger a patient’s life.
- Fails to practice medicine in an acceptable professional manner consistent with public health and welfare.
- Is removed, suspended or subject to discipline by peers.
- Is subject to repeated or recurring meritorious health care liability claims.
- Is disciplined by another state board.
- Submits false or misleading documents in application for licensure.
- Commits unprofessional conduct likely to deceive or defraud the public.
- Uses an advertising statement that is false, misleading or deceptive, or advertises professional superiority in a manner not readily subject to verification. This includes claiming certification by an ABMS board when such is not the case, or claiming certification by a board not recognized by the TMB.
- Purchases, barter or uses a medical degree, license or diploma, or alters with fraudulent intent, a license, certificate, diploma or transcript, or uses such a document, or subverts the examination process for licensure.
- Impersonates a physician.
- Employs or associates in practice with a person whose license to practice has been suspended, canceled or revoked.
- Performs or procures a criminal abortion; performs an abortion on a viable unborn child during the third trimester of pregnancy (with certain exceptions); performs an abortion on an unemancipated minor without proper consent.
- Aids and abets the unlicensed practice of medicine.
- Violates any state or federal law connected to the practice of medicine (a complaint, indictment or conviction is not necessary; proof of commission of the act is sufficient).
- Fails to keep records of purchase and disposal of controlled substances.
- Writes false or fictitious prescriptions.
- Prescribes nontherapeutically.
- Fails to adequately supervise those to whom the physician delegates or delegates to someone known to be unqualified.” (1)

## **Who is on the Board**

The Texas Medical Board consists of 19 members appointed by the governor, with approval by the Senate, and they serve in staggered six-year terms. Board members do not receive any salary for their duty, although they do receive a per diem.

Nine members of the Board must be licensed Texas physicians who hold a degree of doctor of medicine (i.e., an allopathic physician); three must be licensed Texas physicians with degrees in osteopathic medicine. The remaining seven are public members who are Texas residents for five years preceding their appointment, and who have no direct connection with the practice or the business of medicine.

Physician members must be actively engaged in the practice of medicine for at least five years preceding their appointment and involved in peer review at a health entity for no less than the past three years prior to the appointment.

There are additional restrictions on who may be a member of the Board. Members must be over the age of 18 and may not hold stock in a medical school, or be a member of the Board of trustees of a medical school. Further, an individual may not be an officer with a statewide or national professional or trade association that represents the field of health care or a national organization incorporated to represent the entire profession licensed to practice in Texas or the United States or if a person's spouse is in a substantially similar capacity. A public member may not be an officer, employee, or paid consultant in the health care field and may not have a spouse in such a position. Also, a registered lobbyist may not serve on the Board.

The TMB usually meets six times a year. Typically, Board members spend between 20 to 40 days in Austin serving in their official capacity each year. Individual members may also serve on Panels of the Board (this will be discussed in detail later).

The Board appoints an executive director to run day-to-day operations. The executive director sets the policies of the Board in motion and enforces the law. The executive director is not required to be a physician; however, for the past several decades, most executive directors have been physicians and two have been attorneys. If the TMB ever appoints a non-physician to be the executive director, he or she must then appoint a medical director to the Board's staff. The medical director must be a Texas licensee who is primarily responsible for implementing and maintaining policies, systems, and measures regarding clinical and professional issues and determination. Naturally, because of these broad powers, a non-physician executive director would have difficulty maintaining full control over the agency.

The executive director maintains a staff of 139 (as of August 2007) full-time employees, including attorneys, nurses, investigators, computer staff, and support personnel.

## **Powers and duties**

The Medical Practice Act gives the TMB broad powers to create rules and policies necessary to perform its function to protect the public and to ensure an adequately trained physician workforce.

Foremost among the Board's powers is the ability to regulate the practice of medicine in Texas. Historically, the Board has shied away from mandating what a physician can and cannot do in the daily practice of medicine. However, in the past several years, the Board has been more willing to engage in rule making and policy creation that limits some practices. Recent examples include: prescribing for oneself, family members, and colleagues; office-based anesthesia; use of lasers; and prescribing for pain.

The Board also is statutorily mandated to create rules on the maintenance of patient records and telemedicine. The rules on medical records are of critical importance for physicians and their staffs to review, as this is one of the most frequently violated provisions. (See 22 Texas Administrative Code Section 165).

One of the most powerful tools the Board possesses is the ability to issue subpoenas. This means the Board has access to any information (such as patient records) from physicians, hospitals, individuals, pharmacies, and businesses. Absent a conflicting law, failure to comply with a properly served subpoena could result in a physician having his or her medical license sanctioned by the Board. Subpoenas issued to non-licensees are enforced in district court.

Those with HIPAA concerns can rest assured that there is a HIPAA exception for medical Board investigations. In fact, the only time federal and state law conflict on this issue is when the request concerns release of drug and alcohol treatment records. Should this occur, a physician can refuse to release the records without patient authorization. The Board must then seek a court order for release of these records. This provides the physician with a level of protection they would not otherwise have.

While the legislature has placed a cap on the amount that can be charged for a medical licensure fee, the law also provides the Board the authority to set reasonable and necessary fees in the amount needed to perform its duties under the law. The TMB is a self-funded agency, meaning that licensing fees collected by the Board help to cover operating costs. With this said, the Board only keeps a percentage of the money it collects in licensing fees and gives the majority to the state for general revenue purposes, such as roads, schools, and prisons. In reality, the licensing fees are a form of professional taxation.

There are a few restrictions on the Board's authority. Interestingly, the TMB has no authority over advertising and competitive bidding, unless it is to prevent false, misleading, or deceptive practices. Another key prohibition for the Board is the expressed adoption of a fee schedule for medical services. However, they do issue rules on medical records copying fees.

### **Public information**

Over the past several years, the Board has radically changed the methods by which it informs the public of its actions. Information the Board collects is easily and readily available to the public. Such accessibility has had the positive effect of creating better educated and more informed patients, and the adverse effect of publicizing negative information, such as the occasional mistake that can seriously effect a physician's practice.

In the past, the Board's sole outlet of public information was their quarterly newsletter — *the Texas Medical Board Bulletin* — that is distributed to licensed Texas physicians, public libraries, and people who sign up to receive a copy. In the early 1990s, at the direction of the legislature, the Board instituted a toll-free telephone number for the public to learn about the disciplinary history of a physician or to file a complaint. TMB requires public posting of this number in all physician offices and hospitals. Through this effort, the public slowly has become aware of the Board and the degree of information it has about physicians. Initially, consumers were provided with licensure verification and were told whether or not the Board had taken any action against the physician. Over time, there was a push to expand the information available to the public.

By the late 1990s, the legislature instituted the Physician Profile Project, which gives anyone with Internet access a wealth of information on each physician including: biographical and educational information; actions taken by TMB or other Boards; past criminal activities; and malpractice histories. With increased access to information, the Board processed more than 3.3 million verifications of licensees in the 2006 fiscal year in written, electronic, and telephone forms.

Despite the increased information available to the public, some data is still withheld, including active investigations and Board-initiated investigations that are dropped or dismissed. However, hospitals and other state Boards may request this data.

The TMB's web site ([www.tmb.state.tx.us](http://www.tmb.state.tx.us)) contains a wealth of information. All physicians and their employees should have this site bookmarked. The information includes statutes, rules, and polices; a calendar of events; forms; and frequently asked questions. Other items of note are a summary of Board actions from prior meetings; statistical information categorizing complaint information filed with the Board; and public disciplinary actions the Board has taken since its last meeting.

In recent years, the TMB has been proactive in sending press releases to the media regarding its actions. These releases often end up in local newspapers. When the facts of a case and the action taken are serious and/or interesting, it may make local television and radio news. For physicians in smaller towns, it is fairly likely that the local media will report disciplinary actions.

It is also worth noting that, as of the Fall 2007, the TMB made a change regarding how it releases information to the public about "administrative violations" (formerly known as "minimal statutory violations"). These actions, although still public and part of the physician's record, will not be listed in TMB press releases or the TMB newsletter by physician's name. Only the numbers of such violations will be listed. "Administrative violations" are based on violations that do not involve the standard of care and are for rule violations such as failing to release medical records in a timely fashion, failure to obtain required CME, or failure to timely sign a death certificate. (For more information on "administrative violations," please see page 32.)

## **TMB physician profiles**

As noted previously, physician profiles provide patients with information about physicians in Texas. Previously, this information was either impossible or very difficult to find. Now consumers have access to professional, educational, biographical, and legal information:

- name, place of birth, gender, and race;
- medical school or school attended, and date of graduation;
- list of postgraduate training including dates, type, location, and specialty;
- specialty certification;
- number of years practicing medicine in the United States and/or Canada;
- primary and secondary areas of medicine identified as a practice area;
- number of years practicing medicine in Texas;
- issue and expiration date of the Texas license;
- the name of each Texas hospital the individual has privileges with;
- primary practice location, which includes street address, city, state, and zip code;
- type of translation services provided, if any, at the primary practice location;
- whether the individual's primary practice is accessible to the disabled;
- if the individual participates in Medicaid;
- list of up to five awards, honors, publications, or academic appointments received;
- description of any conviction for felony or misdemeanor involving moral turpitude;
- description of any action taken by the Board, even if previously resolved;
- description of any action taken by another licensing agency;
- description of any charge reported to TMB where the individual has pled no contest, received deferred adjudication or pretrial diversion, or a plea of guilty where the matter was continued;
- description of any formal complaint filed by TMB against the individual at the State Office of Administrative Hearings;
- description of any TMB investigation resulting from three medical malpractice claims filed over a five-year time period and the outcome of the investigation; and
- description of any final resolution resulting from medical malpractice claims, including all settlement agreements.

All licensees must supply this information to the TMB and update their records upon renewal. Failure to comply will result in license revocation. Further, providing false or misleading information could subject the individual to an investigation and disciplinary action by the Board.

It is imperative that physicians check their profiles on a regular basis to ensure the information is correct. In addition to its own records and information provided directly from licensees, the Board also receives information from third parties.

## **Confidentiality**

Though the TMB makes a good deal of information available to the public, some privacy protections are in place. For example, Social Security numbers are not part of the public domain; neither is a physician's home address, unless it is listed as a mailing address. Consequently, it is recommended that you list your business address as your default mailing address.

What happens if you are investigated by the TMB and the matter is dismissed? Is that public information? The answer is “maybe.” As noted above, the fact that a physician is under investigation normally is not given to the public, but hospitals, insurance carriers, and other states may learn about an ongoing investigation should they query the Board while the investigation is still open. It is therefore wise to review your hospital bylaws and employment contracts to see if you are required to inform such entities that you are under investigation. Failure to inform a hospital or an employer may cause more harm than the investigation itself and could result in peer review action or denial of privileges.

If the TMB investigates a physician, is the information that the Board provides and collects subject to disclosure? Current law says no. Any information the Board either creates or collects for an investigation, a hearing, and some compliance matters is generally confidential. As with all things in government, there are exceptions, including information disclosed during a public disciplinary proceeding (such as a SOAH proceeding), under a court order, for research purposes, to the Texas Department of Insurance Division of Workers' Compensation, and to other states, peer review organizations, or associations that are dealing with the same issue.

As the Board continues to collect information on its licensees, there will be a continued effort among consumer groups, insurance companies, and others to break down the barriers remaining to full, unfettered access to information, including information gathered during an investigation. As the Internet has become ubiquitous in our society, the call for such information will continue. Access to all of this information is both good and bad for the licensee. It is certainly better to have an informed, educated patient, but it also is difficult to know how much the patient knows about you, perhaps creating false assumptions based on the information taken from the TMB's web site.

#### **Source**

1. Patrick DW. Know the law that regulates your practice. *Texas Medical Board Bulletin*. Fall 2007. 5:1(2). Available at <http://www.tmb.state.tx.us/news/newsletters.php>. Accessed on January 18, 2008

## Texas Medical Board complaint process

### The disciplinary function of the TMB

For physicians, the disciplinary function is the most visible, most misunderstood, and certainly the most disconcerting aspect of the Board's duties. The consequences of a single complaint can range from a dismissal to license revocation; enormous expenditure of stress and time; and damage to a physician's professional reputation. (Please see page 8 for information on the types of violations for which the TMB can discipline or sanction.)

According to the TMB web site, between 2001 and 2007, there was a 196.2% increase in disciplinary actions and an 87.7% increase in the number of investigations opened. In fiscal year 2007, the Board disciplined 311 physicians for violations ranging from failure to meet the standard of care to maintaining inadequate medical records. (1)

### Texas Medical Board Statistics — Fiscal Years 2001-2007 <sup>1</sup>

	FY 2007	FY 2006	FY 2005	FY 2004	FY2003	FY2002	FY2001
<b>Complaints/investigations</b>							
Complaints received	6893	5211	6038	6090	4942	5164	4648
Nonjurisdictional	1425	1158	3807	4190	3167	3439	3283
Jurisdictional Not Filed	2905	2020	NA <sup>2</sup>	NA <sup>2</sup>	NA <sup>2</sup>	NA <sup>2</sup>	NA <sup>2</sup>
Investigations opened	2563	2032	2231	1900	1775	1725	1365
Investigations completed	2550	1866	1994	1977	1851	1448	1567
<b>Litigation</b>							
Informal settlement conferences	482	427	469	420	477	172	187
Cases filed at SOAH	48	34	63	45	48	35	27
<b>Disciplinary actions (physicians)</b>							
Percent quality of care cases	68	67	52	NA	56.6	63.8	54.7
Administrative penalty	\$523,094	\$478,100	\$1,457,354	\$434,500	\$393,500	\$175,880	\$59,800
Temporary suspensions	21	11	20	8	7	19	9
<b>Compliance</b>							
Probationers (all types of license)	687	652	622	553	430	321	287
Drug screens (all types of license)	8529	8501	7537	7211	5683	2179	NA <sup>3</sup>
<b>Licensure</b>							
Physician applications received	4041	4026	2992	2947	2561	2552	2445
Physician licenses issued	3324	2516	2692	2343	2513	2828	1370

1. The state fiscal year runs September 1 to August 31.

2. Nonjurisdictional and Jurisdictional Not Filed were separated for the first time in FY 2006.

3. New screening program was instituted in FY 2002.

**Physicians are strongly urged to do the following as soon as they are notified of any disciplinary action by the TMB:**

1. Contact TMLT. Your TMLT policy includes a Meddefense Endorsement that provides reimbursement for legal expenses you incur for disciplinary actions by the TMB. The policy states that a policyholder has 60 days to report an insured event in order to receive reimbursement for covered expenses. (Please see page 6 for more information on TMLT’s Meddefense coverage.)
2. Consider retaining an experienced attorney as early as possible in this process. “An attorney experienced with handling Board complaints is required because there are certain ways to phrase the initial response and particular issues that the Board or investigator wants addressed, which if delineated in the initial response, can result in early closure,” says Gregory Myers, an attorney with Kroger, Myers, Frisby & Hirsch in Houston.

The attorney should have experience handling Board complaints. Upon request, TMLT can provide policyholders with the contact information of attorneys who have experience handling disciplinary proceedings.

**Sidebar: TMB’s temporary suspension powers**

Legislation passed in 2003 strengthened the Board’s powers. If evidence shows a physician is a “continuing threat to the public welfare,” the Board may, *without notice or hearing*, temporarily suspend or restrict a physician’s license. The Board must immediately provide notice of the suspension to the physician and conduct a hearing at the earliest possible date after 10 days of notice. If the suspension is upheld after this hearing, an informal settlement conference (more on this below) is then convened. The physician can attend the hearing or waive it. If the physician waives the hearing or

**Who files complaints**

In fiscal year 2007, the TMB received 6,893 complaints. Considering there are approximately 58,343 physicians with a Texas license (44,545 live in Texas), the Board received or initiated complaints on about 11.8 percent of licensed Texas physicians. Of those, the TMB opened 2,563 investigations against physicians. This was a record number of investigations opened.

Approximately 60 percent of the complaints communicated to the Board are from consumers — normally patients and families of patients. Nearly 30 percent of the complaints come from other physicians or are initiated by the Board to gather additional information for an ongoing investigation. The remaining 10 percent come from peer review organizations, other government agencies, law enforcement, and other non-physician health care individuals or entities.



### **The pre-investigation process**

When a complaint is filed, the first goal for Board staff is to determine whether the complaint falls within the powers and authority of TMB to regulate. For example, if a physician's staff member is rude to a patient, this is not a jurisdictional complaint. Whereas, if a physician's staff member is diagnosing illnesses and recommending treatment, that is a jurisdictional complaint. Once the Board receives a complaint, it has 30 days to complete an initial review determining whether or not it is jurisdictional.

At the conclusion of the 30-day screening period, Board staff may determine the complaint is non-jurisdictional and forward it to the Disciplinary Process Review Committee (DPRC), which is made up of half the Board membership. The DPRC will confirm the staff's decision and forward its recommendation to the full Board for confirmation. The complainant will be notified in writing of the Board's decision not to open the complaint to a full investigation.

Even though TMB staff may determine that the complaint is not jurisdictional, it may be a violation of other state or federal laws. In this case, the matter may be referred to law enforcement if it is believed that a crime has been committed or to a different government body for further investigation.

Once it is determined that the case falls under TMB's jurisdiction, the evaluator gathers all the Board's data concerning the physician under complaint. This information can include past Board action and investigations, the number of complaints, and medical malpractice history. Staff also review biographical information such as education, training, specialty, and Board certification, along with data as collected by various data banks.

A staff member then contacts the complainant to clarify the facts of the complaint. Staff also send a letter to the physician asking for a response to the complaint. The letter provides a general notion of the complaint, advising that this is a pre-investigation and the physician's response may play a role in whether the Board opens a full investigation. Normally, the physician is given 14 days from the date of the letter, not the date of receipt, to provide a written response. Failure to respond usually defaults into the opening of an investigation. It does not matter if a physician may have been on vacation or failed to notify the Board of a change in address. The deadline is solid.

If the physician presents evidence that there is no violation, the case is counted as "jurisdictional — not filed." For example, the complaint may be that the physician failed to take x-rays, and if the physician submits those x-rays, there is no violation found. If the staff member finds that the allegations — if they prove to be true — would violate the Medical Practice Act, the case is filed as a complaint and assigned to an investigator.

This pre-investigation stage is a good time to consult with legal counsel, with the goal of responding appropriately and professionally to the allegation(s) by demonstrating that the physician's actions were within the standard of care. Supporting materials, like medical records or journal articles, are suitable for submission, when the materials reflect positively on the physician. At this point, consulting with an attorney is worth the investment because counsel will know what is appropriate to submit to the TMB. The obvious goal is to stop the investigation

before it formally starts. Be warned: All information provided to the Board can and will be used if the investigation continues.

### **The investigation**

Once a complaint becomes an investigation, it is transferred to the investigation division of the TMB. The majority of investigators are nurses with several years of experience; the remaining have law or administrative enforcement backgrounds.

The investigator reviews initial information supplied by the Board, and with the assistance of the staff member who performed the initial review, formulates a plan of action. This includes which documents to request and what questions to ask the physician under investigation, the complainant, and other witnesses. Contacts to both the complainant and the physician under investigation may sometimes be made by phone, but more frequently by letter.

The physician under investigation will receive a notice letter informing him or her which section of the Medical Practice Act has allegedly been violated and providing a brief description of the factual basis of the investigation. For example, the letter may cite Section 164.051(a)(6): practice inconsistent with the public health and welfare. It would then state the factual claim. For example, “from 01/01 to 01/03, you failed to adequately monitor Jane Doe’s blood pressure and prescribe appropriate medication, which contributed to Ms. Doe’s death.”

The notice letter typically directs the physician to complete a Medical Practice Questionnaire (MPQ) that provides the investigator background information and some idea of what the physician’s practice is like. The notice letter also may ask for narrative on the allegation and perhaps additional information.

If the physician has not yet contacted an attorney with experience in this process, it should be done now. The investigation period is critical, because at this stage evidence is gathered, statements are made, and one’s professional character is put to the test.

There are a few rules to remember when you are under investigation:

**The Board has subpoena power.** The Board can demand copies of any medical, business, or other records deemed necessary for the investigation. In most cases, once Board staff issue a subpoena, they can have what they want. HIPAA regulations create an exception concerning drug and alcohol-related records, but the law has not been fully settled on this issue. Consequently, if the Board subpoenas the drug and alcohol records of a patient who refuses to sign a release, consult an attorney. Failure to comply with a subpoena is a violation of the act and can subject you to disciplinary action. It is equally important to note that the Board created a rule whereby, upon request (oral or written presumably) of the Board or a Board representative, a physician must provide copies of medical records within a time prescribed by the requestor. (There is some debate in the legal community about whether this is legal.) You are within your right to request that the Board issue a subpoena to request such records and it is good protection in case the patient is upset that his records were released to a government agency.

**Be professional.** An investigation is, in many ways, a test itself. It is stressful and scary, but if you react in an unprofessional manner toward Board staff, it may be reflected in the report and analysis. Rudeness to Board staff alerts the investigator that there may be deeper issues involved. A physician's behavior during the investigation can be a factor when determining an appropriate sanction.

**Be factual.** When you provide information to the Board, either in writing or orally, provide only the facts you know through personal observation. If you have learned something by reviewing a document, state what document it is. Do not speculate or guess, and do not provide information that someone else told you. Simply state that an individual may have additional information.

**Be clinical.** A physician should provide information to the Board as if drafting medical records or presenting a journal article. If there is a complex medical issue, it should be addressed accordingly, without trying to "dumb" things down. The investigators are medical professionals in their own right. Moreover, medical issues are given to other physicians to review and inform the Board members. The response should be highly clinical.

**Do not lie or mislead.** The worse possible thing you can do during the course of an investigation is to get caught providing inaccurate information. Not only does it insinuate that you committed the act that you are accused of, but the cover up reflects on your professional character. If you lie, the next question the Board will ask is: What else is the individual lying about? Does this physician lie to patients or other health care professionals? Along those lines, be careful when addressing a question from the Board. Try not to be sarcastic, engage in a battle over semantics, or argue what the definition of "is" is. If a question is unclear, ask for clarification.

**Patterns and practices may be reviewed.** Board investigators are sometimes permitted to expand the scope of their investigation. They will search the Board's records to view past investigations and malpractice cases to determine if the current issue has occurred before. It is sometimes hard to justify taking action against a physician for a single poor outcome. However, if an individual has a string of poor outcomes based on the same or similar circumstances, it becomes extremely relevant to the investigation. If the Board discovers that an individual has a pattern and a practice regarding a certain issue, it reserves the right to reopen cases to determine if a larger issue exists. This is true in the areas of competency, professional behavior, and appropriate boundaries, just to name a few.

Because the Board had previously received considerable criticism over the length of time it took to complete investigations, the Texas Legislature stepped in and placed time limits on investigations. Once an investigation has begun (the date on the notice of investigation letter), the Board has 180 days to complete it and schedule it for an Informal Settlement Conference. The term "complete" is a bit of a misnomer, as it actually means that the active investigation has been conducted and the case is waiting for committee determination on where it goes next.

A staff committee reviews each investigation first to determine if the investigation is truly complete, then to decide if evidence shows a violation of the Medical Practice Act. If there is sufficient evidence to indicate a violation, the case is referred to the legal division. If evidence is

incomplete, the committee reactivates the case to gather additional information. If the evidence does not show a violation, the matter is referred to the Disciplinary Process Review Committee.

There are exceptions to the 180-day timeline, such as the Board's "good cause" provision that takes into account circumstances such as the unavailability of key documents, refusal of the person under investigation to cooperate with the Board, or other events beyond the Board's control.

In general, information gathered during the course of an investigation is confidential by law and not subject to the Open Records Act. Complaints, adverse reports, investigative files, investigator reports, and other information gathered and created during the investigation cannot be disclosed.

Of course, there are exceptions. If the Board prosecutes the case, this information obviously is used and disclosed to the individual under investigation. Should the case go to State Office of Administrative Hearings, evidence used in the case is normally subject to public disclosure. Information may also be disclosed to other licensing Boards; peer review committees when they consider physician applications for privileges; law enforcement; and other regulatory bodies, as required by law.

### **Standard of care investigations**

About 60% of TMB investigations are based on an alleged violation of the standard of care. The remaining investigations involve boundary issues, impairment, inadequate medical records, and some lesser violations that are assessed as "administrative violations."

As with all Board inquiries, the investigator will ask for both a narrative about the incident and the associated medical records that should include office notes, diagnostic tests, hospital records, and names of other physicians who treated the patient.

After gathering the appropriate material, the investigator creates a summary and forwards the information to a TMB consultant. Every standard of care case opened by the Board should optimally be reviewed by at least two physician consultants whose training and experience are similar to the physician under investigation.

The TMB has a large roster of consultants available, and after the case materials are prepared, they are provided to the lead consultant and a second consultant. If both physicians agree there is no violation, the case is recommended to the Board for dismissal. If they both agree that there is a violation of the standard of care, the case goes forward. If they disagree in either direction, the case goes to a third consultant. If two of the three say there is no violation, the case is recommended for dismissal. If two agree there is a violation, the lead consultant prepares a report and the case goes back to an investigator, who prepares a final summary.

**Sidebar: Other types of investigations**

As previously discussed, the TMB looks into an average of 6,000 complaints on an annual basis. But investigations can be initiated by other means.

**Malpractice history**

In order to gain votes for the passage of Proposition 12 (the Constitutional amendment to limit certain types of malpractice awards) in 2003, the legislature strengthened Section 164.201 of the Medical Practice Act, an existing statute that TMB had not previously robustly enforced. Simply put, the Board is now required to open a medical competency investigation against any physician with three medical malpractice lawsuits in a five-year period. Conventional wisdom says the Board will look for patterns and practices, taking into consideration “shotgun” suits where the patient sues everyone involved in his care. The Board also will look at the role the physician played in caring for the patient. In the past few years, the TMB has more vigorously examined malpractice claims and opened more investigations and prosecutions as a result of this statutory provision.

**Peer review investigations**

While hospitals and other health care entities usually report peer review actions to the TMB, it does not automatically mean the Board will take action. According to the law, the Board must prove that the peer review action: 1) is based on unprofessional conduct or professional incompetence likely to harm the public, and 2) is appropriate and reasonably supported by the evidence submitted to the Board.

The Board does not always fulfill this burden of proof. During the investigation phase, it is important for physicians to disclose any reasons the entity pursued such action, if the action is inappropriate or unsupported by the evidence. Any information an individual provides to the Board in this regard can be helpful.

**Closing the investigation**

Once all the narratives, documents, and consultant reports have been gathered, the investigator drafts a summary and an analysis of the investigation. The Quality Assurance Committee then reviews this information. The committee comprises the enforcement director, the litigation manager, and the executive director. Each case is discussed to determine whether to close the case for lack of evidence or lack of jurisdiction, or to forward it to the legal division. This committee can also reject the case as incomplete and return it for further investigation.

The case is next reviewed by the Disciplinary Process Review Committee, which can accept the staff committee’s recommendation to close the case, direct the case to legal for prosecution, or reject the case because it needs further investigation. Over the years, about 25 percent of the cases investigated have been referred to the legal division for prosecution, while 75 percent are closed, finding no evidence to support a violation of the Medical Practice Act.

### **The informal settlement conference**

Once it has been decided that there is enough evidence to suggest a physician violated the Medical Practice Act, the case is referred to the Litigation Department. The TMB has another 180 days to bring it to a hearing. The case is assigned to a Board attorney and another complex process begins.

First, the attorney reviews the case for sufficiency. If it is deemed sufficient, the attorney proceeds. If the attorney finds the case to be insufficient, the legal management team reviews it. The case is then either returned to investigations or is sent to the attorney for guidance on how to proceed. Next, a legal assistant prepares case materials and an informal settlement conference (ISC) is scheduled. The attorney finalizes the allegations for the Board disciplinary panel that will hear the ISC proceeding. The physician is notified at least 60 days before the ISC. In standard of care cases, the TMB staff will also send a copy of the Board consultant's report and permits a rebuttal of the consultant's opinion. The case is then given to a Board prosecutor who will review the investigation and create an ISC packet. At least 30 days before the hearing, the ISC packet is distributed to the disciplinary panel, the physician, and the hearings counsel. The packet contains four items:

- 1. Summary of allegations.** This document summarizes all the evidence and information within the packet and contains biographical data, information about the physician's practice, the alleged violations of the law, and an overview of the evidence and how it equates to the violation.
- 2. Notice letter.** The notice letter details the legal structure of an ISC and specifies the date and time of the hearing. It also provides information on the alleged violation and other legal information, such as how to ask for a continuance, how and when to submit additional information to the Board, and a reminder that the physician has a right to legal representation.
- 3. Documentary evidence.** All the information used by the Board is cited by what the Board calls "tabs." Each tab refers to documentary evidence that supports the Board's claim. This evidence can be anything: expert opinions, medical records, witness statements, prescription runs, etc. Information that the physician submits to the Board during the investigation is often part of the packet.
- 4. Public physician profile.** This document shows all the information a member of the public would receive about the physician.

### **The ISC panel**

When the time comes, the physician must travel to the TMB headquarters in Austin to appear before an ISC Panel. The review panel comprises two members, at least one of which is a member of the Board. The second individual may also be a member of the Board or a member of the District Review Committee. By statute, one panel member must be a physician and one must be a public member. If the case involves a standard-of-care issue, the Board reportedly tries to secure a panel member with some background in that area; however, that is not always possible.

Also seated with the panel is a second attorney known as Board counsel who provides ground rules for the ISC, tries to keep the process moving forward, and keeps the forum professional. The Board counsel also advises the Board on the law and what the Board has done in the past under similar circumstances.

As a rule, the prosecutor starts by asking the physician three questions: 1) Are you licensed in any other state? (If yes, what states?); 2) Do you currently hold any hospital privileges? (If yes, what are they?); and 3) Do you supervise physician assistants or nurse practitioners? After this, the prosecutor gives a short opening statement describing the basic facts of the case, and points to key evidence within the ISC packet. The prosecutor may discuss the alleged violation of the law and attempt to apply the law to the factual allegations. At the conclusion of the opening statement, the prosecutor yields the floor to Board counsel.

The counsel then allows either the physician or the physician's attorney to make a brief opening statement. If the attorney speaks, the panel customarily gives the lawyer the same amount of time the prosecutor had. If the physician speaks, the panel gives the individual as much time as needed, as long as the underlying issues are addressed. ***Panel members really want to hear from the physician.***

Although the process seems formal, remember that the "I" in ISC stands for "informal." The process lacks courtroom rules and structure, the ISC is not electronically or otherwise recorded, and no one is under oath. What is said at an ISC is strictly confidential and cannot be used in court. There are no rules of evidence to be considered, and there are rarely witnesses.

The ISC is meant to be a question-and-answer session. Panel members ask the physician questions, based chiefly on the information gathered by Board staff. However, the panel is not limited to that information and may ask any question, even if it seems off the subject. It is critical to remember that any of the Board staff can ask questions. It is not uncommon for the Board prosecutor and Board counsel to ask questions. Some are simply clarifying questions when the physician is confused, but some questions are asked for another purpose, perhaps because the attorney believes the physician has lied or is attempting to mislead the panel. If there is ever a time to be completely honest, the ISC is the time. There is nothing the Board hates more than feeling that they have been intentionally misled. The Board has no patience for this and the consequences are extremely serious.

After all the questions are asked and answered, Board counsel usually asks if the physician has any final words. If counsel does not offer this, the physician should not hesitate to ask if he may have some final words. Though this is generally allowed, the panel likes a brief summation.

An ISC is unlike anything most people have experienced. It is quasi-legal in nature, a cross between a trial and a mortality-morbidity discussion. It can be hostile or professional, a pleasant experience or a nightmare. Although an ISC is a question-and-answer session, the questions only go one way. It is strongly recommended that a physician enter the ISC room prepared and with legal counsel. In fiscal year 2007, the TMB has conducted 482 ISCs.

When all is said and done, Board counsel asks the physician, the physician's representative, and the Board prosecutor to leave the room. The disciplinary panel deliberates and makes a recommendation for Board action. Physicians need to keep in mind that decisions made by the ISC Panel are no more than recommendations to the full Board. More often than not, the Board accepts the panel's decision, but they are not rubber stamped. There are often very lively discussions among Board members — some seen, some unseen — as to whether an ISC Panel has made the proper decision.

Once the panel makes a decision, the prosecutor, the physician, and the physician's representatives are brought back into the ISC room, and Board counsel (usually) announces the decision. Often, panel members explain their decision, verbally admonishing, advising, or even apologizing to the physician.

ISC Panel members may choose from six outcomes: dismissal, deferral, agreed order, confidential order, SOAH hearing, and temporary suspension.

### **1. Dismissal**

A dismissal is the outcome every physician wants when faced with an ISC. According to statistics from the past five years, 35 percent of cases are dismissed. Dismissals at the ISC level usually occur because physicians are able to provide reasonable and logical responses to why something occurred or they admit to a mistake and document how the error has been corrected.

The dismissal outcome from an ISC is not the end of the case. Again, the decision to dismiss is only a recommendation. The Disciplinary Process Review Committee (DPRC) must review the panel's recommendation and consider the ISC packet.

The DPRC meeting is a closed, confidential setting where members and Board staff make decisions based solely on what is in the file. As this committee comprises half of the Board membership, it is possible that a panel member from the ISC is on the committee. Having a panel member present is of great benefit when questions arise concerning the evidence.

The DPRC can take three actions based on the recommendations of the panel.

1. Accept the panel's recommendation, which occurs more than 90 percent of the time.
2. Reject the recommendation. In this instance, the DPRC can request the case go back to investigation for additional information. This recommendation is extremely rare.
3. Refer the case for a second ISC. In this instance, the Board selects a new panel to consider the evidence, and the physician may face the same questions. Some have suggested that second ISCs are illegal, as the first panel already made the decision. But from a legal point of view, remember that the panel's decision is only a recommendation—only the full Board can make the final decision. In theory, it is possible to have multiple recommendations to dismiss a case, only to have the DPRC reject them. Historically, if two panels recommend dismissal of a case, DPRC accepts the decisions, but this is not always the case.



## **2. Deferral**

The second possible outcome is a deferral. A case is deferred if the ISC Panel members cannot decide on an outcome because they believe that they did not have enough information. This allows the physician additional time to gather information to resolve the matter in a positive way.

Deferrals are rare and generally include cases involving allegations of mental illness, physical disability, or even impairment. For example, the allegations may appear serious on paper, but when panel members meet the physician, the physician appears “normal.” To gain additional information, the Board allows the physician to submit to psychiatric or physical evaluations from a Board-approved physician.

In standard of care cases, there is frequently a need for an additional expert opinion or critical documentation that, for one reason or another, was not gathered during the investigation. Deferral is likely to occur only when there appears to be significant contradictory information between what is in the file and what was presented at the ISC.

Depending on conclusions drawn from additional information gathered, panel members may 1) dismiss the case, 2) recommend a sanction, or 3) demand a second ISC.

## **3. An Agreed Order**

Agreed Orders are the most common resolution of an ISC. It is similar to a settlement offer, asking the physician to agree to the settlement and avoid court. An Agreed Order can be almost any sanction. For example, if the panel sees a particular area of skill that the physician is lacking, they may recommend that the physician be allowed to continue practicing, but prohibit that procedure. A fine may also be assessed.

There are five parts to an Agreed Order:

1. The preamble. This section states that an ISC took place with certain people present and that the panel made recommendations to the Board, which are listed later in the document.
2. The findings of fact — spell out what the panel has “found” to prove that the physician has violated the act. This is often an area of contention as the facts are sometimes biographical and benign in nature; at other times they are very direct and damning of the individual’s conduct.
3. The conclusions of law — specifically cites which sections of the Medical Practice Act and TMB rules have been violated on the basis of the facts.
4. The order — this is the provision with the most flexibility. An Agreed Order can be as simple as a fine or as unsettling as an agreed revocation of a license. The order defines in detail what duties and conditions the physician must follow to remain in good standing with the Board. There is typically a stated time period for the physician to be under the Agreed Order and conditions can be anything from completing continuing medical education courses to having a supervising physician, from being tested for competency to

being tested for drugs. The Board may restrict some physicians from practicing a particular procedure or to only practicing certain hours. It can be any kind of sanction, as long as the physician consents to it. The thing to remember is that the process is a negotiated settlement.

5. Waiver and signatures — in this section, the parties agree this is the conclusion of the matter and the physician is waiving certain rights to settle the matter. The parties also sign the agreement in this section.

After the ISC, the Board prosecutor drafts the Agreed Order and mails it to the appropriate party. If the document is acceptable, the physician signs and returns it for approval by the full Board. If the document is not acceptable, the two sides negotiate until they reach a resolution or an impasse. Should negotiations fail and neither party agrees to the document, the matter will proceed to the State Office of Administrative Hearings (discussed later in SOAH Proceedings).

When negotiating, a physician needs to understand that the ultimate decision makers are the Board members on the ISC Panel. They decide whether to accept any physician-desired changes to the order. On some issues, the Board is flexible; on others they are not. The Board reviews each item on a case-by-case basis. As with all negotiations, there is usually some give and take by both sides in order to reach a mutually acceptable resolution.

#### **4. Confidential order**

Under very limited circumstances, a panel may offer what is known as a Confidential, Non-Public, Non-Disciplinary Agreed Rehabilitation Order (or Confidential Order). A Confidential Order is similar to an Agreed Order, but it is not a disciplinary order, nor is it disclosed to the public or any of the data banks.

A Confidential Order may only legally be given to an individual who self-reports a drug or alcohol problem, or a physical or mental illness, and the Board wants to maintain the physician's confidentiality. The Board is judicious in granting Confidential Orders and a violation of the order by the physician results in the order becoming a public document and strong disciplinary action by the Board.

#### **5. SOAH**

If the disciplinary panel finds a violation occurred, but the physician does not agree to the order, the case goes to the State Office of Administrative Hearings (SOAH) for a contested case hearing. (Read more about SOAH on page 28.)

#### **6. Temporary suspension**

The final option is temporary suspension of the physician's license. In circumstances where the panel feels the physician poses an immediate threat to the public health and welfare, the panel can call for a temporary suspension hearing. This hearing is essentially a show-cause hearing, to indicate the physician is a threat and the license must be removed immediately to ensure the

public is not harmed. The Board is required to hold a hearing as soon as is practical to allow a full, due process hearing. This is a rare outcome of an ISC.

Temporary suspension can be called before an ISC if the Board receives evidence strongly indicating the physician is a danger to the public. Historically, this has occurred when a physician continues to practice medicine after it becomes known the individual is an active abuser of drugs or alcohol. Other instances include a physician's arrest for a serious crime that could affect licensure, such as assaulting a patient or selling narcotics.

More recently, the Board has temporarily suspended licenses for standard of care violations. In these instances, strings of particularly bad outcomes have created strong concerns regarding the physicians' skills and abilities. In the summer of 2003, the Board received expanded powers from the Texas Legislature to temporarily suspend and restrict a physician's ability to practice. Under the new law, the Board may suspend or restrict the license of a physician on an emergency basis and is not required to notify the physician of the temporary suspension hearing until after the fact. Under such circumstances, the Board acts under a strict deadline to hold a hearing to demonstrate the underlying basis for the Board's actions. Once a license is taken or restricted, it is difficult to get reinstated.

The Temporary Suspension hearing is a public hearing. It is more formal than an ISC, but the rules of evidence still do not generally apply. The TMB can hold a hearing by providing notice to the physician of the hearing; however, the TMB can also hold a hearing without any notice, stripping a physician of his or her license without ever hearing from that individual. Because temporary suspension is a powerful weapon, the Board is generally very careful about when it exerts this authority. In fiscal year 2007, the TMB issued 21 temporary suspensions.

### **The role of the full Board**

You will recall that Agreed Orders do not become final until the full Board votes on it. Agreed and Confidential Orders are presented en mass at a regularly scheduled Board meeting. The Board president asks if there are orders any Board member would like to pull for discussion. Any member can pull an order. Once the Board has discussed it, the Board votes on the remaining orders and approves them by a voice vote.

At any given Board meeting, between 5 and 10 percent of the orders are pulled for discussion. The Agreed Orders are discussed one-by-one in open session, with the Board member who has questions initiating the discussion. The Board member who acted as the panel member defends or gives the rationale for the ISC Panel's decision. Sometimes, the Board prosecutor also discusses the legal reason behind a decision. When discussion ends, the Board votes on each discussed order separately. The Board goes through the same process for Confidential Orders, but the discussion phase is done in executive session to preserve the confidentiality of the physicians in question. The vote, however, is in public.

Should the Board approve the order en mass or individually, the order is final and goes into effect, upon the signature of the Board president. If the order is rejected, the Board prosecutor is given instructions about changes, possibly stronger facts, more violations of the act listed, a

longer order, or heavier sanctions. Again, the physician in question must agree to this. At this point, there is less ability to negotiate for the physician due to the input of the full Board. The prosecutor may be flexible on a word or two, but overall, his hands are tied. The physician can either accept the order or fight the decision in court. By statute, should the full Board reject an order, the physician is to receive notice that this occurred and any stated rationale why the order was rejected.

## **SOAH**

In the event that the ISC Panel directs, or the Board and the physician cannot mutually agree to terms, the next step is the State Office of Administrative Hearings. SOAH is a state agency that hears the majority of contested cases between the state and people licensed by the state.

The SOAH process is a long and expensive one. Most cases take a year or more to resolve, and a simple case can cost several thousand dollars. A complex standard of care case involving multiple experts and numerous patients can reach into six figures. The SOAH process is also very stressful, as the issue is out of the physician's control.

Although SOAH is similar to a court, it is not part of the court system. As an executive agency, its rules and statutes are governed by the Texas Legislature. The Administrative Law Judges (ALJs) who rule on cases are not elected or appointed; they are SOAH employees. ALJs are attorneys whose job it is to decide on the findings of fact and the conclusions of law, and make recommendations for an outcome. ALJs are judges for all intents and purposes, as they have significant power and authority over the entire proceeding.

### **The SOAH process**

The SOAH process starts when the Board files a complaint against the physician in question. The TMB filed 48 complaints against doctors at SOAH by the end of fiscal year 2007. This complaint is similar to those filed in a civil lawsuit. It states what the Board believes that it can prove, the legal authority for its actions, and what kind of sanction the Board desires for the physician. When the Board files the complaint, a complex process starts.

Once the physician is notified that the Board has filed a complaint, there are 20 days to provide the Board with a responsive pleading to the complaint. This document should indicate what, if anything, the physician agrees with and all the facts that are in disagreement. If the physician has not yet hired an attorney, one should definitely be retained at this time. Failure to respond to the pleading in a timely fashion could lead to a default judgment, meaning the Board files its own motion before the full Board seeking the stated action in complaint, which is typically revocation. The Board almost always votes to accept the motion.

After the physician files the response, discovery starts. Discovery is the method attorneys use to gather information to support the case, which includes various written forms of evidence as well as depositions.

There may be a pre-hearing conference before the ALJ where discovery disputes are addressed and other legal maneuvering occurs. The burden of proof belongs to the Board's attorney, who must prove by a preponderance of the evidence, that the physician violated the law.

Both parties begin with an opening statement, which is meant to provide the ALJ with a road map of the evidence. The Board presents its side, then the defense has an opportunity to question the evidence and cross-examine witnesses. This continues until the Board rests its case. Then the defense starts, and the roles are reversed. The parties may call rebuttal witnesses, but such testimony is rare. The parties may make a closing argument if the ALJ allows it.

As the decision maker, the ALJ carefully considers all the evidence and has 60 days from the date the hearing ends to offer a preliminary decision. Note that the hearing is not closed until the ALJ says it is closed. Often, the ALJ requests additional written arguments, heavily citing the transcripts and evidence of the case, as well as proposed findings of fact and conclusions of law.

At the close of the 60 days, the ALJ makes a preliminary decision. A draft Proposal for Decision (PFD) is presented which explains factual and legal rationale for the decision. In the PFD, the ALJ proposes findings of fact, conclusions, and a recommended resolution to the hearing.

Both parties have 20 days to file written exceptions to the preliminary PFD. Then, each party has 10 days to reply to the exceptions that the other party filed. After an additional 20 days has passed, the ALJ presents the final PFD.

This document is called a Proposal for Decision because the full Board can approve the PFD, or under certain limited circumstances, reject or amend it. The Board has been known to do all three. Further, as the ALJ has no authority to order a resolution, it is ultimately the Board that decides what to do, including revoking a license, dismissing the matter, and all points in between.

Should the Board decide to counter the ALJ's ruling or accept it, and the physician is not happy with the decision, he or she must file a motion to reconsider within 20 days. The Board will then reconsider its decision. If more than half of the Board membership decides to reconsider the decision, then it will do so at the next full meeting of the Board. If not, the decision is final.

Once it becomes a final decision, the physician can continue to fight the matter in district court and such an action must be filed in Travis County. Should the physician continue to lose, the decision may be appealed to the Third Court of Appeals, and then the Texas Supreme Court, should it accept the case. Winning on an appeal to the court depends on the facts and circumstances surrounding the case, and especially the actions of the Board. These appeals processes take years and a considerable amount of money.

The SOAH process is a long and difficult journey. An attorney who is familiar with the process will attempt to avoid a SOAH hearing for all the reasons discussed above. However, in some cases, a SOAH hearing may be a necessary. If the physician does not believe the law was violated but the evidence maintains that it was (i.e., if it is merely a question of professional

judgment versus standard of care), and still the Board wants to take action, then a SOAH hearing may be required.

### **The effects of TMB actions**

If a physician consents to an Agreed Order, or loses at the SOAH hearing, what are the consequences beyond the terms and conditions imposed by the Board? As noted in the public information section, this information is broadcast to the public through the Internet, press releases, and data banks. Not only may this cause embarrassment, but it also can cause economic hardship due to loss of existing patients and future patients.

The most far-reaching effect may come from health insurance provider programs. Under most plans, action taken by any state agency, especially by a medical licensing board, leads to automatic exclusion from provider lists. Some providers drop physicians from the provider list no matter what was done or why, while others allow for an appeals process. For example the Texas Department of Insurance Division of Workers' Compensation instituted a new rule stating that any physician against whom the TMB had taken action could no longer participate in the worker's compensation program. This ban from the program is not subject to review or appeal until the Board action is completed.

Many physicians have had success becoming re-enrolled, but this is very time-consuming and expensive. During the months it takes to become re-enrolled, a practice loses its base as patients seek a physician who can take their insurance. If a physician is a solo practitioner, or even in partnership, this can be economically devastating.

Physicians who have had actions taken against them for standard of care issues, drug-related issues, or other issues that affect care have seen their medical malpractice insurance costs increase or their coverage terminated. Most employment contracts and hospital privileges have standard language stating that if a medical licensing board takes action, the physician is under an affirmative duty to inform them of it. Additionally, most of these same contracts provide that a board taking action could constitute grounds for terminating employment or revoking privileges.

The American Board of Medical Specialties has a clause in its charter indicating that if the license of a physician is restricted, it may be grounds for losing certification. If the physician has licenses in other states, the other states' medical boards may take mirror action against the licensee. Additionally, if there is not a specific exception granted in the board order, someone with an order cannot supervise a physician's assistant or a nurse practitioner.

Texas physicians also are required to disclose the TMB's action (the order) to the U.S. Drug Enforcement Administration and the Texas Department of Public Safety. Depending on the issue, it may cause the two enforcement agencies to look at the issue independently to see if the physician's controlled substance certificate should be limited or even revoked. In some instances, an investigation may be opened to pursue criminal proceedings.

Another effect of the order, one that is not well known, is the Board's compliance program. Once the physician has signed an agreed order, TMB compliance officers follow up to make sure the

physician complies with the terms of the order. Each physician is assigned a compliance officer, a link to the TMB for as long as the physician is under order. The compliance officer regularly communicates with the physician via phone, letter, or e-mail, and may visit the physician. By and large, compliance officers visit the physician's primary place of practice, but they have been known to visit the physician's home, and visits may or may not be announced.

### **Other common violations**

In addition to standard of care violations — which account for about 60% of TMB disciplinary actions — there are many other ways a physician's actions can initiate a Board investigation. Some of the most common non-standard of care violations are listed below. Board rules that are cited can be found at [www.tmb.state.tx.us/rules/rules/bdrules.php](http://www.tmb.state.tx.us/rules/rules/bdrules.php).

**Non-therapeutic prescribing** — the Board has taken an increasing number of actions against physicians who prescribe without a valid reason; who prescribe the same “pain cocktail” to every patient, frequently on a cash basis; and who prescribe to known abusers.

**Prescribing to self, family, friends, or employees without keeping medical records.** This violation can trip up well-meaning physicians. According to TMB rules, such prescribing is a violation if it is done “without taking an adequate history, performing a proper physical examination, and creating and maintaining adequate records.” Most TMB actions related to this violation involve prescribing controlled substances. It is always wise to create a patient record for anyone to whom a physician prescribes.

**Impairment due to alcohol or drugs** — physicians who practice while under the influence of alcohol or drugs are a danger to themselves, patients, and the public. The TMB has a rigorous drug-testing program for physicians under orders for impairment. A self-reported problem with drugs or alcohol, if there has been no other complaint and no patient harm, may allow for a nonpublic, nondisciplinary order.

**Boundary violations** — typically involve “inappropriate conduct involving physician-patient relationship.” Sometimes sexual or romantic, sometimes financial, such personal relationships can harm patients and ruin a physician's reputation. Avoid becoming emotionally or financially involved with patients outside the office.

**Inadequate medical records** — the bane of many physicians because it can make it difficult to determine whether a physician is practicing within the standard of care. When a patient files a complaint and the records are inadequate to confirm why the physician did what he or she did, the Board may take action on the inadequacy of the records. (Please see page 34 for additional information on TMB documentation requirements.)

**Administrative violations** — the Board has the authority to enter agreed orders without an ISC for certain violations. These are referred to as “administrative violations” (formerly known as “minimal statutory violations”) and can include the following.

- Failure to provide medical records in a timely fashion — the TMB rule requires a physician to provide properly requested records within 15 business days.
- Failure to store or discard records in a manner that preserves confidentiality. The full medical records rule is Chapter 165.
- Failure to obtain required CME. Board rules require at least 24 hours of CME each year, with at least 12 hours being category I, and at least one hour in ethics or professional responsibility. Additional requirements can be found in Chapter 166, section 166.2. (Please see page 38 for more information on CME requirements.)
- Inappropriate advertising includes advertising that is misleading or contains testimonials. Touting nonexistent board certification, or certification with a non-approved board, is also a violation of Chapter 164 of the Board rules. (Please see page 41 for more information on physician advertising.)
- Failure to sign a death certificate. Section 193.005(c) of the Texas Health and Safety Code requires that a physician sign a death certificate within 10 days of receipt.

In March 2008, new rules went into effect regarding administrative violations. The new rules require the TMB to notify the physician that they have evidence of a violation and to offer the physician the option of signing an order and paying a fine instead of appearing at an ISC. If the physician wishes to contest the allegation, the option of attending an ISC is still available and the complaint process will proceed.

The new rules are intended to provide incentives for both physicians and the Board to resolve administrative violations quickly and efficiently. It is also important to note that any administrative violations will be part of the physician’s public profile and the agreed order will be subject to open records requests. However, administrative violations will not be reported to the NPDB because a disciplinary action with a fine and no other sanctions does not have to be reported to NPDB.

According to Dr. Donald Patrick, Executive Director of the TMB, “There has been recent criticism that taking action on these minor rules infractions is a waste of the board’s time and unnecessarily singles out otherwise good physicians. If board members believe there is a violation of the MPA, [Medical Practice Act] the board is legally compelled to take action.” (2)



### **Common sense solutions**

Should you find yourself involved in the Board disciplinary process, the following is a list of common sense solutions.

**Hire an attorney with experience dealing with the Board.** You should hire an attorney knowledgeable about the Board's investigation process and its rules/procedures. Dealing with the laws governing state agencies (known as administrative law) is a rule-specific process, and hiring an experienced attorney will aid you greatly.

**Cooperate.** There is no reason to be difficult with the Board. The TMB has tremendous authority to gather information and is able to gather the information it needs with or without your help. It does not help your case to make the Board members angry.

**Be honest.** If you made a mistake, it is better to admit it; Board members understand that mistakes can and are made. (Perfection is not the standard of care.) There is no reason to make them think you have something to hide.

**Keep good records.** Good records can make all the difference in quality of care cases. The Board strongly believes in the axiom: "if it is not documented, it was not done."

**Communicate.** Most complaints submitted to the Board are the result of poor communication. Patients, their families, staff, and colleagues all feel that the better communicator you are, the less likely you will experience a Board complaint.

### **Sources**

1. Texas Medical Board. Texas Medical Board statistics, Fiscal Years 2001-2007. Available at <http://www.tmb.state.tx.us/reportsandstats.php>. Accessed January 21, 2008.
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## **TMB documentation requirements**

The rules for medical records are complex and can be confusing. Carelessness and ignorance of TMB rules have resulted in TMB sanctions for many physicians. Taking time to create and maintain appropriate medical records can help physicians provide better patient care and avoid TMB complaints.

### **New rules**

For years, TMB rules regarding medical record documentation merely required that physicians maintain “adequate medical records,” defined as “any records documenting or memorializing the history, diagnosis and treatment of any patient.” (1) Recently however, TMB staff determined that this rule was incomplete and failed to convey the importance of the medical record. As a result, the TMB radically rewrote the rules defining the requirements for “adequate” medical records.

### **What exactly does the TMB require?**

The rule governing medical record documentation may be found in either the Texas Administrative Code Section 165.1, or in the Board rules posted on the TMB’s web site. (2) The Texas Administrative Code is the legal designation for the TMB’s rules. The rule states medical records must be “. . . complete, contemporaneous and legible.” (1) Therefore, documentation must include complete details for each patient encounter, be created close to the time the physician treated the patient, and be legible to the average person.

### **Contemporaneous**

The TMB rule does not specifically define “contemporaneous.” However, by practice, most TMB members emphasize that documentation should be completed immediately after, if not during, the actual patient encounter. If a physician chooses to complete the records at the end of the day instead of after the patient encounter, it appears that he or she would be in compliance, assuming the physician did not see a considerable number of patients that day. However, many TMB members are of the opinion that the records then become too general, and it is likely the physician may forget relevant information.

### **Legible**

Legibility has long been an issue for physicians. The advent of electronic medical records and transcribed records is beginning to have a positive impact. However, for physicians who still handwrite notes, illegibility will likely be viewed by the TMB as a lack of compliance with Board rules. When evaluating standard of care issues, all records are reviewed by at least two TMB consultants. These consultants must be able to read the records.

Use caution when employing templates or preprinted forms that contain “check boxes” to designate systems as normal or abnormal. This includes emergency department records and the forms suggested by Medicaid. These forms are often intended to facilitate documentation by

prompting the physician to address multiple aspects of the patient encounter. However, often the space for handwritten entries is limited, resulting in illegible notes. When using such forms, write legibly and use an additional page to fully describe findings, if necessary.

### **Complete**

The Board requires that each patient encounter must be documented and include the following:

- a. reason for the encounter and relevant history, physical exam findings, and prior diagnostic test results;
- b. an assessment, clinical impression, or diagnosis;
- c. plan for care, including discharge plan; and
- d. the date and legible identity of the observer. (1)

There is an expectation that an appreciable connection be made between each of the above four requirements, and that the connection is explored and documented. Therefore, physicians need to demonstrate how they got from the objective and subjective findings to the diagnosis and treatment.

The rule also requires that “past and present diagnoses should be accessible to the treating and/or consulting physician.” (2) This means that records should be readily available to physicians treating the patient. Furthermore, the rationale for (if not apparent) and the results of diagnostic testing and other ancillary services should be included in the medical record. (1) This may even include an explanation of the results and how they affect the treatment of the patient.

The rule also requires that the patient’s progress be documented, including response to treatment, change in diagnosis, and the patient’s noncompliance. (1) Defending a standard of care case by alleging the patient was noncompliant may be disregarded if there is a lack of documentation in the record supporting that stance.

Finally, the TMB has traditionally required that physicians document patient follow-up instructions in the medical record. Again, it is recommended that a comment be included regarding how the follow-up instructions were provided to the patient.

### **Informed consent**

The new rules also require documentation of informed consent. Documentation needs to demonstrate that the physician provided the patient (and/or the patient’s family) with education on the diagnosis and treatment, as well as the risks of any treatment. Board members have been critical of physicians who did not document that the diagnosis was adequately explained to the patient, including the differential diagnosis and the affect on the method of treatment.

### **Treatment plans**

The TMB rules also require an appropriate written treatment plan for patients. (1) However, the Board fails to define “appropriate.” As the rules are written, include the following in the plan section of a SOAP note:

1. treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
2. any referrals and consultations;
3. patient/family education; and
4. specific instructions for follow up. (1)

In certain situations, the Board members may expect to see a treatment plan containing more information than what is listed in the four requirements. They actually may request a formal “treatment plan.” This is a written course of action given to the patient with both subjective and objective measures to which the physician and patient agree in order to achieve their stated medical goal.

Generally, TMB members expect a formal treatment plan for patients who have complex or chronic medical conditions. A treatment plan is a requirement when treating patients for issues of chronic pain. (3) The treatment of chronic pain has very specific rules and requirements that are not covered in this publication. Physicians who provide treatment for chronic pain, should closely review the TMB rules on that subject and contact people with expertise on this rule, such as TMB staff, attorneys specializing in representing physicians before the TMB, or physicians specializing in pain management.

### **Referrals and consultations**

If the physician determines that a referral or consultation is necessary, the rules require that it be documented in the medical record. A copy of the referral or consulting physician’s report should be placed in the medical record. To facilitate patient safety and continuity of care, it is recommended that the referring physician provide a copy of the patient’s medical record or a summary of the patient’s care to the consultant.

Physicians being investigated by the TMB are often unable to demonstrate that they have reviewed the records of prior treating physicians. The TMB rule states that records received from other health care professionals involved in the care of the patient shall be maintained as part of the patient’s medical records. (1) This means that physicians are required to maintain not only the records they create, but also those they have received from other physicians.

### **Patient education**

There have been instances during ISCs where a physician has written nothing more than “patient education” in the medical record. In those situations, the Board has emphatically told the physician that the documentation was inadequate. TMB members require that the documentation provide some indication of what was discussed and how the patient was educated.

### **Conclusion**

The rules for medical records are complex and can cause confusion. Carelessness and ignorance of TMB rules have resulted in TMB sanctions for many physicians. Taking time to create and

maintain appropriate medical records can help physicians provide better patient care and avoid TMB complaints.

**Sources**

1. Texas Administrative Code. Section 165.1.
2. Texas Medical Board. Board Rules Chapter 165 Medical Records. Available at [www.tmb.state.tx.us/rules/docs/CurrentRulesRevised09-20-07.doc#Toc179255764](http://www.tmb.state.tx.us/rules/docs/CurrentRulesRevised09-20-07.doc#Toc179255764). Accessed January 2, 2008.
3. Texas Medical Board. Board Rules Chapter 170 Pain Management. Available at [www.tmb.state.tx.us/rules/docs/CurrentRulesRevised09-20-07.doc#Toc179255764](http://www.tmb.state.tx.us/rules/docs/CurrentRulesRevised09-20-07.doc#Toc179255764). Accessed January 2, 2008.

## **TMB CME requirements**

The TMB requires physicians to complete 24 hours of continuing medical education (CME) every 12 months. Physicians must report if they have completed the required CME on the registration permit application.

### **Formal activities**

At least 12 hours every 12 months — including 1 hour of ethics and/or professional responsibility education — must be completed through participation in formal CME activities. All 24 hours may be completed in this category, which includes conferences, seminars, lecture presentations, grand rounds, case conferences, self-study courses, etc. These activities are formally designated for credit as:

1. Category 1 of the Physician's Recognition Award of the American Medical Association
2. Prescribed credit of the American Academy of Family Physicians
3. Category 1A and 2B credit of the American Osteopathic Association

The promotional materials for CME activities will carry a specific statement advising physicians if the activity has been approved for any of the above types of credit.

Whether a particular hour of CME involves the study of medical ethics and/or professional responsibility is determined by a CME provider accredited by the Accreditation Council for Continuing Medical Education, a state medical society, the American Academy of Family Physicians, or an accredited CME provider approved by the American Osteopathic Association.

### **Documentation of formal activities**

Documentation of attendance at formal CME activities can be obtained from the provider of the activity in the form of a CME reporting form, attendance certificate, CME transcript or letter of verification of attendance.

Documentation to verify attendance **should not** be submitted to the TMB with the registration payment. Physicians should retain this documentation for reporting CME hours and in the event that verification is requested by the TMB in a random audit.

### **Informal activities**

Physicians may complete up to 12 hours (of the required total 24 hours every 12 months) by participating in informal CME activities. The following may be reported as informal hours:

- Conferences, seminars, grand rounds, case conferences, journal clubs, etc. not designated for formal credit. Record activity title; date; and clock hours expended.
- Self-instructional materials or courses not designated for formal credit and self-assessment examinations and reviews. Record activity/course title; date of use; and clock hours expended.

- Reading clinically relevant medical journals or articles and use of literature search databases in connection with the provision of patient care. Record name of publication or database used; date read/used; clock hours expended.
- Participation in patient care review activities (peer review or hospital quality of care review committees).
- Research/preparation time for medical presentations delivered to health professionals.
- Up to 10 hours may be claimed for: publication of a medical or medically related article; for each chapter of a medical or medically related book or other medical education materials; preparation of an exhibit displayed at a scientific medical meeting or other CME activity. Articles must be published in a recognized medical journal that is primarily read by physicians or other health professionals. Credit may be claimed only once for publications or exhibits even if it is reissued in a changed format. Record the type of activity; date completed; and clock hours expended.
- Up to 6 hours may be claimed for volunteer services at a site serving medically underserved populations, as defined in the Medical Practice Act. The volunteer hours should be at a site other than the physician's primary practice location.

Informal activities are not always verifiable. If available, physicians should retain transcripts or certificates of attendance. If not available, a log sheet may assist in maintaining a personal record that could be submitted to the TMB if requested.

### **Excess hours carried forward**

Excess hours earned in one 12-month period may be applied to the next year's requirements. A maximum of 48 excess hours may be carried forward and these hours must be applied within two years following the date of the registration period during which they were earned. A physician under a two-year license period may apply up to 24 CME hours retroactively to the preceding year's annual requirement. These hours may be counted only toward one registration period.

### **Board certification**

A physician will be presumed to have complied with the CME requirement if in the preceding 36 months he/she becomes board certified or recertified in a medical specialty. The TMB has determined that the activities undertaken to become board certified or recertified equal the 24-hour requirement. Since 24 hours are required every 12 months, the board certification process would fulfill the licensure requirement for one year only. Physicians in residency or fellowship training or who have completed such training within six months before the license expiration date will satisfy the formal and informal CME requirements by their residency or fellowship program.

### **Retired physicians**

Retired physicians "on official retired status" with the TMB are not required to report CME activities. Physicians who are retired from practice but wish to retain an active license must meet the CME requirement.

**Exemption request**

Exemptions are subject to the approval of the executive director of the TMB and must be requested in writing at least 30 days before the expiration date of the license.

An exemption may be requested for the following reasons:

1. catastrophic illness;
2. military service of longer than one year's duration outside Texas;
3. medical practice and residence of longer than one year's duration outside the U.S.; and
4. good cause on written application of the licensee that gives satisfactory evidence to the Board why the physician is not able to comply.

**Noncompliance**

Failure to obtain and report 24 hours of CME every 12 months at the time of license renewal will result in nonrenewal of the license until the physician obtains and reports the required CME hours. However, the executive director of the Board may issue a temporary license for a period of up to 90 days to the physician who has not complied with the CME requirement. Note that this 90-day extension through the temporary license is at the discretion of the executive director and is not an automatic grace period. The temporary license not only allows the Board time to verify the accuracy of information related to the physician's CME hours, but also allows the physician an opportunity to correct any deficiency so as not to terminate ongoing patient care.

Any CME hours obtained after a physician's renewal date for the purpose of satisfying the CME requirement for the preceding year's licensure renewal, if above and beyond the 24 hours necessary for renewal, may be used to meet the CME requirement for the current year.

Failure to comply with the CME requirement for renewal of a license invokes the fine for late registration and may invoke administrative penalties as determined by the Disciplinary Process Review Committee of the Board. A false report or statement to the Board regarding CME hours is basis for disciplinary action by the Board.



## **TMB advertising requirements for physicians**

There was a time when advertising by physicians — beyond listing their name, specialty and contact information — was considered not only unethical but also illegal. The American Medical Association’s ban on advertising, which had been formulated in the 19th century, was intended to preserve ethical and professional standards against the “encroachment of distasteful commercialism.” (1)

This ban persisted until 1979 when the Federal Trade Commission found that the AMA’s ban unreasonably restricted the advertising of its members and denied consumers the opportunity to learn more about physicians’ services. The FTC issued an order prohibiting the AMA from any effort to prevent advertising. The AMA appealed the order; and, in 1982 the Supreme Court granted physicians the right to advertise. (1)

Twenty-five years later we have witnessed a dramatic change in the way physicians advertise their services. According to the FTC, 95% of all physicians now engage in some form of paid advertising. (2) And, “advertising” per se, is no longer just a placement in the yellow pages. The TMB has adopted a broad definition of physician advertising to include “signs, nameplates, professional cards, announcements, letterheads, listings in telephone directories and other directories, brochures, radio and television appearances, and information disseminated on the internet or web.” (3) Anything done to inform or promote the services of a physician can be considered advertising and falls under the jurisdiction of the TMB.

This section will review the TMB’s advertising rules, specifically those related to deceptive advertising and the use of the term “board certified,” as well as offer guidelines on how to avoid litigation related to advertising.

### **Misleading or deceptive advertising**

The TMB rules state: “No physician shall disseminate or cause the dissemination of any advertisement that is in any way false, deceptive, or misleading. Any advertisement shall be deemed by the board to be false, deceptive, or misleading, if it:

- (1) contains material false claims or misrepresentations of material facts which cannot be substantiated;
- (2) contains material implied false claims or implied misrepresentations of material fact;
- (3) omits material facts;
- (4) makes a representation likely to create an unjustified expectation about the results of a health care service or procedure;
- (5) advertises or assures a permanent cure for an incurable disease;
- (6) compares a health care professional's services with another health care professional's services unless the comparison can be factually substantiated;
- (7) advertises professional superiority or the performance of professional service in a superior manner if the advertising is not subject to verification;
- (8) contains a testimonial that includes false, deceptive, or misleading statements, or fails to include disclaimers or warnings as to the credentials of the person making the testimonial;

- (9) includes photographs or other representations of models or actors without explicitly identifying them as models and not actual patients;
- (10) causes confusion or misunderstanding as to the credentials, education, or licensure of a health care professional;
- (11) represents that health care insurance deductibles or copayments may be waived or are not applicable to health care services to be provided if the deductibles or copayments are required;
- (12) represents that the benefits of a health benefit plan will be accepted as full payment when deductibles or copayments are required;
- (13) states that a service is free when it is not, or contains untruthful or deceptive claims regarding costs and fees. If other costs are frequently incurred when the advertised service is obtained then this should be disclosed. Offers of free service must indeed be free. To state that a service is free but a third party is billed is deceptive and subject to disciplinary action;
- (14) makes a representation that is designed to take advantage of the fears or emotions of a particularly susceptible type of patient;
- (15) advertises or represents in the use of a professional name, a title or professional identification that is expressly or commonly reserved to or used by another profession or professional;
- (16) claims that a physician has a unique or exclusive skill without substantiation of such claim;
- (17) involves uninvited solicitation such as door to door solicitation of a given population or other such tactics for "drumming" patients; or
- (18) fails to disclose the fact of giving compensation or anything of value to representatives of the press, radio, television or other communicative medium in anticipation of or in return for any advertisement, article, or infomercial, unless the nature, format or medium of such advertisement makes the fact of compensation apparent.” (3)

### **Board certification**

The TMB has also established rules regarding the use of the term “board certified” in advertising. These include:

“(a) A physician is authorized to use the term ‘board certified’ in any advertising for his or her practice only if the specialty board that conferred the certification and the certifying organization is a member board of the American Board of Medical Specialties, or the Bureau of Osteopathic Specialists, or the American Board of Oral and Maxillofacial Surgery.

(b) A physician is authorized to advertise that the physician is a member, fellow, diplomate, or certified by a named organization or other designation calculated to convey a similar meaning, if such designation is accurate, only if the organization meets the following requirements:

- (1) the organization requires all physicians who are seeking certification to successfully pass a written or an oral examination or both, which tests the applicant's knowledge and skills in the specialty or subspecialty area of medicine. All or part of the examination may be delegated to a testing organization. All examinations require a psychometric evaluation for validation;

(2) the organization has written proof of a determination by the Internal Revenue Service that the certifying board is tax exempt under the Internal Revenue Code pursuant to Section 501(c);

(3) the organization has a permanent headquarters and staff;

(4) the organization has at least 100 duly licensed members, fellows, diplomates, or certificate holders from at least one-third of the states; and

(5) the organization requires all physicians who are seeking certification to have satisfactorily completed identifiable and substantial training in the specialty or subspecialty area of medicine in which the physician is seeking certification, and the organization utilizes appropriate peer review. This identifiable training shall be deemed acceptable unless determined by the Texas Medical Board to be inadequate in scope, content, and duration in that specialty or subspecialty area of medicine in order to protect the public health and safety.

(c) A physician may not authorize the use of or use the term ‘board certified’ if the claimed board certification has expired and has not been renewed at the time the advertising in question was ordered.

(d) The terms ‘board eligible,’ ‘board qualified,’ or any similar words or phrase calculated to convey the same meaning may not be used in physician advertising.

(e) A physician's authorization of or use of the term ‘board certified’, or any similar words or phrase calculated to convey the same meaning in any advertising for his or her practice shall constitute misleading or deceptive advertising unless the specialty board which conferred the certification and the certifying organization meet the requirements in subsection (a) of this section.

(f) A physician may advertise a field of interest if the physician is certified by, or a member, fellow, or diplomate of an organization that meets the requirements of subsection (a) or (b) of this section.

(g) A board-certified physician who advertises board certification may advertise a field of interest that is different from the certified specialty only if the physician identifies the specialty for which the physician is board certified in an equal size of type or emphasis.

(h) A physician who is not board certified by, or a member, fellow, or diplomate of an organization that meets either the requirements of subsection (a) or (b) of this section may not advertise a field of interest, except that the physician may advertise that his or her practice is ‘limited to’ a certain practice area.” (3)

### **Risk management considerations**

According to the TMB, the most common advertising violation is stating that the physician is board certified when he or she is not board certified as defined in Rule 164. The typical resolution for this violation is payment of a fine and requiring the physician to change the ad.

Physicians can consider the following guidelines to avoid a TMB action related to improper advertising.

- Become familiar with the TMB's rules for physician advertising.
- Avoid making any guarantees or using any language that may inadvertently cause you to be held to a higher standard of care.
- Avoid subjective terms such as beautiful, slim, young, or completely cured.
- "Testimonials of patients as to the physician's skill or the quality of the physician's professional services tend to be deceptive when they do not reflect the results that patients with conditions comparable to the testimoniant's condition generally receive." (4)
- Claims regarding the experience, competence, and the quality of physicians should only be made if they can be supported by facts. Generalized statements of patient satisfaction should only be made if they are representative of all patients.
- "It is unlikely that a physician will have a truly exclusive or unique skill or remedy. Claims that imply such a skill or remedy therefore can be deceptive. Statements that a physician has an exclusive or unique skill or remedy in a particular geographic area, if true, however, are permissible." (4)
- Uninvited solicitation, solicitation of a certain population or other tactics for "drumming" patients is prohibited by the Medical Practice Act of Texas. (3)
- Advertising must be clearly and conspicuously identified as advertising. This includes articles that appear in "special advertising sections" of magazines or newspapers.
- The promotional use of before and after photos that use different lighting, poses or other photographic techniques to misrepresent results can be difficult to defend.

**Sidebar: How to say it**

To illustrate how the TMB rules can be applied, we have created advertising/web copy for two fictional practices.

***Anywhere Pediatrics***

*Questionable* — “My daughter has never been healthier since seeing the physicians at Anywhere Pediatrics.” This testimonial quote most likely does not reflect the overall experience of your patients, and its use should be avoided.

*Better* — If you use patient testimonials, use them to describe objective, verifiable services, such as extended office hours or walk-in services. “I really appreciate the convenience of the walk-in sick clinic hours.” or “There is always plenty of free parking at Anywhere Pediatrics.”

*Questionable* — “All our pediatricians are board certified.” This statement is questionable because it is non-specific. The reader may believe that all the physicians are board certified in pediatrics, when in fact two may be board certified by the American Board of Pediatrics and one may be board certified by the American Board of Family Practice

*Better* — “All our physicians are board certified by the American Board of Pediatrics.”

*Questionable* — “We offer the best pediatric care in Anywhere, Texas.” If you are the only physicians in town treating children, it may be permissible to say this. But keep in mind that the family physician across the street and the walk-in clinic at the hospital may also treat children.

*Better* — “Thank you for trusting Anywhere Pediatrics to take care of your child’s needs. You have chosen professionals with special interests in the health and well being of your child.”

***Anywhere Plastic Surgery***

*Questionable* — “Trust our surgeons to make you look younger and more beautiful. Cosmetic surgery delivers coveted results. The idea of having the body you have always dreamed of is exhilarating.” Avoid making promises that cannot be fulfilled.

*Better* — “A facelift may make you look younger, but it cannot give you a totally different look, nor can it restore the health and vitality of your youth. Before you decide to have surgery, think carefully about your expectations and concerns and discuss them thoroughly with your surgeon.”

*Questionable* — “There has never been a better or safer time to consider cosmetic surgery. Complications from these procedures are rare and cannot cause permanent damage.” It is difficult to justify promotional materials that minimize the potential complications from a procedure.

*Better* — “Dramatic as the end results can be, this is not a simple procedure. Complications can occur, and the estimated recovery time is a week to 10 days.”

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