

**Texas Medical Board
News Release
FOR IMMEDIATE RELEASE
Friday, November 13, 2009***

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Medical Board Disciplines 75 Doctors and Issues 669 Licenses

Since its August 20-21 board meeting, the Texas Medical Board has taken disciplinary action against 75 licensed physicians.

The actions included 19 violations based on quality of care; 12 actions based on unprofessional conduct; three nontherapeutic prescribing violations; nine actions based on inadequate medical records violations; one action based on a peer review action; two actions based on failure to properly supervise or delegate; two actions based on violation of probation or prior order; two actions based on actions by another state or entity; eight voluntary surrenders; two orders modifying a prior order; one action for failure to provide medical records; and one automatic suspension. The board issued 13 orders for minor statutory violations. The Board also issued a Reversal of Temporary Suspension. At its October 22 meeting, the Texas Physician Assistant Board took action against one physician assistant. The Medical Board issued one cease and desist order and the Texas State Board of Acupuncture Examiners issued two cease and desist orders.

At its November 5-6 meeting, the board issued **669** physician licenses.

RULE CHANGES ADOPTED

The board adopted the following rule changes that were published in the *Texas Register*:

Chapter 163, Licensure: amendments to §163.1, relating to Definitions; §163.4, relating to Procedural Rules for Licensure Applicants; §163.5, relating to Licensure Documentation; §163.6, relating to Examinations Accepted for Licensure; §163.7, relating to Ten-Year Rule; and §163.11, relating to Active Practice of Medicine.

Chapter 166, Physician Registration: amendments to §166.1, relating to Physician Registration; §166.2, relating to Continuing Medical Education; §166.3, relating to Retired Physician Exception; §166.4, relating to Expired Registration Permits; and §166.6, relating to Voluntary Charity Care Exemption.

Chapter 168, Criminal History Evaluation Letters: amendments to §168.1, relating to Purpose; and §168.2, relating to Criminal History Evaluation Letters.

Chapter 171. Postgraduate Training Permits: amendments to §171.3, relating to Physician-in-Training Permits; §171.4, relating to Board-Approved Fellowships; and §171.5, relating to Duties of PIT Holders to Report.

Chapter 172, Temporary and Limited Licenses: amendments to §172.8, relating to Faculty Temporary License; and §172.16, relating to Provisional Licenses for Medically Underserved Areas.

Chapter 173, Physician Profiles: amendments to §173.1, relating to Profile Contents; and

§173.4, relating to Updates to the Physician's Profile Due to Board Action.

Chapter 175, Fees, Penalties, and Forms: amendments to §175.1, relating to Application Fees, and repeal of §175.4, relating to Application Form.

Chapter 179, Investigations: amendments to §179.4, relating to Request for Information and Records from Physicians.

Chapter 180, Texas Physician Health Program and Rehabilitation Orders: amendments to new rule §180.1, relating to Rehabilitation Orders; §180.2, relating to Definitions; §180.3, relating to Texas Physician Health Program; and new rule §180.7, relating to Rehabilitation Orders. In addition §180.4, Operation of Program, was adopted on an emergency basis.

Chapter 187, Procedural Rules: amendments to §187.25, relating to Notice of Adjudicative Hearing; §187.26, relating to Service in SOAH Proceedings; §187.27, relating to Written Answers in Proceedings and Default Orders; and §187.37, relating to Final Decisions and Orders.

Chapter 190, Disciplinary Guidelines: amendments to §190.2, relating to Board's Role, and new rule §190.14, relating to Disciplinary Sanction Guidelines.

Chapter 192, Office Based Anesthesia Services: amendments to §192.1, relating to Definitions; §192.4, relating to Registration; §192.5, relating to Inspections; §192.6, relating to Request for Inspection and Advisory Opinions; and new rule §192.7, relating to Operation of Pain Management Clinics.

Chapter 193, Standing Delegation Orders: amendments to §193.6, relating to Delegation of the Carrying Out or Signing of Prescription Drug Orders to Physician Assistants and Advanced Practice Nurses; and §193.7, relating to Delegated Drug Therapy Management.

Chapter 194, Non-Certified Radiologic Technicians: amendments to §194.2, relating to Definitions; §194.3, relating to Registration; and §194.5, relating to Non-Certified Technician's Scope of Practice.

Proposed changes to Chapter 174, Telemedicine, were withdrawn for additional stakeholder input.

PROPOSED RULE CHANGES

The following proposed rule changes will be published in the *Texas Register* for public comment.

Chapter 187, Procedural Rules: proposed rule §187.14, Informal Resolution of Disciplinary Issues Against a Licensee.

Chapter 175, Fees, Penalties and Forms: proposed amendments to §175.5 regarding fee refunds for applicants who withdraw their applications within 45 days of initial application.

Board Approves Revised Tanning Advisory Statement

In accordance with HB 1310 enacted by the 81st Legislature, the Texas Medical Board approved the following revised statement:

WARNING

TANNING IS ONE OF THE LEADING CAUSES OF SKIN CANCER.

TANNING MAY CAUSE SEVERE BURNS, BLISTERING AND SCARRING.

- The U.S. Department of Health and Human Services has declared ultraviolet radiation (UV) to be a cancer causing substance.
- Both indoor and outdoor tanning expose a person to ultraviolet radiation because UV radiation can come from the sun and artificial sources, such as tanning beds and sun lamps.
- The amount of UV radiation received during indoor tanning is similar to the amount received from the sun, and in some cases may be stronger.
- People who tan greatly increase their risk of developing skin cancer.
- Numerous medical studies have shown that exposure to UV radiation, from tanning outside or with indoor tanning devices, is associated with an increased risk of skin cancer.
- The number of skin cancers has been rising over the past several years due to increasing exposure to UV radiation from the sun, tanning beds, and sun lamps.
- In the United States, a person dies every 62 minutes from melanoma, the deadliest form of skin cancer.
- Exposure to UV radiation from indoor tanning devices can also lead to premature skin aging, eye damage, and damage to the immune system.
- The effects of UV radiation are cumulative and may show up several years after the exposure.
- The adverse effects of UV radiation are increased when a person is exposed during their twenties, teens, or even younger.
- PHYSICIANS, THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES AND OTHER HEALTH ORGANIZATION RECOMMEND THAT A PERSON, ESPECIALLY CHILDREN UNDER 18, REDUCE THEIR EXPOSURE TO ULTRAVIOLET RADIATION FROM INDOOR TANNING DEVICES TO HELP PREVENT SKIN CANCER.

DISCIPLINARY ACTIONS

Open records requests for orders may be made to openrecords@tmb.state.tx.us. **Media** contact Jill Wiggins at (512) 305-7018 or jill.wiggins@tmb.state.tx.us. Orders are posted on the TMB web site at http://reg.tmb.state.tx.us/OnLineVerif/Phys_NoticeVerif.asp about 10 days after the board meeting.

QUALITY OF CARE VIOLATIONS

Bailey, Charles F. Jr., M.D., Lic. #C6859, Snyder TX

On November 6, 2009, the Board and Dr. Bailey entered into an agreed order requiring that within one year he obtain 24 hours of continuing medical education as follows: eight hours of diagnosis and management of dementia, eight hours of evaluation and treatment of head injuries in family medicine, and eight hours of medical recordkeeping. The action was based on Dr. Bailey's failure to perform neurological and mental status examinations on a patient who presented after a fall with a high risk for a CVA or intracranial bleed. Although the subsequent

MRI was negative for evidence of a CVA or intracranial bleed, Dr. Bailey failed to safeguard against potential complications given the patient's clinical presentation.

Battle, Robert M., M.D., Lic. #D2355, Houston TX

On November 6, 2009, the Board and Dr. Battle entered into a mediated agreed order requiring the following: that within 180 days Dr. Battle obtain 10 hours of continuing medical education in medical recordkeeping and 10 hours CME in family practice; he maintain adequate medical records; and within one year his charts will be subject to a one-time monitor; within 90 days he create an informed consent form to be provided to complementary and alternative medicine patients to be approved by TMB's executive director; and he provide his patients with a brochure or handout of estimated costs of his treatments. The action was based on Dr. Battle's use of tests and treatments not generally recognized in traditional medical practice, and on his inadequate medical records.

Breeling, Charles, M.D., Lic. #F9232, Corpus Christi TX

On November 6, 2009, the Board and Dr. Breeling entered into an agreed order requiring that within one year Dr. Breeling complete 10 hours of continuing medical education in medical recordkeeping and 15 hours in coronary artery disease and that he have a practice monitor for two years. The action was based on Dr. Breeling's failure to provide appropriate follow-up care for a patient who had received an aorta repair by graft and who died of internal bleeding 10 days after surgery.

Caddell, James D., D.O., Lic. #F6497, Dallas TX

On November 6, 2009, the Board and Dr. Caddell entered into an agreed order requiring that within one year he obtain four hours each of continuing medical education in medical recordkeeping, treatment of cardiovascular diseases, and coding and documentation, and pay an administrative penalty of \$1,000 within 90 days. The action was based on Dr. Caddell's failure to use proper diligence in treating a patient's hypertension and hypercholesterolemia and his failure to provide sufficient documentation to support coding.

Campbell, Andrew William, M.D., Lic. #G7790, Spring TX

On November 6, 2009, the Board entered an Amended Final Order regarding Andrew William Campbell, M.D., suspending Dr. Campbell's medical license for a period of eight months, with other provisions that include the following: a public reprimand; a five-year practice monitor following the termination of the suspension; 25 hours of continuing medical education in the legal obligations that accompany the physician/patient relationship; 25 hours of CME in the standard of care on the use of new techniques or medications and/or the new uses of existing techniques or medications; payment of an administrative penalty of \$64,000 within two years of entry of the order; and payment of \$8,396.50 for transcription costs within 45 days of entry of the order. The order reflects the result of an appeal by Dr. Campbell to a Travis County District Court order that affirmed in part, reversed in part, and remanded in part, an earlier 2007 Final Order that issued from the State Office of Administrative Hearings. The Board's original SOAH Complaint related to issues in nine patient cases that included the following issues: standard of care; non-therapeutic prescribing; improper billing and documentation; unprofessional conduct; and the violation of state or federal law connected with medical practice.

Clemons, Patrick, D.O., Lic. #J1933, La Grange TX

On November 6, 2009, the Board and Dr. Clemons entered into an agreed order requiring that within one year he obtain 20 hours of continuing medical education in patient assessment, diagnostic testing and evaluation in family practice. The action was based on Dr. Clemons' failure to exercise diligence in treating a patient with upper respiratory ailments.

Davenport, Donald, D.O., Lic. #L0118, Odessa TX

On November 6, 2009, the Board and Dr. Davenport entered into an agreed order requiring that within one year he obtain four hours of continuing medical education in medical recordkeeping. The action was based on Dr. Davenport's failure to properly document vital signs for a patient's post-operative visits after a Roux-en-Y gastric bypass; his failure to document blood work for a post-operative visit; and his failure to document the patient's noncompliance with an order for lab work.

Dunham, Jocelyn B., M.D., Lic. #J1979, Flower Mound TX

On November 6, 2009, the Board and Dr. Dunham entered into an agreed order requiring that within one year Dr. Dunham obtain 16 hours of continuing medical education, including eight hours in medical recordkeeping and eight hours in physician-patient communication. The action was based on Dr. Dunham's failure to properly communicate and discuss MRI results with a patient.

Lackey, James M., M.D., Lic. #L5014, San Antonio TX

On November 6, 2009, the Board and Dr. Lackey entered into a two-year agreed order requiring that his practice be monitored; that within one year Dr. Lackey obtain 10 hours each of continuing medical education in medical recordkeeping, risk management and treatment of chronic pain; and that within 90 days he pay an administrative penalty of \$1,000. The action was based on Dr. Lackey's failure to meet the standard of care and failure to maintain adequate medical records in the treatment of a pain patient.

Li, Lucy Quan, M.D., Lic. #L6496, Frisco TX

On August 21, 2009, the Board and Dr. Li entered into an agreed order restricting her from performing solo cosmetic blepharoplasty surgery until she receives board approval; requiring that she obtain additional surgery training in cosmetic blepharoplasty; and requiring that she obtain six hours of continuing medical education in risk management. The action as based on Dr. Li's failure to meet the standard of care by performing blepharoplasty surgery without adequate training.

Mays, Steven C., D.O., Lic. #G4169, San Antonio TX

On August 21, 2009, the Board and Dr. Mays entered into a one-year agreed order of public reprimand requiring that, within one year, Dr. Mays take and pass the Texas Medical Jurisprudence Examination; that he have a practice monitor; that within one year he obtain 30 hours of continuing medical education, including 10 hours each in medical recordkeeping, prescribing for family medicine practice, five hours in endocrinology including thyroid disorders, and five hours in ethics; and that within 180 days he pay an administrative penalty of \$10,000. The action was based on Dr. Mays' failure to meet the standard of care in assessment, diagnosis, treatment and documentation for 12 patients in a clinic for which he was medical

director; his responsibility for false and misleading advertising for the clinic's treatments and therapies for weight-loss, thyroid and other hormone replacement therapies; his delegating to unlicensed staff members to conduct exams and prescribe controlled substances; his responsibility for disorganized and incomplete medical records; and his failure to update his physician profile as required.

Morehead, David B., D.O., Lic. #J4373, Waxahachie TX

On November 6, 2009, the Board and Dr. Morehead entered into an agreed order requiring the following: that within one year he complete the professional boundaries course offered by either the Vanderbilt University Center for Professional Health or the University of California San Diego Physician Assessment and Clinical Education (PACE); within one year he complete eight hours of continuing medical education in ethics; and within 60 days he pay an administrative penalty of \$2,000. The action was based on Dr. Morehead's prescribing to a personal acquaintance without maintaining medical records or performing an examination.

Morrill, Thomas, D.O., Lic. #H2620, Garland TX

On November 6, 2009, the Board and Dr. Morrill entered into an agreed order of public reprimand requiring the following: that within one year he complete a professional boundaries course; within one year he obtain 20 hours of continuing medical education, including 10 hours in medical recordkeeping and 10 hours in treatment and prescribing for chronic pain; and within 180 days he pay an administrative penalty of \$10,000. The action was based on his providing frequent and inappropriately large doses of narcotics without proper documentation to a patient with whom he had a sexual relationship.

Raj, Jhansi M., M.D., Lic. #G8735, Fort Worth TX

On November 6, 2009, the Board and Dr. Raj entered into an agreed order requiring that within one year Dr. Raj obtain eight hours of continuing medical education in psychopharmacology and four hours in risk management. The action was based on Dr. Raj's failure to adequately monitor serum lithium levels or to obtain thyroid or renal function tests for a patient with bipolar and schizoaffective disorders.

Schack, M. Ricardo C., M.D., Lic. #G2013, Waxahachie TX

On November 6, 2009, the Board and Dr. Schack entered into an agreed order requiring that within one year he complete 10 hours of continuing medical education in medical recordkeeping and 10 hours in psychopharmacology. That action was based on Dr. Schack's failure to properly document mental status exams and risks, benefits, side effects or adverse effects of treatment of a bipolar patient.

Syed, Mohsin M., M.D., Lic. #K2295, Midland TX

On November 6, 2009, the Board and Dr. Syed entered into a mediated agreed order requiring that within one year he complete the patient prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) and that he have a one-time practice monitor. The action was based on Dr. Syed's failure to meet the standard of care in follow-up for a patient experiencing side effects from prescribed medication.

Walter, Henry J. Jr., M.D., Lic. #F7958, Richardson TX

On November 6, 2009, the Board and Dr. Walter entered into an agreed order requiring the following: that within one year Dr. Walter obtain 25 hours in continuing medical education, including 10 hours in medical recordkeeping, 10 hours in general prescribing practices, and five hour in ethics; within one year he take and pass the Texas Medical Jurisprudence Examination; and within 120 days he pay an administrative penalty of \$1,000. The action was based on Dr. Walter's prescribing sedatives to a friend with chronic insomnia without performing proper examination or evaluation.

Weprin, Rebecca B., M.D., Lic. #J4015, Dallas TX

On November 6, 2009, the Board and Dr. Weprin entered into an agreed order requiring that within one year she obtain 10 hours of continuing medical education in risk management in obstetrics and that she pay an administrative penalty of \$2,000 within 180 days. The action was based on her failure to diagnose and treat an ectopic pregnancy.

White, Edward S., M.D., Lic. #D8109, Paris TX

On November 6, 2009, the Board and Dr. White entered into a two-year agreed order requiring the following: that his practice be monitored; within one year Dr. White obtain eight hours of continuing medical education in medical recordkeeping; and he inform the board of any reissuance of DEA or DPS prescribing certification. The action was based on Dr. White's deficiencies in the care and treatment of 11 pain patients, including failure to offer alternative methods; failure to produce adequate supportive documentation to substantiate ongoing use of narcotics and anxiolytics; and failure to act on suspicions of abuse and misuse of prescribed drugs by several patients.

UNPROFESSIONAL CONDUCT VIOLATIONS

Chase, C.C., M.D., Lic. #K5080, Corpus Christi TX

On November 6, 2009, the Board and Dr. Chase entered into an agreed order in which a \$500 administrative penalty already paid to the board will be applied to the order. The action was based on his initial refusal to refund payment for an unused portion of a Mesotherapy package

Cochran, Phillip D., M.D., Lic. #L0092, Midland TX

On November 6, 2009, the Board and Dr. Cochran entered into a mediated agreed order of public reprimand requiring the following: that within two years he complete the Professional/Problem-Based Ethics (ProBE) course in physician ethics; within one year he take and pass the Texas Medical Jurisprudence Examination; and within one year he pay an administrative penalty of \$1,000. The action was based on Dr. Cochran's providing prescriptions to a patient with whom he had a sexual relationship, and providing prescriptions to the patient's spouse, without documented medical justification.

Dayian, Ara R., M.D., Lic. #K2443, Dallas TX

On November 6, 2009, the Board and Dr. Dayian entered into an agreed order requiring that within one year Dr. Dayian obtain 12 hours of continuing medical education, including eight hours in medical recordkeeping and four hours in ethics; and that within 90 days he pay an

administrative penalty of \$2,000. The action was based on his office inappropriately withholding medical and billing records from a patient because of an outstanding balance.

Echols, Ben H., M.D., Lic. #F6227, Houston TX

On November 6, 2009, the Board and Dr. Echols entered into an agreed order of public reprimand requiring that within one year he take and pass the Texas Medical Jurisprudence Examination and that within 90 days he pay an administrative penalty of \$5,000. The action was based on Dr. Echols' allowing his staff to falsify records in order for a patient to continue to receive workers' compensation benefits.

Halberdier, John E., M.D., Lic. #D9475, Conroe TX

On November 6, 2009, the Board and Dr. Halberdier entered into an agreed order of public reprimand prohibiting Dr. Halberdier from treating or dispensing drugs to his immediate family; requiring that within one year he complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) and within one year he complete the professional boundaries course offered by the PACE program; and that he obtain 10 hours of continuing medical education in medical ethics. The action was based on Dr. Halberdier's failure to keep records for a patient with whom he developed a romantic relationship and eventually married; and when the couple became estranged he committed a third degree felony by violating a protective order related to family violence.

Lane, Randall B., M.D., Lic. #E2667, Dallas TX

On November 6, 2009, the Board and Dr. Lane entered into an agreed order requiring that within one year he obtain 25 hours of continuing medical education as follows: 10 hours of medical recordkeeping, 10 hours of CPT coding, and five hours of ethics; and that he pay an administrative penalty of \$5,000 in a series of payments to be completed by April 15, 2010. The action was based on Dr. Lane's inadequate medical records and incorrect CPT coding for four patients.

Majczenko, Tricia, M.D., Lic. #BP10031893, El Paso TX

On November 6, 2009, the Board and Dr. Majczenko entered into an agreed order of public reprimand. The action was based on Dr. Majczenko's submitting forged and falsified documents for her physician-in-training permit.

Maxwell, Rebecca H., M.D., Lic. #L6519, Houston TX

On November 6, 2009, the Board and Dr. Maxwell entered into a mediated agreed order of public reprimand requiring that within one year she submit documentation of her already having completed the course in maintaining professional boundaries at the Vanderbilt University Center for Professional Health and that she continue care and treatment from her current psychiatrist. The action was based on Dr. Maxwell's having a personal relationship with a patient for whom she continued to prescribe medications, and attempting to conceal the relationship, for which she pled no contest to a Class A Misdemeanor and received deferred adjudication.

Taube, Justina P., M.D., Lic. #J4553, Pasadena TX

On November 6, 2009, the Board and Dr. Taube entered into an agreed order of public reprimand requiring that she complete 10 hours of continuing medical education in ethics and

that she pay an administrative penalty of \$2,500 within 90 days. The action was based on Dr. Taube's allowing an unlicensed person to use her medical license wall certificate to order, prescribe, dispense and sell herbal supplements that were acquired with Dr. Taube's Texas medical license.

Zamora-Quezada, Jorge C., M.D., Lic. #J0739, Edinburg TX

On November 6, 2009, the Board and Dr. Zamora-Quezada entered into a two-year agreed order of public reprimand requiring that his practice be monitored; that within 90 days he have an independent audit of his billing practices; that within one year he obtain 10 hours each of continuing medical education in medical recordkeeping, ethics and appropriate billing and coding; and that within one year he pay an administrative penalty of \$30,000. The action was based on Dr. Zamora-Quezada's ordering excessive laboratory tests and imaging studies for multiple patients without adequate justification or documentation.

Zuzukin, George V., M.D., Lic. #G9255, Beaumont TX

On November 6, 2009, the Board and Dr. Zuzukin entered into an agreed order requiring that within one year he complete the anger management course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE); and that within 60 days he pay an administrative penalty of \$2,500. The action was based on Dr. Zuzukin's unprofessional behavior towards hospital staff.

NONTHERAPEUTIC PRESCRIBING VIOLATIONS

Arroyo, Carlos, M.D., Lic. #F9148, Kemah TX

On November 6, 2009, the Board and Dr. Arroyo entered into an agreed order revoking his Texas medical license. He may petition the board for reinstatement after one year. The action was based on his prescribing controlled substances without adequate documentation, including medical rationale for drug therapy, and failing to comply with board rules related to treatment of 16 chronic pain patients.

O'Neill, James R., M.D., Lic. #B9022, San Antonio TX

On November 6, 2009, the Board and Dr. O'Neill entered into an agreed order prohibiting him from prescribing Schedule II, III, IV and V drugs and prohibiting him from accepting new patients. The action was based on Dr. O'Neill's inappropriately prescribing weight-loss and anti-anxiety drugs to one patient.

Su, Alex Min-Chang, M.D., Lic. #K7912, Houston TX

On November 6, 2009, the Board and Dr. Su entered into a two-year agreed order of public reprimand requiring the following: that he have a practice monitor; within one year he complete the physician prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE); and within 90 days he pay an administrative penalty of \$5,000. The action was based on inappropriately prescribing to a patient with a long history of drug abuse who died of an accidental overdose.

INADEQUATE MEDICAL RECORDS

Acosta, Carlos, M.D., Lic. #F3681, Arlington TX

On November 6, 2009, the Board and Dr. Acosta entered into an agreed order requiring that he obtain 10 hours of continuing medical education in medical recordkeeping within one year and pay an administrative penalty of \$1,000 within 90 days. The action was based on Dr. Acosta's failure to maintain medical records showing proper indications for two spinal surgeries on one patient.

Caruth, Jeffrey, M.D., Lic. #H6102, Plano TX

On November 6, 2009, the Board and Dr. Caruth entered into an agreed order requiring that he pay an administrative penalty of \$1,000 within 90 days. The action was based on Dr. Caruth's failure to adequately document physical examinations prior to surgery and/or specific medications that were prescribed for weight-loss management for eight patients. None of the patients experienced any complications.

Caterbone, Philip W., D.O., Lic. #J9995, Pflugerville TX

On November 6, 2009, the Board and Dr. Caterbone entered into an agreed order requiring that he pay an administrative penalty of \$1,000 within 60 days. The action was based on his failure to properly document one patient's visit.

Ferguson, Charles E. Jr., M.D., Lic. #K2689, Magnolia TX

On November 6, 2009, the Board and Dr. Ferguson entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in medical recordkeeping. The action was based on Dr. Ferguson's failure to properly document his diagnosis of constipation for a patient who presented to the hospital with lower back and groin pain.

Gadasalli, Suresh N., M.D., Lic. #J5765, Odessa TX

On November 6, 2009, the Board and Dr. Gadasalli entered into an agreed order requiring the following: that within one year he take and pass the Texas Medical Jurisprudence Examination; within one year he obtain five hours of continuing medical education in medical ethics; and within 180 days he pay an administrative penalty of \$10,000. The action was based on Dr. Gadasalli's interpersonal communication difficulties with hospital staff and his inadequate maintenance of a patient's medical record.

Hogue, Robert L., M.D., Lic. #E6419, Brownwood TX

On November 6, 2009, the Board and Dr. Hogue entered into an agreed order requiring that within one year he obtain eight hours of continuing medical education in medical recordkeeping and eight hours in gynecological oncology; and that within 60 days he pay an administrative penalty of \$2,000. The action was based on Dr. Hogue's failure to fully document his discussion of the treatment plan with a patient who two years later had a recurrence of the cervical cancer.

Morris, James M., M.D., Lic. #H1397, Rusk TX

On November 6, 2009, the Board and Dr. Morris entered into an agreed order requiring that within one year Dr. Morris obtain 10 hours of continuing medical education in medical recordkeeping and 10 hours in chronic pain management. The action was based on medical records that were inadequate to explain Dr. Morris' treatment rationale and prescribing decisions for several patients.

Rorig, James C., M.D., Lic. #L9586, Bay City TX

On November 6, 2009, the Board and Dr. Rorig entered into a mediated agreed order requiring the following: that within six months he complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE); following completion of the PACE course, he have a practice monitor; and within 90 days he pay an administrative penalty of \$5,000. The action was based on Dr. Rorig's failure to document history and examination in a patient with a lung mass.

Rotman, Harris, M.D., Lic. #D5828, Houston TX

On November 6, 2009, the Board and Dr. Rotman entered into an agreed order requiring that within one year he complete eight hours of continuing medical education in medical recordkeeping. The action was based on Dr. Rotman's failure to adequately document his rationale for using a larger margin and delayed suture removal in the excision of a mole.

Spurlock, William M., M.D., Lic. #J7209, Dallas TX

On November 6, 2009, the Board and Dr. Spurlock entered into an agreed order requiring that within one year Dr. Spurlock complete 10 hours of continuing medical education in medical recordkeeping and that within 90 days he pay an administrative penalty of \$2,000. The action was based on Dr. Spurlock's failure to properly document prescribing pain medications to two patients.

PEER REVIEW ACTIONS

Ravdel, Arnold, M.D., Lic. #E8838, Houston TX

On November 6, 2009, the Board and Dr. Ravdel entered into a mediated agreed order requiring that within one year he take and pass the Texas Medical Jurisprudence Examination and that within 90 days he pay an administrative penalty of \$2,500. The action was based on Dr. Ravdel's resigning his privileges at Triumph Health Care while under, or to avoid, an investigation related to professional competence.

SUPERVISION OR DELEGATION VIOLATIONS

Heckrodt, Stanly B., M.D., Lic. #E7420, San Antonio TX

On November 6, 2009, the Board and Dr. Heckrodt entered into an agreed order requiring that within one year he obtain 20 hours of continuing medical education as follows: five hours in medical recordkeeping, five hours in risk management, and 10 hours in the treatment of obesity; and that within 90 days he pay an administrative penalty of \$5,000. The action was based on Dr. Heckrodt's inadequate supervision of midlevel providers who provided treatment and medications to weight-loss patients.

Kirk, Lisa J., D.O., Lic. #K3775, Waco TX

On November 6, 2009, the Board and Dr. Kirk entered into an agreed order requiring that within 60 days she submit to the board written protocols and standing delegation orders for her medical spa and that she pay an administrative penalty of \$1,000 within 60 days. The action was based on Dr. Kirk's failure to have written protocols and standing delegation orders for laser hair removal patients.

VIOLATION OF PROBATION OR PRIOR ORDER

Bukhari, Rizwan H., M.D., Lic. #J1900, Dallas TX

On November 6, 2009, the Board and Dr. Bukhari entered into a 10-year agreed order making his previous nonpublic rehabilitation order public and requiring that within 90 days he pay an administrative penalty of \$1,000. The action was based on Dr. Bukhari's failure to submit letters from up to three board-certified psychiatrists willing to treat him, in violation of his previous order.

Koch, Justin L., M.D., Lic. #M7339, Dallas TX

On November 6, 2009, the Board and Dr. Koch entered into an eight-year agreed order requiring the following: that Dr. Koch abstain from prohibited substances; participate in the board's drug-testing program; within 30 days begin care and treatment with an approved psychiatrist; continue care with his treating psychotherapist; and continue to participate in AA or a similar program. The action was based on Dr. Koch's violation of an abstinence requirement of his 2007 Agreed Licensure Order.

ACTIONS BY ANOTHER STATE OR ENTITY

Patel, Sanjeev C., M.D., Lic. #M2442, Jacksonville FL

On November 6, 2009, the Board and Dr. Patel entered into an agreed order requiring that within 60 days he pay an administrative penalty of \$1,000 and submit a document detailing corrective measures to reduce wrong-site procedures. The action was based on action by the Florida Board of Medicine for Dr. Patel's administering a nerve block to the wrong knee prior to surgery.

Song, Wei, M.D., Lic. #M9020, Miami FL

On November 6, 2009, the Board and Dr. Song entered into an agreed order requiring that within 60 days he pay an administrative penalty of \$1,000 and submit a document detailing corrective measures to reduce wrong-site procedures. The action was based on action by the Florida Board of Medicine for Dr. Song's administering a nerve block to the wrong knee prior to surgery.

VOLUNTARY SURRENDERS

Avery, Parnell, M.D., Lic. #D8849, Houston TX

On November 6, 2009, the Board and Dr. Avery entered into an agreed order in which he voluntarily surrendered his Texas medical license because of a physical condition.

Burman, Matthew, M.D., Lic. #E2155, Bloomfield Hills MI

On November 6, 2009, the Board and Dr. Berman entered into an agreed order in which he voluntarily surrendered his Texas medical license. The action was based on a pending investigation based on physician misconduct in Michigan.

Dotson, Rodney, M.D., Lic. #D9988, Canyon TX

On November 6, 2009, the Board and Dr. Dotson entered into an agreed order in which he voluntarily surrendered his Texas medical license. The action was based on Dr. Dotson's desire to retire from practice in lieu of disciplinary proceedings.

Froberg, Larry M., M.D., Lic. #G5064, Little Rock AR

On November 6, 2009, the Board and Dr. Froberg entered into an agreed order in which he voluntarily surrendered his Texas medical license because of a physical condition and his desire to retire from practice in lieu of disciplinary proceedings.

Hoblit, David L., M.D., Lic. #E0056, Dallas TX

On November 6, 2009, the Board and Dr. Hoblit entered into an agreed order in which he voluntarily surrendered his Texas medical license in lieu of further disciplinary proceedings.

McNutt, Steven S., M.D., Lic #L0413, Dover OH

On November 6, 2009, the Board and Dr. McNutt entered into an agreed order in which he voluntarily surrendered his Texas medical license. The action was based on Dr. McNutt's failure to notify patients or the board when he moved and left no forwarding address and on his failure to provide requested records to a patient.

Romack, Anthoni R., M.D., Lic. #G5553, Grand Saline TX

On November 6, 2009, the Board and Dr. Romack entered into an agreed order in which he voluntarily surrendered his Texas medical license. The action was based on Dr. Romack's non-therapeutically prescribing addictive medications on multiple occasions.

Coleman, Brent J., D.O., Lic. #G3241, South Padre Island TX

On November 6, 2009, the Board and Dr. Coleman entered into an agreed order in which he voluntarily surrendered his Texas medical license in lieu of further disciplinary proceedings. The action was based on Dr. Coleman's violation of his October 28, 2008, agreed order.

ORDERS MODIFYING PRIOR ORDERS

Bailey, Charles F. Jr., M.D., Lic. #C6859, Snyder TX

On November 6, 2009, the Board and Dr. Bailey entered into an agreed order modifying his order of February 8, 2008, from a requirement that he practice only in a prison setting to a requirement that he practice in a group or institutional setting. The action was based on Dr. Bailey's compliance with the 2008 order and his desire to seek employment outside the Texas Department of Corrections.

Loya, Juan F., M.D., Lic. #J4309, El Paso TX

On November 6, 2009, the Board and Dr. Loya entered into an agreed order modifying his order of April 7, 2006, to require him to submit names of treating psychiatrists for approval and that he see the treating psychiatrist at least quarterly or on an as-needed basis; and adding a practice monitor for one year. The action was based on Dr. Loya's request for a modification to remove the requirement for an evaluating psychiatrist and on concerns over charting.

FAILURE TO PROVIDE MEDICAL RECORDS

Valdez, Marcos J., M.D., Lic. #L2721, McAllen TX

On November 6, 2009, the Board and Dr. Valdez entered into an agreed order requiring that

within 60 days he pay an administrative penalty of \$2,000. The action was based on Dr. Valdez's failure to provide medical records for several patients in a timely manner.

AUTOMATIC SUSPENSION

Carlin Grant Bartschi, M.D., Lic. #J0916, Gilbert, AZ

On October 6, 2009, the Board entered an automatic Order of Suspension against Dr. Bartschi due to his incarceration in a federal penitentiary following a felony conviction in Arizona for tax evasion and fraud. The suspension is for an indefinite period, and may be terminated at such time as Dr. Bartschi appears before the Board and demonstrates his physical and mental competence to practice medicine, and that he is otherwise safe to return to practice.

REVERSAL OF TEMPORARY SUSPENSION

Odette Louise Campbell, M.D., License #H9609, Denton, TX

On October 16, 2009, a Disciplinary Panel of the Board entered an Order Denying Temporary Suspension or Restriction of Texas Medical License (With Notice of Hearing), in the matter of the license of Odette Louise Campbell, M.D. Based on the evidence presented, the Disciplinary Panel was unable to determine that Dr. Campbell presented a continuing threat to the public welfare from acts or omissions as alleged by the Board. Following an evidentiary hearing, the Board's Application for Temporary Suspension or Restriction of License of Dr. Campbell's medical license was denied. This action by the Board supersedes and reverses the previous Order of Temporary Suspension (Without Notice of Hearing) that had been entered on August 19. Dr. Campbell's license is no longer temporarily suspended as a result.

MINOR STATUTORY VIOLATIONS

The board took actions against 13 physicians for minor statutory violations ("fast-track orders").

PHYSICIAN ASSISTANT

Thad William Houseman, P.A., Lic. #PA01862, Whitney TX

On October 22, 2009, the Texas Physician Assistant Board entered an Automatic Order of Suspension suspending Mr. Houseman's license. The action was based on the violation of an agreed order of March 22, 2005, requiring Mr. Houseman to abstain from consumption of alcohol, dangerous drugs or controlled substances, that he submit a list of prescribed medications to the board, and providing that if he tested positive for any prohibited substance his license would be immediately suspended. On June 9, 2009, Mr. Houseman submitted a random drug screen specimen that tested positive for a prohibited substance, Meprobamate, a tranquilizer. The length of the suspension is indefinite and it remains in effect until the board takes further action.

CEASE AND DESIST ORDERS

Brooke Herrick, PSY.D, (no license number) Waxahachie, TX

On November 6, 2009, the Texas Medical Board and Brooke Herrick, Psy.D., who does not hold a current license to practice medicine in Texas, entered into an Agreed Cease and Desist Order. The order was based on Dr. Herrick's unlicensed practice of medicine in Ellis County by holding herself out as a physician; using the title "doctor," and writing prescriptions for one or more persons while using the authorizations of other licensed healthcare professionals, all of which Dr. Herrick denies. The order requires Dr. Herrick to immediately halt all such activity.

Idalia Rodriguez Flores, (no license number) McAllen, TX

On October 30, 2009, the Texas State Board of Acupuncture Examiners and Idalia Rodriguez Flores, who does not hold a current license to practice acupuncture in Texas, entered into an Agreed Cease and Desist Order. The order was based on Ms. Flores' performance of acupuncture on one or more patients in Hidalgo County and holding herself out as a "Doctor of Chinese Medicine," which Ms. Flores denies. The order requires Ms. Flores to immediately halt all such activity.

Lucy Shih, (no license number) Colleyville, TX

On October 30, 2009, the Texas State Board of Acupuncture Examiners and Lucy Shih, who does not hold a current license to practice acupuncture in Texas, entered into an Agreed Cease and Desist Order. The order was based on Ms. Shih's administration of acupuncture treatments to one or more patients in Tarrant County. The order requires Ms. Shih to immediately halt all such activity.

CORRECTION

In the August 28, 2009, news release the summary for Michael Bertino, M.D., Lic. #D4928, should have been listed under Inadequate Medical Records.

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** This version posted 9/29/12 to reflect changing category for Dr. Gadasalli to **Inadequate Medical Records**. Includes changes posted 12/2/09 changing the category for Drs. Hogue and Rorig to **Inadequate Medical Records**.*