Texas Medical Board Press Release

FOR IMMEDIATE RELEASE
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Media contact: Jarrett Schneider, 512-305-7018
Customer service: 512-305-7030 or 800-248-4062

TMB disciplines 45 physicians at June meeting, adopts rule changes

At its June 27, 2014 meeting, the Texas Medical Board disciplined 45 licensed physicians and issued five cease and desist orders. The disciplinary actions included eight orders related to quality of care violations, seven orders related to unprofessional conduct, one revocation, five voluntary revocations, five voluntary surrenders, two suspensions, two orders related to peer review actions, four orders related to other states’ actions, three orders related to failure to properly supervise or delegate, two orders related to inappropriate prescribing, two orders related to violation of prior board order, one order related to violation of Board rules, one order related to Texas Physician Health Program violations, one order related to inadequate medical records, and one order related to failure to use the Texas Electronic Death Registry System.

The Board issued 139 physician licenses at the June meeting, bringing the total number of physician licenses issued in FY14 to 3,047.

RULE CHANGES ADOPTED

§163.4, Procedural Rules for Licensure Applicants

The Amendments to rule 163.4, relating to Procedural Rules for Licensure Applicants, relocates language located in Rule 187.13(a) to 163.4(d), in order to clarify the licensure process and options for applicants prior to appearing before the licensure committee as well as the procedures followed by the board during such process.

§163.5, Licensure Documentation

The Amendment to rule 163.5, related to Licensure Documentation, adds language to 163.5(b)(11) to clarify the mechanism by which an applicant can remedy a single deficient U.S. clerkship.

§166.6, Exemption from Registration Fee for Retired Physician Providing Voluntary Charity Care

The Amendments to rule 166.6, relating to Exemption from Registration Fee for Retired Physician Providing Voluntary Charity Care, adds language in Section 166.6(g)-(j) which sets forth the process for a retired physician, providing voluntary charity care, to return to active status.

§172.5, Visiting Physician Temporary Permit

The Amendments to rule 172.5, relating to Visiting Physician Temporary Permit, amends 172.5(b)(1)(B) to provide that a Visiting Physician Temporary Permit holder participating in KSTAR must be supervised by a physician that has not been the subject of a disciplinary order, unless administrative in nature.

§172.8, Faculty Temporary License

The Amendment to rule 172.8, relating to Faculty Temporary License, is amended to provide that an applicant for a Faculty Temporary license is ineligible if they hold a license elsewhere that has been subject to disciplinary action.
§184.4, Qualifications for Licensure for Surgical Assistants

The Amendments to rule 184.4, relating to Qualifications for Licensure for Surgical Assistants, amends language in 184.4(a)(13)(B) in order to correctly identify substantially equivalent surgical assistant programs.

§184.16, Discipline of Surgical Assistants

The Amendment to rule 184.16, related to Discipline of Surgical Assistants, deletes subsection (c) referencing confidential rehabilitative orders, and amends language under subsection (a) so that the Board may enter agreed orders or remedial plans with a surgical assistant.

§187.13, Informal Board Proceedings Relating to Licensure Eligibility

The Amendment to rule 187.13, related to Informal Board Proceedings Relating to Licensure Eligibility, relocates language located in 187.13(a) to 163.4 (Relating to Procedural Rules for Licensure Applicants) in order to organize and group the procedural rules pertaining to the licensure process for an applicant who has been referred to appear before the licensure committee. The Amendment adds a definition for “disciplinary licensure investigation” to 187.13(b). The Amendment adds language to 187.13(c)(1) and (2) which sets forth effect of an applicant who withdraws an application or fails to appear before the licensure committee after being referred and the procedure followed by the Board. Additional Amendments to 187.13(c)(3) and (4) clarify the outcomes relating to an applicant who is offered licensure with terms and conditions and those who are determined ineligible by the licensure committee.

§187.24, Pleadings

The Amendment to rule 187.24, related to Pleadings, adds language to 187.24(b) to set forth the procedure for an applicant to request an appeal of the board’s ineligibility determination at SOAH and delineates the board’s and applicant’s duties with respect to order of filings. The Amendment further sets forth the effect of an applicant who withdraws their intent to file an appeal at SOAH or fails to timely file the requisite affirmative pleading and the procedure followed by the Board after such events.

§187.26, Service in SOAH Proceedings

The Amendment to rule 187.26, related to Service in SOAH Proceedings, deletes erroneous language relating to the required notice of default as it pertains to licensure cases at SOAH, due to its inapplicability in licensure cases.

§187.28, Discovery

The Amendment to rule 187.28, related to Discovery, adds language to subsection (a) referencing §164.007(d) of the Medical Practice Act and deletes language under 187.28(b)(1)(C) requiring that an expert report be provided in the designation of a testifying expert witness.

§187.29, Mediated Settlement Conferences

The Amendment to rule 187.29, related to Mediated Settlement Conferences, deletes language under 187.29(a)(1) referencing licensure matters.

§190.8, Violation Guidelines

The Amendment to rule 190.8, related to Violation Guidelines, amends subsection (L)(iii)(II) so that physicians are not required to establish a professional relationship prior to prescribing dangerous drugs for a patient's close contacts if the physician diagnoses the patient with one or more of the listed infectious diseases. The amendments further add language defining a close contact and requiring that the physician document the treatment in medical record related to...
the patient connected to the close contact. The amendments delete language allowing a physician to provide such prophylactic treatment only in the case in which the patient has an illness determined by the Centers for Disease Control and Prevention, the World Health Organization, or the Governor’s Office to be pandemic, and limits the exception to the provision of dangerous drugs.

§190.14, Disciplinary Sanction Guidelines

The Amendment to rule 190.14, related to Disciplinary Sanction Guidelines, amends the range and scope of sanctions for violations of the Medical Practice Act.

DISCIPLINARY ACTIONS

QUALITY OF CARE

Aggarwal, Ajay, M.D., Lic. No. J7879, Bay City
On June 27, 2014, the Board and Ajay Aggarwal, M.D., entered into an Agreed Order requiring Dr. Aggarwal to limit his interventional pain management procedures to those procedures he is currently performing, specifically: lumbar epidural steroid injections, cervical epidural steroid injections, joint injections, SI joint injections, tailbone coccyx injections, median branch blocks, and radio frequency lumbar and cervical nerve ablation, using the visual aids he is currently employing; maintain one midlevel provider at each of his practice sites at any time he is performing procedures; have his practice monitored by another physician for consecutive monitoring cycles until this term is modified or terminated; and within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Aggarwal did not use proper diligence in his practice and did not adequately document his treatment of multiple patients, including documenting medical necessity for suboxone patients and the medical necessity for the treatment of patients with interventional treatments.

Aguilera, R. Juan, M.D., Lic. No. E2966, Edinburg
On June 27, 2014, the Board and R. Juan Aguilera, M.D., entered into an Agreed Order requiring Dr. Aguilera to within one year complete at least eight hours of CME in risk management. The Board found Dr. Aguilera’s employee discharged a patient prior to the completion of the 20 minute waiting period following an allergy shot. The patient had an adverse reaction that required an emergency room visit and hospitalization. Dr. Aguilera’s employee administered an incorrect dosage of the shot possibly leading to the adverse reaction.

On June 27, 2014, the Board and Flavio Humberto Alvarez, M.D., entered into an Agreed Order requiring Dr. Alvarez to have his practice monitored by another physician for four consecutive monitoring cycles; and within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours of risk management. The Board found Dr. Alvarez failed to sufficiently indicate that an order of 10mmol potassium phosphate to be administered intravenously to a patient had been updated to 20 mmol. This resulted in the nurse and the pharmacist reading the order as “120 mmol” rather than “20 mmol.” The resulting death of the patient was caused by a system failure at the hospital, in that neither the pharmacist nor the nurse questioned the extremely unusual order for 120 mmol of potassium phosphate.

Bader, Elliot, M.D., Lic. No. F0129, DeSoto
On June 27, 2014, the Board and Elliot Bader, M.D., entered into an Agreed Order on Formal Filing, subjecting Dr. Bader to the following terms and conditions: shall not perform any type of surgical procedures, limiting Dr. Bader’s practice to non-surgical procedures and shall appear before a Board panel should he desire to return to performing surgery; and shall obtain an assessment of his practice of medicine by the Texas A&M Health Science Center Rural and Community Health Institute (K-STAR) prior to requesting an appearance before a panel of this Board. The Board found Dr. Bader failed to meet the standard of care in treatment of one patient. Specifically, Dr. Bader performed a laparoscopic cholecystectomy that led to an unplanned nephrectomy. This order resolves a formal complaint filed at the State Office of Administrative Hearings.
Blair, Donald Levester, Jr., M.D., Lic. No. H4171, Dallas
On June 27, 2014, the Board and Donald Levester Blair, Jr., M.D., entered into an Agreed Order requiring Dr. Blair to within one year complete at least 16 hours of CME, divided as follows: eight hours in handling high-risk obstetrics cases and eight hours in risk management. The Board found Dr. Blair failed to appropriately evaluate and treat a patient’s high blood sugar, and signed another patient’s electronic medical record without notifying the physician in his practice who was the patient’s primary care physician of the abnormal glucose test results in the record. The patient’s primary care physician discovered the abnormal results and followed up with the patient.

Kohli, Nandini Dhir, M.D., Lic. No. L2969, Austin
On June 27, 2014, the Board and Nandini Dhir Kohli, M.D., entered into an Agreed Order publicly reprimanding Dr. Kohli and requiring Dr. Kohli to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and within one year complete at least 16 hours of CME, divided as follows: eight hours in diagnosis and management of pulmonary emboli and eight hours in reactive airway disease. The Board found Dr. Kohli failed to treat a patient’s complaints of persistent chest tightness and shortness of breath, failed to monitor the patient’s medications properly, and failed to keep adequate medical records for the patient.

Miranda, Hernan Emilio, M.D., Lic. No. N0984, Amarillo
On June 27, 2014, the Board and Hernan Emilio Miranda, M.D., entered into an Agreed Order requiring Dr. Miranda to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 20 hours of CME, divided as follows: eight hours in risk management, eight hours in medical recordkeeping, and four hours in evaluation, treatment and diagnosis of adult liver disease; pay an administrative penalty of $3,000 within 60 days; and Dr. Miranda shall not engage in locum tenens work. The Board found Dr. Miranda’s diagnosis of “hepatic tumor with porcelain gallbladder” in a patient was not medically supported and he failed to adequately document the basis of this diagnosis and his recommendation for future diagnostic testing based on the suspicion of porcelain gallbladder and hepatic tumor. Dr. Miranda lacked diligence in his approach to the treatment of the patient; failed to maintain adequate medical records for the patient; and was terminated by the medical center where he worked as a locum tenens physician.

Yentis, Richard David, M.D., Lic. No. D5333, Fort Worth
On June 27, 2014, the Board and Richard David Yentis, M.D., entered into an Agreed Order requiring Dr. Yentis to have is practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete at least 16 hours of CME, divided as follows: eight hours in identifying drug seeking behavior, and eight hours in risk management; and pay an administrative penalty of $5,000 within 60 days. The Board found Dr. Yentis prescribed drugs, including Xanax and Adderall, both of which have high risk of abuse, to a patient with a known addiction, and confirmed diagnoses of ADHD (attention deficit hyperactivity disorder) and anxiety, increased the above dosages throughout the patient’s treatment but did not adequately document the rationale for the increased dosages, failed to document the results of drug screens that he performed on the patient in his medical records, and failed to obtain previous medical records from treatment programs. The Board also found that for a second patient, Dr. Yentis prescribed Xanax and Ritalin without adequately documenting the second patient’s mental status and/or evaluation for such treatment.

UNPROFESSIONAL CONDUCT
Anderson, Timothy W., M.D., Lic. No. F5819, Houston
On June 27, 2014, the Board and Timothy W. Anderson, M.D., entered into an Agreed Order requiring Dr. Anderson to within six months complete at least eight hours of in-person CME, divided as follows: four hours in risk management and four hours in medical ethics; and pay and administrative penalty of $3,000 within 60 days. The Board found Dr. Anderson failed to obtain the hours required within the time set out in his 2012 Order. Dr. Anderson has since completed the eight pre-approved hours.
On June 27, 2014, the Board and Lisa Libertiny Gardner, D.O., entered into an Agreed Order requiring Dr. Gardner to pay an administrative penalty of $1,000 within 90 days. The Board found Dr. Gardner failed to timely respond to Board staff’s inquiries regarding the completion of CME hours required by her November 30, 2012 Remedial Plan.

Murcia, Jamie Daniel, M.D., Lic. No. J4661, Plainview
On June 27, 2014, the Board and Jamie Daniel Murcia, M.D., entered into a Mediated Agreed Order requiring Dr. Murcia to have a chaperone present anytime he performs a physical examination on a female patient or performs a physical examination on any patient where a female family member of the patient is present; for two years, make his medical records available for inspection by the Compliance Division of the Board; within one year complete the Maintaining Proper Boundaries course offered by the Santé Institute of Professional Education and Research through the University of Texas Southwestern Medical Center; and within one year and three attempts pass the Medical Jurisprudence Exam. The Board found Dr. Murcia engaged in sexually inappropriate behavior towards a patient, a patient’s family member, and two employees. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Pucillo, Ronald Michael, M.D., Lic. No. G2207, Sugar Land
On June 27, 2014, the Board and Ronald Michael Pucillo, M.D., entered into an Agreed Order publicly reprimanding Dr. Pucillo and requiring him to have a chaperone present when performing a physician examination on a female patient; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete at least eight hours of CME in ethics; and pay an administrative penalty of $3,000 within 60 days. The Board found Dr. Pucillo admitted to having sexual encounters with a patient in May and June of 2013.

Rizo-Patron, Carlos, M.D., Lic. No. J9303, Lubbock
On June 27, 2014, the Board and Carlos Rizo-Patron, M.D., entered into a Mediated Agreed Order requiring Dr. Rizo-Patron to within one year and three attempts pass the Medical Jurisprudence Exam; and within one year complete at least 14 hours of CME, divided as follows: six hours in anger management and eight hours in ethics. The Board found Dr. Rizo-Patron engaged in unprofessional conduct by verbally abusing other licensees and staff members at his workplace. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Roberts, Dennis Donald, M.D., Lic. No. M6362, Woodville
On June 27, 2014, the Board and Dennis Donald Roberts, M.D., entered into an Agreed Order publicly reprimanding Dr. Roberts and requiring Dr. Roberts to within ten days present proof to the Board that he has cured his student loan default with Texas Guaranteed Student Loan Corporation. The Board found Dr. Roberts defaulted on his Texas Guaranteed Student Loan Corporation Loan and was still in default at the time of the ISC hearing.

Villacres, David F., M.D., Lic. No. H7099, Kingwood
On June 27, 2014, the Board and David F. Villacres, M.D., entered into an Agreed Order publicly reprimanding Dr. Villacres and requiring him to have a chaperone present anytime he performs a physical examination on a female patient; within one year complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 16 hours of CME, divided as follows: eight hours of ethics and eight hours of medical recordkeeping; and pay an administrative penalty of $2,000 within 60 days. The Board found Dr. Villacres engaged in inappropriate behavior with a patient on or about May 9, 2009 by exposing his genitalia to a female patient in an exam room during the course of treatment. Dr. Villacres subsequently employed the patient as an assistant in his clinic and entered into an inappropriate relationship with the patient.
REVOCATION
On June 27, 2014, the Board approved a Final Order revoking Daniel K. Leong, D.O.’s Texas medical license. The Board found Dr. Leong pleaded guilty to one felony count of Conspiracy to Commit Health Care Fraud and was sentenced to 48 months of imprisonment, followed by one year of supervised release. Dr. Leong is currently incarcerated following his conviction. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Leong has 20 days from the service of the order to file a motion for rehearing.

VOLUNTARY REVOCATION
Bianchi, Anthony Steven, M.D., Lic. No. K1161, Fallbrook, CA
On June 27, 2014, the Board and Anthony Steven Bianchi, M.D., entered into an Agreed Order of Revocation, revoking Dr. Bianchi’s Texas Medical license and requiring him to immediately cease practice in Texas. Dr. Bianchi agreed to the revocation of his license in lieu of further disciplinary proceedings. The Board found on December 20, 2013, Dr. Bianchi entered into a Stipulated Settlement and Disciplinary Order with the Medical Board of California, suspending Dr. Bianchi for 30 days and then placing him on probation for five years during which he may not treat female patients. This action was based on unprofessional conduct with two female patients.

Covington, Karl K., M.D., Lic. No. G9083, Houston
On June 27, 2014, the Board and Karl G. Covington, M.D., entered into an Agreed Order of Voluntary Revocation, revoking Dr. Covington’s Texas medical license and requiring him to immediately cease practice in Texas. Dr. Covington agreed to the revocation of his license in lieu of further disciplinary proceedings. The Board found Dr. Covington pled guilty to the second degree felony offense of engaging in organized criminal activity, which resulted in an Order of Deferred Adjudication, which placed him on community supervision for five years. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Gorman, Mary, M.D., Lic. No. H3249, Austin
On June 27, 2014, the Board and Mary Gorman, M.D., entered into an Agreed Voluntary Revocation Order, revoking Dr. Gorman’s Texas medical license and requiring her to immediately cease practice in Texas. Dr. Gorman agreed to the revocation of her license in lieu of further disciplinary proceedings. The Board found Dr. Gorman, on multiple occasions, prescribed controlled substances to a close personal friend while she was not on duty at the hospital. Dr. Gorman admitted that she committed the violations and stated that she continued to violate her 2011 Order. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Ramsey, Edward Earl, Jr., M.D., Lic. No. J6679, Houston
On June 27, 2014, the Board and Edward Earl Ramsey, Jr., M.D., entered into an Agreed Order of Revocation, revoking Dr. Ramsey’s Texas medical license and requiring him to immediately cease practice in Texas. Dr. Ramsey agreed to the revocation of his license in lieu of further disciplinary proceedings. Dr. Ramsey was under investigation by the Board for allegations that include failure to meet the standard of care, nontherapeutic prescribing, failure to adequately supervise delegates, and operation of an illegal pain management clinic.

Saetrum, Brent Bjorn, M.D., Lic. No. K4994, Santa Rosa, CA
On June 27, 2014, the Board and Brent Bjorn Saetrum, M.D., entered into an Agreed Order of Revocation, revoking Dr. Saetrum’s Texas Medical license and requiring him to immediately cease practice in Texas. Dr. Saetrum agreed to the revocation of his license in lieu of further disciplinary proceedings. The Board found on April 8, 2013, the Medical Board of California revoked Dr. Saetrum’s California medical license, stayed the revocation, and placed Dr. Saetrum on probation with suspension. This action was based on Dr. Saetrum’s diversion of controlled substances for his own personal use by writing fictitious prescriptions.
VOLUNTARY SURRENDER

Bittle, Charles Carroll, M.D., Lic. No. H0184, Tahoka

On June 27, 2014, the Board and Charles Carroll Bittle, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Bittle agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings and requiring Dr. Bittle to immediately cease practice in Texas. Dr. Bittle was currently suspended from practicing medicine in the state of Texas, after the Board entered an Order of Temporary Suspension on April 22, 2014, related to Dr. Bittle’s nontherapeutic prescribing to seven patients.

Harris, Michael Justin, M.D., Lic. No. M3574, Los Angeles, CA

On June 27, 2014, the Board and Michael Justin Harris, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Harris agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings and requiring Dr. Harris to immediately cease practice in Texas. The Board found Dr. Harris is currently under investigation for allegations related to his self-report of a DUI in the state of California, non-compliance with the Texas Physician Health Program (PHP), and a Consent Order entered by the Arizona Medical Board.

Huq, Nisar Mikail, M.D., Lic. No. M0761, Amarillo

On June 27, 2014, the Board and Nisar Mikail Huq, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Huq agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings and requiring Dr. Huq to immediately cease practice in Texas. The Board found Dr. Huq on January 23, 2014, signed an Undertaking with the College of Physicians and Surgeons of Ontario (CPSO) voluntarily restricting his practice to non-invasive/non-interventional cardiology in an ambulatory clinical setting. Dr. Huq reported to the Board that he has a medical condition which precludes him from practicing medicine with reasonable skill and safety to patients.

Robinson, Herbert Joel, M.D., Lic. No. D5568, Windcrest

On June 27, 2014, the Board and Herbert Joel Robinson, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Robinson agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings and requiring Dr. Robinson to immediately cease practice in Texas. Dr. Robinson was under investigation for allegations of non-therapeutic prescribing and failure to meet the standard of care in relation to several patients.

Wimmer, Patrick, M.D., Lic. No. J2418, Bedford

On June 27, 2014, the Board and Patrick Wimmer, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Wimmer agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings and requiring Dr. Wimmer to immediately cease practice in Texas. Dr. Wimmer was under investigation for allegations related to his failure to comply with his June 14, 2013 Order. Dr. Wimmer reported to the Board that he has a medical condition which precludes him from practicing medicine with reasonable skill and safety to patients. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

SUSPENSION


On June 27, 2014, the Board and Yassar I. Ahmed, M.D., entered into an Agreed Order of Voluntary Suspension. Dr. Ahmed requested and agreed to a voluntary suspension of his medical license. The suspension of Dr. Ahmed’s Texas medical license lasts until such a time as he requests in writing to have the suspension stayed or lifted, appears before the Board and provides clear and convincing evidence that he is physically, mentally, and otherwise competent to safely practice medicine.

Vance, Carol Klett, M.D., Lic. No. F7253, Idaho Falls, ID

On June 27, 2014, the Board and Carol Klett Vance, M.D., entered into an Agreed Order of Suspension, suspending Dr. Vance’s Texas medical license until such a time as she requests in writing to have the suspension stayed or lifted, appears before the Board and provides clear and convincing evidence that she is physically, mentally, and otherwise competent to safely practice medicine. The Board found Dr. Vance is currently being investigated by the Idaho State
Board of Medicine for impairment that may impede her ability to safely and effectively practice medicine. In view of the actions by the Idaho State Board of Medicine, Dr. Vance agreed to the voluntary suspension of her license to practice medicine in the state of Texas.

PEER REVIEW ACTIONS

Santos, Alejandro, M.D., Lic. No. H1725, Austin
On June 27, 2014, the Board and Alejandro Santos, M.D., entered into an Agreed Order requiring Dr. Santos to pay an administrative penalty of $1,000 within 120 days. The Board found Dr. Santos’ privileges were terminated by University General Hospital in Dallas for practicing medicine with an expired and/or delinquent Texas medical license.

Virlar, Jesus Alfredo, M.D., Lic. No. L7592, San Antonio
On June 27, 2014, the Board and Jesus Alfredo Virlar, M.D., entered into an Agreed Order publicly reprimanding Dr. Virlar and requiring him to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 24 hours of CME, divided as follows: eight hours in risk management, eight hours in ethics and eight hours in professional communications; and pay an administrative penalty of $5,000 within 180 days. The Board found Dr. Virlar was the subject of disciplinary action by peers at Methodist Healthcare System which resulted in Dr. Virlar’s membership and clinical privileges being revoked.

OTHER STATES’ ACTIONS

Basco, Michael Angelo, M.D., Lic. No. H5151, Frederick, MD
On June 27, 2014, the Board and Michael Angelo Basco, M.D., entered into an Agreed Order publicly reprimanding Dr. Basco. In addition, Dr. Basco shall not practice medicine in Texas until such a time as he requests in writing to have the suspension stayed or lifted, appears before the Board and provides clear and convincing evidence that he is physically, mentally, and otherwise competent to safely practice medicine. Dr. Basco shall comply with all terms of the Order entered by the Maryland Board of Physicians. The Board found on May 29, 2013, the Maryland Board of Physicians entered an Order of Summary Suspension of License to Practice Medicine against Dr. Basco.

Bohman, Van Reid, M.D., Lic. No. H3228, Las Vegas, NV
On June 27, 2014, the Board and Van Reid Bohman, M.D., entered into an Agreed Order requiring Dr. Bohman to within one year complete at least six hours of CME in medical recordkeeping and ethics; and pay an administrative penalty of $1,500 within 90 days. The Board found Dr. Bohman was disciplined by the Nevada State Board of Medical Examiners after being the subject of a medical malpractice suit that was dismissed with prejudice and inadequate medical recordkeeping in regard to one patient.

Gaddis, Todd Donavon, M.D., Lic. No. P3152, Aubrey
On June 27, 2014, the Board and Todd Donavon Gaddis, M.D., entered into an Agreed Order requiring Dr. Gaddis to provide the Board evidence of full compliance with the terms and conditions of the Louisiana State Board of Medical Examiners’ Consent Order entered against Dr. Gaddis on September 23, 2013. The Board found Dr. Gaddis was disciplined by the Louisiana State Board of Medical Examiners following allegations that Dr. Gaddis violated Louisiana telemedicine rules.

Schilling, Paul Joseph, M.D., Lic. No. H6584, Gainesville, FL
On June 27, 2014, the Board and Paul Joseph Schilling, M.D., entered into an Agreed Order requiring Dr. Schilling to within one year complete at least eight hours of CME in risk management; and pay an administrative penalty of $1,000 within 60 days. The Board found Dr. Schilling entered into a Settlement Agreement with the Florida Board of Medicine (FBM). The terms of the agreement included a Letter of Concern, $7,500 administrative fine, completion of 15 hours of CME, and the requirement to present a one hour seminar addressing brachytherapy quality assurance. On December 20, 2013 the FBM issued a Final Order accepting the Settlement Agreement.
FAILURE TO PROPERLY SUPERVISE OR DELEGATE
Erickson, Carl Frederick, M.D., Lic. No. H2361, San Antonio
On June 27, 2014, the Board and Carl Frederick Erickson, M.D., entered into an Agreed Order requiring Dr. Erickson within one year to complete at least 10 hours of CME in risk management, including two hours in supervision of mid-level providers and delegation; and pay an administrative penalty of $3,000 within 60 days. The Board found Dr. Erickson did not take adequate measures to verify the license status of a physician assistant that was under his supervision.

Rocha, Ricardo A., M.D., Lic. No. D3385, Dallas
On June 27, 2014, the Board and Ricardo A. Rocha, M.D., entered into an Agreed Order publicly reprimanding Dr. Rocha and requiring him to within 90 days submit copies of his office protocols for delegation and/or supervision processes and procedures to the Board; within one year complete at least 20 hours of CME, divided as follows: eight hours in risk management, eight hours in ethics and four hours in recordkeeping; and pay an administrative penalty of $2,000 within 60 days. The Board found Dr. Rocha improperly supervised and allowed an unlicensed individual to practice medicine and failed to keep adequate medical records.

Walker, Richard W., Jr., M.D., Lic. No. G0641, Houston
On June 27, 2014, the Board and Richard W. Walker, Jr., M.D., entered into an Agreed Order on Formal Filing, requiring Dr. Walker to complete the following terms and conditions: have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 12 hours of CME, divided as follows: four hours in medical recordkeeping, four hours in medical ethics and four hours in pain management; and pay an administrative penalty of $2,500 within 60 days. The Board found Dr. Walker failed to adequately supervise non-licensed clinic staff while serving as the medical director of a clinic. Specifically, the staff placed facsimiles of Dr. Walker’s signature on unauthorized prescriptions for controlled substances issued to five patients without Dr. Walker’s knowledge. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

INAPPROPRIATE PRESCRIBING
Lee, Robert Louis, M.D., Lic. No. K0511, Granbury
On June 27, 2014, the Board and Robert Louis Lee, M.D., entered into an Agreed Order requiring Dr. Lee to within one year complete at least 12 hours of CME, divided as follows: eight hours in risk management and four hours in ethics; and pay an administrative penalty of $1,000 within 90 days. The Board found Dr. Lee prescribed Darvocet to his girlfriend without conducting a proper physical examination and without making a proper medical record.

On June 27, 2014, the Board and Gabriel Tarango, D.O., entered into an Agreed Order requiring Dr. Tarango to within one year and three attempts pass the Medical Jurisprudence Exam; comply with any and all recommendations made by the Texas Physician Health Program (TxPHP); and not reregister or otherwise obtain DEA or DPS Controlled Substances Registration Certificates without authorization from the Board. The Board found Dr. Tarango was self-prescribing Alprazolam with a different doctor’s DEA number and that he voluntarily surrendered his DPS and DEA Controlled Substance Registration Certificates. The Board found Dr. Tarango entered into an in-patient treatment program and signed a contract with the TXPHP on August 5, 2013. Dr. Tarango is in compliance with TXPHP currently and does not have a controlled substance registration.

VIOLATION OF PRIOR ORDER
Howie, David Ian, M.D., Lic. No. H2472, Cleveland
On June 27, 2014, the Board and David Ian Howie, M.D., entered into an Agreed Order Modifying Prior Order requiring Dr. Howie to submit to the Compliance Division of the Board letters from up to three physicians who are board certified in psychiatry and who agreed to serve as Dr. Howie’s approved treating psychiatrist and follow the treating psychiatrist’s
recommendations for care and treatment. Failure to comply shall constitute a violation of the Agreed Order and Board representatives may direct the Executive Director to immediately suspend Dr. Howie’s Texas medical license. The Board found Dr. Howie is not in compliance with his December 2013 Order. Specifically, Dr. Howie has failed to timely provide letters from three board certified psychiatrists who agree to serve as his treating psychiatrist.

**Mann, Christopher Rolan, D.O., Lic. No. H2559, Fort Worth**

On June 27, 2014, the Board and Christopher Rolan Mann, D.O., entered into an Agreed Order requiring Dr. Mann to within one year and three attempts pass the Medical Jurisprudence Exam and within seven days provide a sworn affidavit to the Board that he has completed referrals of all chronic pain patients. The Board found Dr. Mann violated his 2013 Order by continuing to treat chronic pain patients that he was unable to refer within 30 days as required by the Order.

**VIOLATION OF BOARD RULES**

**Warfield, Brett Henry, M.D., Lic. No. L9003, Houston**

On June 27, 2014, the Board and Brett Henry Warfield, M.D., entered into a Mediated Agreed Order requiring Dr. Warfield to within 30 days, provide the Board a copy of the consent forms he provides to all patients he treats with anesthesia procedures/care; within one year complete at least eight hours of CME in risk management; and pay an administrative penalty of $500 within 60 days. The Board found Dr. Warfield failed to obtain the consent necessary to formalize the treatment provided and to document that a doctor-patient relationship had been established. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**TEXAS PHYSICIANS HEALTH PROGRAM (PHP) VIOLATION**

**Davis, Randy J., D.O., Lic. No. N2053, Arlington**

On June 27, 2014, the Board and Randy J. Davis, D.O., entered into an Agreed Order requiring Dr. Davis to within 30 days submit to and obtain an independent medical evaluation and follow all recommendations for care and treatment; continue participating in Alcoholics Anonymous or similar approved program; continue participating in the activities of a county or state medical society committee on physician health and rehabilitation, including participation in weekly meetings, if any; abstain from the consumption of prohibited substances; and participate in the Board’s drug testing program. The Board found Dr. Davis was referred back to the Board from the Texas Physician Health Program (TXPHP) following concerns with his overall program compliance and apparent lapse in his sobriety. Dr. Davis’ history and poor compliance with TXPHP warrants an order requiring that he participate in the Board’s monitoring program. Due to Dr. Davis’ violation of his confidential agreement with TXPHP, his past participation in the program is no longer confidential.

**INADEQUATE MEDICAL RECORDS**

**Pham, Chi Manh, M.D., Lic. No. G1993, Houston**

On June 27, 2014, the Board and Chi Manh Pham, M.D., entered into a Mediated Agreed Order requiring Dr. Pham to have his practice monitored by another physician for six consecutive monitoring cycles; and within one year complete at least 18 hours of in-person CME, divided as follows: 18 hours in medical recordkeeping, with at least six hours in medical recordkeeping in the context of the treatment of chronic pain. The Board found Dr. Pham failed to maintain adequate medical records with respect to five patients. Specifically, Dr. Pham’s medical records lacked documentation of the medical decision-making process, including adequate documentation of the patients’ outcomes. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**FAILURE TO USE TEXAS ELECTRONIC DEATH REGISTRY SYSTEM**

**Aleman, Ruben, M.D., Lic. No. G3106, McAllen**
On June 27, 2014, the Board approved a Final Order requiring Dr. Aleman to within one year and three attempts pass the Medical Jurisprudence Exam; and pay an administrative penalty of $3,000 within 60 days. The Board found Dr. Aleman did not make a good faith effort to file a death certificate electronically within the time frame required by the Texas Health and Safety Code. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Aleman has 20 days from the service of the order to file a motion for rehearing.

CEASE AND DESIST
Black, Dennis, No License, Carrollton
On June 6, 2014, the Board entered a Cease and Desist Order regarding Dennis Black prohibiting him from acting as, or holding himself out to be, a licensed physician in the state of Texas. Mr. Black shall not refer to himself as Dr. Dennis Black, Dr. Dennisblack.com, Dr. Black, and Dr. Dennis Black, N.D., without clearly designating that he is not a medical doctor and that he is not licensed to practice medicine in the state of Texas. This applies to Mr. Black’s information listed in websites, products he attempts to sell, letterhead, stationary, postings in and around his office and in any advertising materials, or as designated in Medical Practice Act, Section 165.156. The designation that he is not a medical doctor and that he is not licensed to practice medicine in Texas, shall appear immediately following any reference to “Doctor” or “N.D.” and the designation must immediately reference the authority under which the title is used. The Board found Mr. Black, through his website, used the designation of doctor without adequately disclosing the basis upon which he used the designation and that Mr. Black engaged in the practice of medicine by offering to treat people. Mr. Black also maintains a Facebook page of “Dr. Dennis Black, Carrollton, Texas.” On this Facebook page Mr. Black gives health tips and medical advice. Mr. Black also has a radio show called “Dr. Dennis Black Live on Word 100.7, Christian Talk Radio.”

Diaz, J. Luis, No License, Houston
On June 27, 2014, the Board entered a Cease and Desist Order regarding J. Luis Diaz, prohibiting from engaging in the unlicensed practice of medicine in the state of Texas. Mr. Diaz shall cease and desist any unlicensed practice of medicine. The Board found Mr. Diaz has practiced medicine in the state of Texas by evaluating, diagnosing and treating patients in Texas at the medical office of J. Jesus Diaz, M.D., while no physician was present at that clinic. Mr. Diaz was identified as a physician by himself, patients and staff.

Payne, Robert Brett, D.C., No License, Euless
On June 27, 2014, the Board entered an Agreed Cease and Desist Order regarding Robert Brett Payne, D.C., prohibiting him from practicing medicine in the state of Texas without a license issued by the Texas Medical Board. Mr. Payne shall refrain from practicing outside the scope of chiropractic and shall cease and desist in diagnosing, treating, or offering to diagnose or treat any condition which is in the absence or licensure or an exception under the law would constitute the unlicensed practice of medicine. The Board found it received a complaint that Mr. Payne engaged in the unlicensed practice of medicine by diagnosing medical conditions and under the direction of a medical director and pursuant to joint agreed treatment protocols, administering IV vitamins and nutritional supplements.

Izekor, Imafidon “Thomas,” No License, Arlington
On May 30, 2014, the Board entered a Cease and Desist Order regarding Imafidon “Thomas” Izekor requiring him to immediately cease posting on websites that he is a medical doctor or doctor without disclosing that he is not licensed in Texas. Furthermore, Mr. Izekor shall not refer to himself with the title “Dr.” or “doctor” without clearly indicating that he is not licensed to practice medicine in the state of Texas. The Board found Mr. Izekor publicly professed/posted on a prominent social media website, LinkedIn, that he was a Medical Doctor in Arlington, Texas. Mr. Izekor’s designation of “Medical Doctor” failed to state as a required disclosure that he is not licensed to practice medicine in Texas.

Sinha, Sangeeta, No License, Houston
On June 27, 2014, the Board entered an Agreed Cease and Desist Order regarding Sangeeta Sinha, prohibiting her from acting as, or holding herself out to be, a licensed physician in the state of Texas. Ms. Sinha shall not refer to herself as a doctor or physician and Dr. Sangeeta Sinha without clearly designating that she is not licensed to practice medicine in
the state of Texas. This applies to information listed on any websites, electronic mail addresses, letterhead, stationary, postings in or around Ms. Sinha's office, and in any advertising materials, or as designated in the Medical Practice Act, Section 165.156. The Board found Ms. Sinha held herself out to the public as “Dr.” and “Doctor” in the context of advertising her services in Texas on various websites, including Facebook and LinkedIn.

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To view disciplinary orders, visit the TMB website, click on "Look Up A License," accept the usage terms, then type in a doctor's name. Click on the name shown in the search results to view the doctor's full profile. Within that profile is a button that says "View Board Actions."

All releases and bulletins are also available on the TMB website under the "Newsroom" heading.