Dr. Willeford Appointed to Board

Governor Rick Perry has appointed George Willeford III, M.D., to the board.

Dr. Willeford attended medical school at the University of Texas Southwestern Medical Branch in Dallas, where he was a member of the Alpha Omega Alpha National Medical Honor Society. He completed his internship and residency at Parkland Memorial Hospital and the Dallas Veterans Administration Hospital. He is board certified in both internal medicine and gastroenterology by the American Board of Internal Medicine. He holds memberships in the Travis County Medical Society, Texas Medical Association and the American College of Physicians. He is a Fellow of the American College of Gastroenterology and has served as secretary-treasurer of the Austin Society of Internal Medicine, a member of the board of directors of the Seton Physician’s Hospital Network, and a member, appointed by then-Governor George W. Bush, of the Managed Health Care Committee. He was also on the board of directors and was chief of internal medicine at Seton Medical Center. Dr. Willeford has practiced in Austin since 1980.

Dr. Willeford replaces Larry Anderson, M.D., who resigned from the board. Dr. Anderson served from August, 2005, until August of this year. During his time on the board he served as chairman of the Licensure Committee, chairman of the Ad Hoc Committee to Study Chapter 192 and as a member of the Executive Committee, the Disciplinary Process Review Committee and the Ad Hoc Committee for Scope of Practice. At the October board meeting, board members thanked Dr. Anderson for his service and presented him with a proclamation and a plaque.

TMB Conducts Town Hall Meetings throughout Texas

Over the course of 14 weeks this summer, the Texas Medical Board conducted 13 Town Hall meetings, visiting every region of the state. Almost 450 people came to the meetings, the vast majority of whom were physicians. Board members and staff listened to a lot of complaints, heard some good ideas and answered many, many questions about the Board and its practices.

TMB has already begun to act on some of the good suggestions that were offered this summer and at meetings earlier in the year:
Administrative violations: The Board heard numerous complaints regarding administrative complaints and the time required to resolve them. Many doctors suggested that TMB should devote far less attention to administrative violations and concentrate more of its resources toward prosecuting doctors who pose a threat to the public. The Board agrees. Earlier this year TMB instituted a fast track procedure for administrative violations. The procedure allows these minor violations to be processed and resolved quickly.

Education: Many suggested that TMB should provide more education for the profession to help physicians avoid violations in the first place. The Board agrees that both licensees and the public are much better served if a violation never occurs. To that end, TMB included in its Legislative Appropriation Request to the 81st Texas Legislature a request for funding for an educational component. If the request is approved, TMB will offer three levels of instruction. The first level would target medical students still in school. The second would be for doctors just completing their residencies, and the third would be for mid-career doctors.

Complaint response time: A frequent complaint was that TMB does not allow a physician sufficient time to respond during the initial 30-day review period before a complaint is filed for investigation. Because the timeline is statutory, this will require a legislative fix. TMB has been talking to key legislators about extending this initial review time to 45 days so the physician will have 28 days to provide an initial response. Currently, 41 per cent of jurisdictional complaints are dismissed after this initial review. If more physicians can provide better responses at this initial stage, both TMB and the licensees will benefit from saved resources.

It is clear from the comments the Board received at the meetings that there is a lot of mistrust of TMB, much of it related to misinformation. A possible source of misunderstanding is the confidentiality that surrounds individual cases. That said, the perception of TMB can be exaggerated and inaccurate, like a caricature. The Board recognizes that the physicians who face Board orders make up a very small subset of the 59,000 physicians licensed in Texas. However, the Board is charged with enforcing the laws surrounding the practice of medicine in this state and will do what is required to fulfill that charge. TMB hopes increased communication and education will help everyone better understand the regulation of the medical profession in this state.

The Board also heard that there is frustration in the medical community about the rapidly increasing number of complaints filed every year and the time it takes to resolve them. While a case is pending, a doctor must work under a cloud of suspicion, even in those cases in which the complaint eventually will be dismissed. And the process, the Board readily admits, is taking too long. The number of complaints the Board receives shot up a couple years ago and shows no signs of easing, resulting in a longer resolution time for all complaints. TMB is complaint-driven. When complaints are received, the agency is
compelled by law to investigate them. The increase has placed an added burden on the staff and has slowed the process. TMB has asked the Texas Legislature for additional employees and appropriations to help break the logjam. Unnecessarily prolonged investigations are a disservice to both the public and to physicians being investigated and detract from the mission of public protection.

The goal for these meetings was to dispel misperceptions and ease frustrations by offering a candid discussion, answering questions and presenting ideas in an open, informal setting. The Board also wanted to collect ideas about what TMB could do to make adherence to the rules easier for physicians without compromising on its vital core mission, which is to protect the public. The Board wanted to achieve a higher level of interaction between the regulator and the regulated.

On these counts, the meetings were successful. TMB learned a lot from the doctors who attended the meetings, and participants left with a better appreciation of what the board seeks to do and the reasoning behind the methods used to accomplish it.

The Board is still analyzing comments and suggestions collected at the Town Hall meetings, but board members and staff know there are other good ideas that were offered for consideration. The Board will be reviewing these further, looking for those suggestions that will help ease the regulatory burden without sacrificing TMB’s mission.

To read the meeting notes from the Town Hall meetings, go to [http://www.tmb.state.tx.us/townhall/meetings2008.php](http://www.tmb.state.tx.us/townhall/meetings2008.php).

**Board Names Interim Executive Director, Medical Director**

The board has named Mari Robinson, J.D., as interim Executive Director of the agency following the retirement of former executive director Donald W. Patrick, M.D., J.D. The board also named Alan T. Moore, M.D., as interim medical director of the agency.

Robinson, originally from Grand Prairie, began her career at TMB as a litigation attorney in 2001 and has served as Director of Enforcement since 2006. She received her B.A. in government (cum laude) from Angelo State University and her J.D. from the University of Texas School of Law, where she also taught as an adjunct professor for the advocacy program. Prior to joining TMB, she worked in a law firm as well as for the Texas Office of the Attorney General. She is active in the Austin Young Lawyers Association and other civic and professional organizations.

Dr. Moore graduated with honors from U.T. Austin and received his medical degree from the University of Texas Southwestern Medical School, where he was a member of Alpha Omega Alpha Honor Society. He completed his anatomic and clinical pathology residency at Parkland Memorial
Hospital in Dallas, where he served as chief resident during his fourth year. He also completed a hematopathology fellowship at Parkland.

Dr. Moore is board certified in anatomic pathology, clinical pathology and hematopathology. He has practiced in Austin for more than 20 years and has served as president of Clinical Pathology Associates as well as on the board of Clinical Pathology Laboratories; medical director of Seton Medical Center Laboratory; chief of Staff at Seton Medical Center; and president of the Texas Society of Pathologists. He has also served as the transplant pathologist for the Seton Medical Center Cardiac Transplant Program.

TMB Issues Record Number of Physician Licenses

With the help of additional resources appropriated by the Texas Legislature, along with some streamlining of its processes, the Texas Medical Board set a record in Fiscal Year 2008 by licensing more than 3,600 doctors. This surpassed the previous record, set in FY 2007, by almost 300 licenses. TMB also eliminated an application backlog that had grown to more than 500 applications by February. The Board also took steps to improve efficiency in the application processing system by conducting a statewide series of licensing seminars to provide training for credentialing, recruiting and other health care entity staff responsible for assisting physicians with their licensure applications. Fewer mistakes on completed applications will usually result in faster processing time.

Texas is a popular place to practice medicine, as evidenced by the dramatic increase over the past few years in the number of doctors who apply to be licensed here, said Dr. Roberta Kalafut, TMB’s board president. We have applicants coming to Texas from all over the country and all over the world.

Our staff has responded to this greatly increased and varied demand, Dr. Kalafut said. We are issuing more licenses than ever, more quickly than ever, and we have eliminated the backlog of applications awaiting processing, all without compromising the quality of physicians licensed in Texas.

TMB licensed 3,621 doctors in FY 2008, an increase of almost nine percent over the former record of 3,324 licenses that were issued in FY 2007. The 2007 record eclipsed by almost 500 licenses the previous record, 2,828 licenses, which were issued in FY 2002.

Processing times for licenses also have been greatly reduced, and exceed legislative requirements. The Board licensed 1,549 doctors in the fourth quarter of 2008 in an average of 42 days. The Texas Legislature in 2007 appropriated six additional employees for the licensing division, while mandating that licenses be issued in an average of 51 days or less.

To build on this success, during the spring and summer of 2008 TMB conducted 13 licensing seminars in all regions of the state. About 200 individuals attended the three-hour seminars, which offered in-depth instruction on proper preparation of a physician licensure application, with an emphasis on the
most common mistakes found on applications. If applications are complete and correct when TMB receives them, processing can be completed much more quickly.

The training is helpful because of the complexity of license applications. Before TMB can license a physician, it first must determine that the physician’s education and training are substantially equivalent to the medical education and training provided in Texas. This can prove challenging, as TMB last year licensed physicians who were trained in 45 states and 83 other countries.

Almost 30 percent of the physicians licensed in Texas last year, 1,032, received their medical educations at international schools.

Rule Changes

The board has adopted the following rules and rule changes since the last issue of the Medical Board Bulletin. The rules can be found on the TMB web site at http://www.tmb.state.tx.us/rules/rules/bdrules_toc.php.

Chapter 161, General Provisions: amendments to 161.6, Committees of the Board, updates the duties of the Licensure Committee; 161.8, Deputy Executive Director, to update the name of Deputy Executive Director to Chief of Staff.

Chapter 163, Licensure: amendments to 163.4, Procedural Rules for Licensure Applicants, to specify instances under statute and Board rule when the Executive Director may determine applicants ineligible for licensure and not have staff process an applicant’s entire application before review by the Licensure committee; 163.5, Licensure Documentation, clarifies when an applicant must submit documentation regarding inpatient treatment, and modifies language regarding alcohol/substance disorder and physical illness that did or could have impaired an applicant’s ability to practice medicine; 163.6, Examinations Accepted for Licensure, provides an exception to the three-attempt limit to conform to statutory requirements adopted by the Legislature in 2007; 163.10, Relicensure, updates requirements to conform to previous rule changes to require that Jurisprudence Examination be taken only once; 163.11, Active Practice of Medicine, deletes passage of SPEX examination as a stated remedy for applicants who cannot demonstrate that they have been in the active practice of medicine, 163.14, Interpretation of 1.51(d), Senate Bill 419, repeals emergency and temporary provision regarding interpretation of three-attempt rule.

Chapter 166, Registration: amendments to 166.1, Physician Registration, updates rule to conform with biennial registration; 166.2, Continuing Medical Education, updates rule to conform with biennial registration and amends provisions related to administrative penalties to be consistent with provisions under Chapter 190 related to disciplinary guidelines; 166.5, Relicensure, clean-up of language;
166.6, Exemption from Registration Fee for Retired Physician Providing Voluntary Charity Care, updates rule to conform with biennial registration.

Chapter 169, Authority of Physicians to Supply Drugs: amendments to 169.2, Definitions, updates name of Texas Medical Board.

Chapter 171, Postgraduate Training Permits: amendments to 171.3, Physician-in-Training Permits, updates the name of the Texas Medical Board, extends period for submitting an application from 90 days to 120 days from the expected start date of the training program, specifies instances under statute and Board rule when the Executive Director may determine applicants ineligible for licensure and not have staff process an applicant’s entire application before review by the Licensure committee, modifies language regarding alcohol/substance disorder and physical illness that did or could have impaired an applicant’s ability to practice medicine; 171.4, Board-Approved Fellowships, repeals expired provisions for fellowships approved before September 1, 2007; 171.5, Institutional Permits, repeals expired provisions related to Institutional Permits and replaces with new rule regarding the Duties of PIT Holders to Report; 171.6, Duties of Program Directors to Report, extends from seven days to 30 days for program directors to report certain matters to the Board, requires reporting of all participants in the training programs, and deletes requirement for annual reports by program directors.

Chapter 172, Temporary and Limited Licenses: amendments to 172.1, Purpose, adds citation of Medical Practice Act to clarify authority for the chapter; 172.2, Construction and Definitions, specifies instances under statute and Board rule when the Executive Director may determine applicants ineligible for licensure and not have staff process an applicant’s entire application before review by the Licensure committee; 172.3 Distinguished Professor Temporary License, 172.6 Visiting Professor Temporary License, and 172.8 Faculty Temporary License, refers to medical schools that are accredited by the Liaison Committee on Medical Education or the American Osteopathic Association Bureau of Professional Education, instead of listing each medical school; and 172.13, Conceded Eminence, clarifies that medical school applying on behalf of the physician must be accredited by the Liaison Committee on Medical Education or the American Osteopathic Association Bureau of Professional Education.

Chapter 173, Physician Profile: 173.1, Profile Contents. Amendment regarding publishing the name as the physician wishes it to be published; year of birth; mailing address.

Chapter 184, Surgical Assistants: amendments to 184.1, Purpose, adds reference to Medical Practice Act and Surgical Assistants Act, authorizing rules; 184.2, Definitions, updates name of the Texas Medical Board; 184.4, Qualifications for Licensure, clarifies what is an acceptable registered nurse first assisting program and a surgical physician assistant program, deletes surgical assistant programs that are not CAAHEP accredited from being acceptable for purposes of licensure, and updates name of LCC-ST; 184.5, Procedural Rules for Licensure Applicants, deletes obsolete provision regarding an applicant who applied prior to September 1, 2002; 184.6, Licensure Documentation, updates reference to alcohol/substance disorders; 184.8, Licensure Renewal, clarifies the rule by setting
forth requirements that an applicant must furnish supplemental explanations on renewal applications and prohibiting a Surgical Assistant from using the identification as a Licensed Surgical Assistant after a license is expired; 184.9, Relic ensure, provides that a license shall be considered to be cancelled if expired more than one year, unless an investigation is pending; 184.18, Administrative Penalties, updates rule to refer to rules regarding imposition of an administrative penalty under chapter 187; 184.19, Complaint Procedure Notification, updates references to other Board rules; 184.20, Investigations, deletes misplaced reference to licensure procedure; and 184.26, Voluntary Relinquishment or Surrender of a License, corrects title of Chapter 196 of the Board Rules.

Chapter 185, Physician Assistants: 185.2 Physician Assistant Definitions. Amendment regarding definition of supervising physician.

Chapter 193, Standing Delegation Orders: amendments to 193.1, Purpose, updates name of Texas Medical Board; 193.2, Definitions, updates name of Texas Physician Assistant Board; 193.4, Scope of Standing Delegation orders, cleanup language; 193.7, Delegated Drug Therapy Management, updates reference to the Texas Pharmacy Act; 193.8, Delegated Administration of Immunizations or Vaccinations by a Pharmacist Under Written Protocol, updates reference to the Texas Medical Practice Act; 193.9, Pronouncement of Death, updates reference to the Texas Medical Practice Act; 193.10, Collaborative Management of Glaucoma, updates reference to the Texas Optometry Act and the name of the Texas Medical Board; and repeal of 193.11, Use of Lasers.

Formal Complaints

Formal Complaints have been filed with the State Office of Administrative Hearings regarding the licensees listed below. Formal Complaints are public documents and are posted on physician profiles on the TMB web site.

The Texas Occupations Code, Medical Practice Act, defines a Formal Complaint as follows: Sec. 164.005. INITIATION OF CHARGES; FORMAL COMPLAINT.

A formal complaint means a written statement made by a credible person under oath that is filed and presented by a board representative charging a person with having committed an act that, if proven, could affect the legal rights or privileges of a license holder or other person under the board's jurisdiction.

A formal complaint must allege with reasonable certainty each specific act relied on by the board to constitute a violation of a specific statute or rule.

These cases were unresolved at the time of publication.
Bernice Anderson, D.O. . . . . H9489 . . . . 6/30/08 . . . . Failure to practice consistent with public health and welfare; unprofessional conduct; inability to practice safely because of illness, drunkenness or excessive use of substances; intemperate use.

George M. Beasley, D.O. . . . . H7882 . . . . 8/19/08 . . . . Unprofessional conduct; nontherapeutic prescribing; failure to maintain adequate medical records; failure to meet the standard of care.

Butler, Christopher D., L.Ac.. . . . AC00222 . . . . 10/6/08 . . . . Unprofessional conduct for holding himself out to be a doctor.

Andrew W. Campbell, M.D. . . . . G7790 . . . . 8/22/08 . . . . Failure to maintain adequate medical records; unprofessional conduct; failure to meet the standard of care; nontherapeutic prescribing; providing unnecessary services; improper billing.

Dale Curtis Davies, M.D. . . . . K1409 . . . . 8/27/08 . . . . Unprofessional conduct; submitting false information on a license application.

Bruce P. Foreman, M.D. . . . . G0707 . . . . 8/28/08 . . . . Violation of the standard of care; unprofessional conduct.

Allegra García-Cantu, M.D. . . none . . . . 7/25/08 . . . . Petition in opposition to licensure based on applicant’s failure to meet examination attempt limits.

Donald Gibson II, M.D. . . . . H5209 . . . . 8/18/08 . . . . Unprofessional conduct; nontherapeutic prescribing; failure to maintain adequate medical records; violation of board pain treatment rule; failure to meet the standard of care.

Thad W. Houseman, P.A. . . . . PA01862 . . . . 9/30/08 . . . . Violation of a board order; unprofessional conduct.

Bernard D. Kornell, M.D. . . . . F2308 . . . . 9/18/08 . . . . Violation of a board order; unprofessional conduct.

Brian E. LeCompte, M.D. . . . . G9615 . . . . 7/22/08 . . . . Failure to practice consistent with public health and welfare; violation of board rules; nontherapeutic prescribing.

Edward A. Luke Jr., D.O. . . . . F9759 . . . . 8/27/08 . . . . Unprofessional conduct; failure to maintain adequate medical records; failure to meet the standard of care; failure to adequately supervise.

Massey, Charles R. Jr., M.D. . . . . G5341 . . . . 10/6/08 . . . . Unprofessional conduct; failure to comply with a board subpoena; failure to cooperate with board staff; failure to keep adequate medical records.

Masaki Oishi, M.D. . . . . L6133 . . . . 9/18/08 . . . . Nontherapeutic prescribing; unprofessional conduct.

William C. Rainey, M.D. ........H9139 .......... 10/14/08 ....Failure to meet the standard of care; unprofessional conduct; nontherapeutic prescribing; violation of a board rule.

Ernesto P. Rhodes, M.D. ........ J3886 ........... 9/18/08 ......Violation of a board order; unprofessional conduct.

Eldon S. Robinson, M.D. ........ J9545 ....... 10/14/08 ....Failure to meet the standard of care; violation of board rules; unprofessional conduct; nontherapeutic prescribing.

H. Dudley Ross, M.D. .......... F7120 ........... 8/27/08 .....Disciplinary action by peers; failure to comply with board subpoena; failure to cooperate with board staff.

David P. Sheridan, M.D. ........ L3820 ........... 8/19/08 .....Providing medically unnecessary services to patient; nontherapeutic prescribing; making a false or fraudulent insurance claim; improper billing; failure to maintain adequate medical records; violation of Board Rule 200 regarding Complementary and Alternative Medicine; failure to practice consistent with public health and welfare; unprofessional conduct.

Michael Dean Smith, M.D. ........ F4545 .......... 6/25/08 .....Unprofessional conduct; failure to comply with a board order to abstain from prohibited substances.

Mark E. Van Wormer, M.D. .... H5986 ............ 7/21/08 .....Conviction of a felony; unprofessional conduct; violation of a law related to the practice of medicine.

Joseph K. Vaughan Jr., M.D. ... L5597 .......... 8/27/08 .....Termination of patient care without reasonable notice; unprofessional conduct; failure to maintain adequate medical records; failure to release medical records in a timely manner.

Khanh N. Vu, D.O. ............... L0676 ........... 9/18/08 .....Disciplinary action by another state based on a criminal conviction; unprofessional conduct.

Michael David Williams, M.D. H2907 ............ 6/30/08 .....Violation of a previous board order; unprofessional conduct.

Qaiser J. Yusuf, M.D. ........... J1818 .......... 6/13/08 .....Failure to meet the standard of care; failure to maintain adequate medical records; failure to practice consistent with public health and welfare; unprofessional conduct; making a false or fraudulent insurance claim; improper billing.

Pablo L. Xiques, M.D. ........... E3823 .......... 8/19/08 ......Unprofessional conduct; nontherapeutic prescribing; failure to maintain adequate medical records; violation of board rule regarding treatment of pain; failure to practice consistent with public health and welfare.

CORRECTION: The Spring 2008 issue of the Medical Board Bulletin contained an erroneous summary of allegations for the Formal Complaint filed against Nancy L. Anderson, M.D. The summary should
have stated: Inability to practice medicine with reasonable skill and safety; intemperate use; unprofessional conduct; failure to practice consistent with public health and welfare.

New Physician Licenses Issued, June-October, 2008

The Texas Medical Board issued licenses to 1,844 physicians between June 27 and October 10. The board congratulates the following new Texas licensed physicians:

Abadeer, Rania, MD * Abbara, Maher Ahmad, MD * Abbasi, Noma, MD * Abbott, John Keith, MD * Abdallah, Hani Yousef, MD * Abdelsayed, Elah, MD * Abel, Edwin Jason, MD * Abo Kayass, Ahmad, MD * Aboutaleb, Sina, MD * Abraham, Anitha Thomas, MD * Abraham, Ayodele Adebola, MD * Abraham, Vinu Mathew, MD * Abramson, Richard Glenn, MD * Adcox, Brent Matthew, MD * Adekile, Ayooola, MD * Adekola, Adekunle Lanre, MD * Adesanyo, Adetunji Enitan, MD * Adewuya, Edore Celestina, MD * Adrada, Beatriz Elena, MD * Adrien, Xavier Gavin, MD * Afanador, Maria Del Mar, MD * Afrina, Mehvesh, MD * Agha, Naureen Imtiaz, MD * Agraval, Vivek Kumar, MD * Aguirre, Jose Carlos, MD * Agyarko, Afua, MD * Ahmad, Khoshnood, MD * Ahmed, Elwaleed Ali, MD * Ahmed, Hala Mohamed Aly, MD * Ahmed, Raees, MD * Ahmed, Shah-Hinan, MD * Ahmed, Shamoona, MD * Aijaz, Asim Syed, MD * Aikawa, Taro, MD * Aikey, Jeremy Lee, DO * Airall-Ryan, Alison Angela Arlene, MD * Ajelabi, Akinbinka Abidemi, MD * Akbar, Salma, MD * Akin, Jay Dale, MD * Akin, Travis Todd, MD * Akingbala, Felicia Ayodeji, MD * Alameddine, Fadi Mahmoud Faissal, MD * Albarado, Rondel Paul, MD * Alberico, Ronald Arthur, MD * Albrecht, Michael Christian, MD * Albusunami, Omar Mahmoud, MD * Alcantara, Mario Alberto, MD * Ales, Noel Cristin, DO * Alexander, Scott Alan, MD * Alhalabi, Mohammad Salem, MD * Ali, Farhan, MD * Al-Khersan, Raid Hashim Fadhilli, MD * Allawa, Shahzad Saeed, MD * Alle, Srinesh, MD * Allen, Barbara Lynne, MD * Allen, Bryce Corban, MD * Allen, Carl Eugene, MD * Allen, Evan David, MD * Allen, Lisa E, DO * Alli, Chaitanya, MD * Almasi, Masoud, MD * Aloudat, Sarah Ibrahim, MD * Alroumo, Nanaf, MD * Alsheikh, Oday, MD * Alsheikh, Omar, MD * Alsheikh, Omar, MD * Alsheikh, Omar, MD * Alsop, Ernest Carson, MD * Alvarado, Ricardo Antonio, MD * Amadi, Chikezie Chidebere, MD * Amaya Chinchilla, Hector Gerardo, MD * Amen, Samuel Alan, MD * Amstutz, Karen Scharenberg, MD * Anapoorni, MD * Arvandi, Aliaqab, MD * Asghar, Arshad, MD * Ashford, Jason Scott, MD * Attec, A Supreme, MD * Auberchottova, Hana, MD * Aune, Gregory John, MD * Avalos Mishaan, Ana Miriam, MD * Avery, Eleanor Elizabeth, MD * Avery, Tiffany Perez, MD * Aviles, Ricardo, MD * Alfonso, Ayo, Dereje Sahle, MD * Azad, Mohammad Abul Kalam, MD * Azem, Syed Shabaz, MD * Aziz, Chimeko Icyinwa, MD * Aziz, Lara Youssef, MD * Babcock, Thomas, MD * Bacares, Edgar, MD * Badlissi, John Kerry, MD * Baine, Ralph Fredrick, MD * Baker, Christina Maria, DO * Baker, Jennifer Landry, MD * Baker, Krystin Calhoun, MD * Baker, Lisa Carol, MD * Bal, Hardeep Kaur, DO * Baldwin, Matthew Thomas, MD * Balentine, Courtney Joshua, MD * Balfanz, Phillip Eugene, MD * Ballester, John Michael, MD * Ball, Adam Grant, MD * Banerjee, Yamin, MD * Barbazar, Dalikrishna Shivashanker, MD * Bangalore, Deepa, MD * Bansal, Vikas, MD * Banuelos, Polo Alberto, MD * Banua, Jitendra, MD * Barakat, Ayman, MD * Barczy, Colette Kiddie, MD * Barkmeier, Andrew John, MD * Barnes, Tinka Ann, MD * Barr, Yael Rachel, MD * Barson, Dennis Bernard, DO * Barthel, Eniko Kiraly, MD * Bashir, Robin Shariief, MD * Basoor, Kalpana K, MD * Basow, William Matthew, MD * Bass, Kathryn Dirkes, MD * Bates, Aaron Michael, MD * Bates, Janee Gableton, MD * Battle, Ivan Ricardo, MD * Batty, George Nicolas, MD * Bauer, Peter Allan, MD * Bauman, Beverly Helene, MD * Bauman, Leslie Stafford, MD * Baxter, Patricia Ann, MD * Bayer, Matthew, MD * Bayne, Aaron Patrick, MD * Beaunon, William James, MD * Bechara, Carlos Fares, MD * Bedeir, Ahmed Saleh, MD * Bedolla, Gabriela Maria, MD * Behrmann, Tiffany Tarrant, MD * Belalcazar Ardila, Rodrigo, MD * Belay, Anteneh Mahari, MD * Bell, Monte Keith, MD * Bell, Stephen Josh, MD * Bendre, Sachin Vilas, MD * Bell, Cal-Gail, MD * Bengtson, Hans Eric, MD * Bennet, Robert Daniel, MD * Benni, Abd Ahraman, MD * Benny, Zhehir Lark, MD * Bercaw, Jennifer Lyrah, MD * Berecky, Ryan Edward, MD * Berg, Joshua Bradley, MD * Berg, Stephanie Marie, MD * Berger, Joseph Rossi, MD * Berkowitz, Barry Jay, MD * Beri, Richard Nazih, MD * Berry, Christopher Edward, MD * Berry, Jarett Dewitt, MD * Bertagnolli, Reono, MD * Bethea, Brian Thomas, MD * Bhakt A,
Physicians need to keep their triplicate prescription pads locked up, according to the Texas Department of Public Safety, which issues the forms and regulates their use for prescribing Schedule II drugs.

DPS investigators are finding that many physicians leave the pads in treatment rooms, lying on desks or in jacket pockets. They are then vulnerable to theft by patients or staff. Staff members who steal prescription pads sometimes move from job to job before they can be caught, making money on sales of the drugs, which have a high street value and which are commonly abused.

These thefts are often not detected immediately because the thief takes only one form, or takes forms out of sequence from deep in the pad. With the high quality of copying machines, thieves then forms out of sequence from deep in the pad. With the high quality of copying machines, thieves then
make multiple copies. The theft is only discovered when DPS tracking catches the same number being reused. Each fraudulent use of one of these prescriptions is a crime, and it endangers the public because of the drugs' deadly potential.

When issued their DPS Controlled Substances Registration permit, physicians are given a copy of the rules regarding safeguarding the prescriptions, but busy physicians often don’t have time to familiarize themselves with the regulations. DPS recommends that physicians handle the prescription pad like they would money. Never leave a pad in an unlocked drawer or lying out in a treatment room. Keep it on your person when you’re using it, and when you’re not using it lock it in a file cabinet, desk drawer or drug cabinet and keep track of the key.

Failure to properly safeguard triplicate prescription forms can result in disciplinary action by both DPS and TMB. DPS actions can range from a reprimand to revocation of the controlled substances permit; TMB actions can include reprimands, fines or other penalties.

Disciplinary Actions

Since the Spring 2008 issue of the Medical Board Bulletin, the Board has taken disciplinary action on 174 physicians and two physician assistants. The following is a summary of those actions.

QUALITY OF CARE VIOLATIONS

AGARWAL, VIRENDRA KUMAR, M.D, LIC. #L7293, GAINESVILLE, TX

On October 10, 2008, the Board and Dr. Agarwal entered into an Agreed Order requiring that within one year Dr. Agarwal complete 10 hours of continuing medical education in medical record-keeping and at least three hours in treatment of orthopedic injuries for primary care physicians. The action was based on Dr. Agarwal’s administering an excessive number of Kenolog injections to a patient’s Achilles area.

ATLAS, RUTH M., M.D., LIC. #G7616, HOUSTON, TX

On August 29, 2008, the Board and Dr. Atlas entered into an Agreed Order requiring that for two years Dr. Atlas not self-prescribe or prescribe to family members; not delegate prescriptive authority to physician assistants or advance practice nurses; have her medical records reviewed by a physician monitor; take and pass the medical jurisprudence examination within one year; obtain 10 hours of continuing medical education in medical record-keeping and 10 hours of CME in ethics each year (in addition to annual requirements); and pay an administrative penalty of $2,000. The action was based on Dr. Atlas’ self-prescribing, failure to keep adequate medical records of medications she was using to self-treat, failure to adequately supervise a member of her staff, and delegating medical responsibility to a member of her staff who was not qualified for such responsibility.

BROWN, JEFFREY JOHN, M.D., LIC. #L4267, MCALLEN, TX

On August 29, 2008, the Board and Dr. Brown entered into an Agreed Order requiring that he obtain eight hours of continuing medical education in intensive care within one year (in addition to annual
requirements) and pay an administrative penalty of $1,000. The action was based on Dr. Brown’s failure to meet the standard of care by not reassessing a patient in-person prior to the patient suffering a code blue, despite being contacted that the patient was having difficulties.

CREEDON-MCVEAN, MORRIS, D.O., LIC. #F6549, WICHITA FALLS, TX

On June 27, 2008, the Board and Dr. Creedon-McVean entered into a three-year Agreed Order that prohibits Dr. Creedon-McVean from prescribing to or treating himself or family members. The order also requires that within the first year Dr. Creedon-McVean obtain 10 hours of continuing medical education in ethics, and he is to pay an administrative penalty of $1,000. The action was based on his prescribing of controlled substances to himself and his family members, his acting as a physician for his family members, and his failure to document adequate medical records regarding his prescriptions to family members.

DIMAZANA, EPIFANIO V., M.D., LIC. #E2188, CORPUS CHRISTI, TX

On August 29, 2008, the Board and Dr. Dimazana entered into an Agreed Order requiring that Dr. Dimazana obtain 10 hours continuing medical education in ethics within one year (in addition to annual requirements) and pay an administrative penalty of $2,000. The action was based on Dr. Dimazana resigning his hospital admitting privileges after disciplinary action there, and for his failure to meet the standard of care, negligent practice, and lack of diligence on two occasions when he was unavailable or did not respond to attempted contacts by hospital staff concerning the admission of patients who had presented at the ER.

FRASER, RONALD LEO, M.D., LIC. #E7929, HOUSTON, TX

On June 27, 2008, the Board and Dr. Fraser entered into an Agreed Order that includes a public reprimand and requires that Dr. Fraser do the following: attend a Board-approved course in boundary violations within one year; submit 30 medical charts for review, and if found deficient, be subject to quarterly reviews of charts by the Board for one year; have a female chaperone present during exams on female patients and document the medical record accordingly; take and pass the medical jurisprudence examination within one year; obtain 10 hours of continuing medical education in pharmacology/drug interactions and medical record-keeping for each year the order is in effect; and pay an administrative penalty of $10,000. The action was based on Dr. Fraser’s admitted sexual relationship in 2005 to 2006 with a patient he had treated since 1998, during which time he continued to prescribe excessive and nontherapeutic amounts of pain medication without adequate documentation in the patient’s medical record.

GARCIA, JOSEPH EDWARD, M.D., LIC. #H0368, AUSTIN, TX

On August 29, 2008, the Board and Dr. Garcia entered into an Agreed Order requiring that he obtain 16 hours of continuing medical education in general surgery for soft tissue in extremities within one year (in addition to annual requirements) and pay an administrative penalty of $500. The action was based on the finding that Dr. Garcia employed a fluoroscopic probing technique in close proximity to a nerve that resulted in an injury.

HARKINS, ANNA MARIE JR., D.O., LIC. #F7257, PASADENA, TX

On October 10, 2008, the Board and Dr. Harkins entered into an Agreed Order requiring that she do the following: within one year of the order, obtain 10 hours of continuing medical education in medical
record-keeping; within two years enroll in and successfully complete the physician-patient communications course offered by the University of California-San Diego Physician Assessment and Clinical Education (PACE) program or an equivalent course; within two years, obtain at least 50 hours of continuing medical education in the area of continuing cardiac care; perform 50 hours of non-medical community service; and pay an administrative penalty of $2,500. The action was based on Dr. Harkins’s failure to meet the standard of care in the treatment of a cardiac patient with regard to the patient’s follow-up care and treatment plan.

HIRSCH, DAVID M., D.O., LIC. #J3119, SAN ANTONIO, TX

On August 29, 2008, the Board and Dr. Hirsch entered into an Agreed Order requiring that he obtain 10 hours of continuing medical education in minimizing risks associated with medical procedures within one year (in addition to annual requirements) and pay an administrative penalty of $2,000. The action was based on Dr. Hirsch’s having administered an injection on the incorrect side of a patient’s back.

HOBLIT, DAVID L., M.D., LIC. #E0056, DALLAS, TX

On June 27, 2008, the Board and Dr. Hoblit entered into an Agreed Order of Voluntary Suspension whereby Dr. Hoblit’s license is suspended indefinitely or until further action by the Board. The action was based on numerous violations including the following: failure to maintain adequate medical records; failure to meet the standard of care; negligence; failure to exercise professional diligence; unprofessional or dishonorable conduct likely to deceive or injure the public; violations of federal or state law; and aiding and abetting the practice of medicine by an unlicensed person. All violations were related to Dr. Hoblit’s actions as medical director for, and medical consultant to, two clinics.

IBONI, ROLAND D., D.O., LIC. #L7424, ROWLETT, TX

On August 29, 2008, the Board and Dr. Iboni entered into an Agreed Order requiring that he obtain eight hours of continuing medical education in neurological trauma within one year (in addition to annual requirements) and pay an administrative penalty of $500. The action was based on his having failed to properly evaluate and diagnose a subluxation and spinal fracture in a patient.

KANNEGANTI, RAVIKUMAR, M.D., LIC. #H6867, BEAUMONT, TX

On June 27, 2008, the Board and Dr. Kanneganti entered into a two-year Agreed Order requiring Dr. Kanneganti to obtain continuing medical education, including 10 hours in chemical dependency within one year of the effective date of the order and 10 hours in psychopharmacology for each of the two years of the order; and to pay an administrative penalty of $500. The action was based on Dr. Kanneganti’s failure to exercise diligence in ensuring that a patient followed his instruction on the use of dangerous drugs he had prescribed, and his failure to stop prescribing the medications after he knew or should have known the patient was abusing the drugs.

MECH, ARNOLD WALTER, M.D., LIC. #G9499, PLANO, TX

On June 27, 2008, the Board and Dr. Mech entered into a five-year Agreed Order that requires him to be subject to a Board chart monitor’s quarterly review of his medical records; to obtain, on a yearly basis, 20 hours of continuing medical education in child and adolescent psychopathology (10 hours) and child and adolescent psychopharmacology (10 hours); to obtain, each year for the first two years, 10 hours of continuing medical education in medical record-keeping; and to pay an administrative penalty of $2,500.
The action was based on Dr. Mech's use of a variety of psychotropic medications, some in high doses, in the treatment of a child. In addition, in the child's treatment, Dr. Mech had failed to document adequate medical records, and had employed a test normally used in research to assist his clinical diagnosis.

MYINT, DANIEL THET, M.D., LIC. #H8550, RICHARDSON, TX

On August 29, 2008, the Board and Dr. Myint entered into an Agreed Order requiring that he obtain 10 hours of continuing medical education in the diagnosis and treatment of an acute abdomen in pediatric patients within one year (in addition to annual requirements) and pay an administrative penalty of $750. The action was based on Dr. Myint's failure to promptly refer a child with an acute abdomen to an emergency room or surgeon for additional evaluation.

NIGHTINGALE, JOSEPH ADRIAN, M.D., LIC. #J6022, PORT NECHES, TX

On June 27, 2008, the Board and Dr. Nightingale entered into an Agreed Order requiring him to obtain 10 hours of continuing medical education in risk management and to pay an administrative penalty of $1,000. The action was based on Dr. Nightingale's error in interpreting a CT scan with an incorrect date, which resulted in a delay in the interpretation of the correct CT scan and the patient's treatment.

PECHERO, RUBEN DANIEL, M.D., LIC. #D4834, MCALLEN, TX

On August 29, 2008, the Board and Dr. Pechero entered into a Mediated Agreed Order requiring him to attend five hours of continuing medical education in spinal pain management and five hours in risk management within one year and pay an administrative penalty of $1,000. The action was based on Dr. Pechero's failure to indicate reasons for orthopedic surgery performed on one patient; failure to indicate reasons for orthopedic surgery, or do an adequate trial of pain management, prior to performing surgery on a second patient; and failure to do an adequate pre-operative workup on a third patient who scheduled for orthopedic surgery.

PHILLIPS, GREGGORY K., M.D., LIC. #H6511, FORT WORTH, TX

On October 10, 2008, the Board and Dr. Phillips entered into an Agreed Order requiring that he pay an administrative penalty of $1,000 within 30 days. The action was based on Dr. Phillips allowing the use of pre-signed prescriptions for controlled substances and failure to maintain control of those prescriptions.

PROVOST, DAVID ANDERS JR., M.D., LIC. #H4629, DALLAS, TX

On June 27, 2008, the Board and Dr. Provost entered into an Agreed Order requiring that, within one year of the effective date of the order, Dr. Provost obtain a total of 50 hours of continuing medical education as follows: 20 hours in risk management; 20 hours in post-operative complications; and 10 hours in medical record-keeping. The action was based on the medical records of three surgery patients that did not adequately document Dr. Provost's rationale for treatment decisions made during or after surgery, and in one case, did not adequately document the patient's informed consent for the procedure.

ROJAS-WALSSON, ROMEO, M.D., LIC. #J8360, SAN ANTONIO, TX

On June 27, 2008, the Board and Dr. Rojas-Walsson entered into an Agreed Order requiring Dr. Rojas-Walsson to obtain 20 hours of continuing medical education in pediatric emergencies and to pay an
administrative penalty of $3,000. The action was based on Dr. Rojas-Walsson’s failure to order appropriate tests, diagnose, and order treatment for an infant who presented with fever and a history of kidney infection.

SALINAS, HILDEBRANDO, M.D., LIC. #L1446, MCALLEN, TX

On August 29, 2008, the Board and Dr. Salinas entered into an Agreed Order requiring that he obtain eight hours of continuing medical education in psychiatric interviews/evaluations and four hours of continuing medical education in physician-patient communication within one year (in addition to annual requirements) and pay an administrative penalty of $1,000. The action was based on Dr. Salinas having failed to thoroughly evaluate a patient on the patient’s initial visit.

SESSIONS, ROGER CARL, M.D., LIC. #G5595, HENDERSON, TX

On June 27, 2008, the Board and Dr. Sessions entered into an Agreed Order that requires Dr. Sessions to obtain 10 hours of continuing medical education in pain management and to pay an administrative penalty of $1,000. The action was based on Dr. Sessions prescribing controlled substances for pain to a foot surgery patient over an extended period of time without sufficient patient contact, or related documentation, to justify the prescriptions, and his failure to comply with Board guidelines for the treatment of pain.

SKIE, GREGORY, M.D., LIC. #G5617, MANSFIELD, TX

On August 29, 2008, the Board and Dr. Skie entered into an Agreed Order requiring the following for two years: that a physician monitor Dr. Skie’s medical records; that within one year of the Order, Dr. Skie attend 10 hours of continuing medical education in medical record-keeping and 10 hours of CME in ethics (in addition to annual requirements); and that he pay an administrative penalty of $2,500. The action was based on Dr. Skie’s failure to adequately document his prescription and treatment decisions for the care he provided these patients.

SURAPANENI, VEENA, M.D., LIC. #K6938, CEDAR PARK, TX

On August 29, 2008, the Board and Dr. Surapaneni entered into an Agreed Order requiring that Dr. Surapaneni have her medical records reviewed by a physician monitor for three years and that she obtain 10 hours of continuing medical education in patient communications and risk management within one year (in addition to annual requirements). The action was based on Dr. Surapaneni’s failure to communicate to her staff a known concern for a patient’s acute risk related to a diabetic condition.

TAYLOR, ROOSEVELT JR., M.D., LIC. #D9896, DALLAS, TX

On June 27, 2008, the Board and Dr. Taylor entered into an Agreed Order requiring that Dr. Taylor be subject to quarterly reviews of his medical records by a Board chart monitor for two years from the effective date of the order; obtain 20 hours of continuing medical education in medical record-keeping (10 hours) and wound care management (10 hours) within one year; and pay an administrative penalty of $5,000. The action was based on Dr. Taylor’s failure to provide diligent patient follow-up, record-keeping, and appropriate wound care for a patient following a cesarean section delivery.

WALL, HAROLD JAMES, M.D., LIC. #F6159, SCHULENBURG, TX
On June 27, 2008, the Board and Dr. Wall entered into an Agreed Order requiring that Dr. Wall obtain 20 hours of continuing medical education as follows: 10 hours in acute pediatric hematology and 10 hours in medical record-keeping. Dr. Wall is also required to pay an administrative penalty of $1,500. The action was based on Dr. Wall’s admitted error of misreading a child patient’s platelet count, which delayed the diagnosis and treatment intervention that later occurred.

WALLACE, BRENT HOLMES, M.D., LIC. #F2093, CLEBURNE, TX

On August 29, 2008, the Board and Dr. Wallace entered into an Agreed Order requiring that Dr. Wallace have his medical records reviewed by a physician monitor for one year. The action was based on Dr. Wallace’s failure to adequately monitor prescriptions and continue follow-up evaluations on a patient receiving treatment for a sleep disorder.

ZAHEER, SYED JAVEED, M.D., LIC. #L2065, SUGARLAND, TX

On June 27, 2008, the Board and Dr. Zaheer entered into a Mediated Agreed Order requiring that Dr. Zaheer obtain 30 hours of continuing medical education in emergency medicine and critical care and 10 hours of CME in medical record-keeping. The action was based on Dr. Zaheer’s failure to practice medicine in a manner that safeguarded a patient against potential complications.

UNPROFESSIONAL CONDUCT VIOLATIONS
CURTIS, LAUREN MARY, M.D., LIC. #H8615, SAN ANTONIO, TX

On June 27, 2008, the Board and Dr. Curtis entered into a Mediated Agreed Order requiring that Dr. Curtis obtain eight hours of continuing medical education and pay an administrative penalty of $500. Although denied in fact by Dr. Curtis, the action was based on the Board’s findings and conclusion that a physician may be disciplined for providing false information to the Board.

DHIMAN, NITIN PAUL, M.D., BP1-0027126, LUBBOCK, TX

On October 10, 2008, the Board and Dr. Dhiman entered into an Agreed Order requiring Dr. Dhiman to pay an administrative penalty of $1,000 within 20 days. The action was based on Dr. Dhiman’s altering and fabricating documents from his residency program at Texas Tech University sent to a University of Connecticut family residency program.

DOSSETT, LUCY MARYANNA, M.D., LIC. #H5438, DALLAS, TX

On June 27, 2008, the Board and Dr. Dossett entered into an Agreed Order requiring Dr. Dossett to pay an administrative penalty of $3,000. The action was based on Dr. Dossett’s failure to inform the Board of a 2003 arrest for driving while intoxicated on her 2004, 2005 and 2006 renewal forms, and for which she was similarly sanctioned by other medical licensing boards in Arkansas, California, and Colorado.

HOGAN, MATTHEW JAMES, M.D., LIC. #H5777, ATLANTA, TX

On August 29, 2008, the Board and Dr. Hogan entered into an Agreed Order requiring that Dr. Hogan attend the professional boundaries course offered by Vanderbilt Medical Center for Professional Health. The action was based on Dr. Hogan having engaged in an inappropriate, non-sexual, personal relationship with a patient.
LEBLANC, MARY, M.D., LIC. #H4481, SAN ANTONIO, TX

On July 10, 2008, the Board issued an indefinite Automatic Suspension Order against Dr. LeBlanc’s medical license. The action was a result of a violation of an October 8, 2004, Agreed Order that placed Dr. LeBlanc on five-year probation for unprofessional or dishonorable conduct related to allowing her husband to engage in the unauthorized practice of medicine. Among other things, the 2004 Agreed Order required Dr. LeBlanc to take and pass the medical jurisprudence examination within one year. As of July, 2008, Dr. LeBlanc had not passed, or even attempted to take, the exam. Therefore, the Board exercised the provision in the 2004 Agreed Order providing for the automatic suspension of her license for failure to complete this requirement.

MCCARTY, TODD MASON, M.D., LIC. #J0108, DALLAS, TX

On June 27, 2008, the Board and Dr. McCarty entered into an Agreed Order requiring that Dr. McCarty attend 10 hours of continuing medical education in patient communication and pay an administrative penalty of $5,000. The action was based on Dr. McCarty’s failure to adequately communicate with, or respond to communications from, a patient and patient’s family during the period she was hospitalized for surgery.

MIKULECKY, MICHAEL STEVEN, M.D., LIC. #L6527, REDDING, CA

On August 29, 2008, the Board and Dr. Mikulecky entered into an Agreed Order requiring that he obtain 10 hours of continuing medical education in ethics within one year (in addition to annual requirements); pay an administrative penalty of $2,000; and maintain compliance with the terms and condition of the Shasta County, California, probation department. The action was based on Dr. Mikulecky’s California conviction for misdemeanor offenses arising out of a domestic incident.

PATEL, KANUBHAI A., M.D., LIC. #G4373, MCKINNEY, TX

On June 27, 2008, the Board and Dr. Patel entered into an Agreed Order requiring that, within one year from the effective date of the order, Dr. Patel attend a course in patient boundaries and communication, as approved by the Board, and pay an administrative penalty of $1,000. The action was based on Dr. Patel’s failure to have a female chaperone present when he carried out a diagnostic test on a female patient that required her to remove her upper-body garments.

PATEL, VIJESH, M.D., LIC. #K1616, PORT NECHES, TX

On October 10, 2008, the Board and Dr. Patel entered into an Agreed Order requiring Dr. Patel to pay an administrative penalty of $250 within 60 days. The action was based on Dr. Patel’s inadequate communication with a patient regarding a dispute over the necessity of the patient’s use of a seizure alert service animal.

VALADEZ, JAVIER ARNOLDO, M.D., LIC. #G5719, DALLAS, TX

On August 29, 2008, the Board and Dr. Valadez entered into an Agreed Order requiring that he be placed on a five-year probation, during which he is required to abstain from alcohol and drugs; submit to random drug screens; attend Alcoholics Anonymous four times per week; take and pass the medical jurisprudence examination within one year; submit to a psychiatric evaluation and follow any treatment recommendations; and pay a $5,000 administrative penalty. Dr. Valadez is required to update his
Physician Profile regarding his criminal history within 30 days of the date of the entry of the order. The action was based on Dr. Valadez’s arrest for possession of an illegal drug in 2003; his unprofessional conduct in failing to report the arrest on his license renewal in 2004 and 2005; and his 2007 self-report to the Board of his intemperate use of an illegal drug.

WALKER, ERIC PRIME, M.D., LIC. #M2186, TEMPLE, TX

On June 27, 2008, the Board and Dr. Walker entered into an Agreed Order requiring that Dr. Walker satisfactorily complete all additional requirements, terms and conditions, personal and professional, required by the Infectious Diseases Fellowship at Scott and White Hospital in the aftermath of disciplinary action taken by the hospital. The basis for this order, and the hospital’s disciplinary action, was Dr. Walker’s accessing a patient’s medical records on several occasions without having a valid physician-patient relationship with the patient.

WILLIAMS, MICHAEL DUANE, M.D., LIC. #E2943, AMARILLO, TX

On August 29, 2008, the Board and Dr. Williams entered into an Agreed Order requiring that, for two years, Dr. Williams have and document that he has a female chaperone present for all examinations of female patients. In addition, the order requires that Dr. Williams attend the professional boundaries course offered by Vanderbilt Medical Center for Professional Health, or a similar Board-approved course. The action was based on Dr. Williams’ failure to follow appropriate practices when examining a female patient.

WOODWARD, JOHN REAGAN, M.D., LIC. #D4884, DALLAS, TX

On August 29, 2008, the Board and Dr. Woodward entered into a Mediated Agreed Order requiring that he pay an administrative penalty of $1,000. The action was based on Dr. Woodward’s failure to exercise professional diligence due to his making reference on his informational web site to a new drug that has serious side effects and that has not yet been approved for the public market by the Food and Drug Administration.

ZAYAS, ROBERTO JR., M.D., LIC. #K2832, OROVILLE, WA

On June 25, 2008, the Board entered a Termination of Temporary Suspension and Entry of an Agreed Order. Dr. Zayas’ license had been temporarily suspended on April 29, 2008, for failure to supervise delegates, lacking standing delegation orders, operating an unlicensed pharmacy, failure to exercise diligence, and inadequate medical records at a series of weight loss clinics known as Internet Medical Clinics. The first of two informal settlement conferences followed on May 30, 2008, and a decision was deferred to allow Dr. Zayas to provide proof of changes at IMC that include a cessation of dispensing medications on-site, development of protocols for care extenders, and correction of deficiencies in the electronic medical and billing records. Dr. Zayas provided satisfactory proof at a second ISC held on June 25. Currently, Dr. Zayas is not actively practicing in Texas but does act as a consultant to IMC. Conditions required of the order terminating Dr. Zayas’ temporary suspension impose the following disciplinary actions: a public reprimand; 10 hours of continuing medical education in risk management or ethics; successfully passing the medical jurisprudence examination, and a $5,000 administrative penalty.

VIOLATION OF PROBATION OR PRIOR ORDER

CANTU, DENNIS DAVID, M.D., LIC. #F1430, LAREDO, TX
On August 29, 2008, the Board and Dr. Cantu entered into an Agreed Order requiring him to attend eight hours of continuing medical education in office management or risk management within one year (in addition to annual requirements) and pay an administrative penalty of $500. The action was based on Dr. Cantu's failure to adequately comply with the educational requirement of a 2007 disciplinary order.

DAVIS, HOWELL EUGENE, D.O., LIC. #H2109, KILLEEN, TX

On June 27, 2008, the Board and Dr. Davis entered an Agreed Order Modifying Prior order modifying Dr. Davis' 10-year 2005 order, which was based on intemperate use of drugs or alcohol, as follows: the term of the 2005 order shall be extended for an additional seven years; Dr. Davis shall undergo weekly basis therapy by a Board-approved psychiatrist or psychologist, in addition to his ongoing treatments by his treating psychiatrist, for the specific purpose of addressing personality issues; and Dr. Davis shall pay a $5,000 administrative penalty. The action was based on Dr. Davis' admission that he consumed two alcoholic beverages that resulted in two positive screens for alcohol in violation of his 2005 order.

DERUSHA, MARTIN ALLYN JR., D.O., LIC. #K0454, FORT WORTH, TX

On October 10, 2008, the Board and Dr. Derusha entered into an Agreed Order of Revocation of his medical license. The action was based on Dr. Derusha's failure to comply with terms of 2004 and 2006 board orders following his DWI arrests.

LAMPLEY, JOSEPH CARVER, D.O., LIC. #J9149, SEMINOLE, TX

On June 27, 2008, the Board and Dr. Lampley entered into an Agreed Order Modifying Prior order that provided for disciplinary action and modification of his 2006 order. This order publicly reprimands Dr. Lampley and assesses another administrative penalty of $2,500. It also extends the time allowed for Dr. Lampley to take and pass the medical jurisprudence examination. The action was based on Dr. Lampley's failure to comply with the requirements of the 2006 order. Dr. Lampley had failed to pay an administrative penalty on time, and he failed to register for the medical jurisprudence examination he was required to take and pass within a prescribed period set out in the 2006 order.

LORENTZ, RICK GENE, M.D., LIC. #J2169, SPRING, TX

On June 27, 2008, the Board and Dr. Lorentz entered into an Agreed Order Modifying Prior Order that extended the terms and conditions of his 2006 Agreed Order, and its 2007 modification, for an additional six months. The action was based on Dr. Lorentz's delay in completing required continuing medical education, and his failure to document compliance with that requirement in a timely manner.

MILLS, VIRGINIA M., M.D., LIC. #J2210, HOUSTON, TX

On August 29, 2008, the Board and Dr. Mills entered into an Agreed Order suspending her license for an indefinite period until such time as she petitions the Board and shows that she is competent to safely return to medical practice. The action was based on Dr. Mills' non-compliance with certain terms of a confidential 1999 order, as modified in 2004, that was issued after Dr. Mills self-reported a mental impairment resulting from a traumatic head injury she suffered in an automobile accident.

OKOSE, PETER CHUKWUEMEKA, M.D., LIC. #J2714, FRIENDSWOOD, TX
On June 27, 2008, the Board and Dr. Okose entered into an Agreed Order Modifying Prior order providing for disciplinary action and modification of his 2006 order, including the following terms: Dr. Okose shall surrender all (Schedules I-IV) DEA/DPS prescription certifications, and shall re-apply for any one or more certifications only with the prior written approval of the Board; Dr. Okose shall take and pass the medical jurisprudence examination within one year of the order’s effective date; and Dr. Okose shall pay an administrative penalty of $1,000. The action was based on Dr. Okose’s failure to obtain the Board’s prior approval to apply for Schedule 2N and 3N DEA/DPS prescription certifications in violation of his 2006 order.

POTTERF, Raymond Dewayne, M.D., Lic. #E8824, San Antonio, TX

On June 27, 2008, the Board and Dr. Potterf entered into an Agreed Order publicly reprimanding Dr. Potterf and requiring him to pay an administrative penalty of $1,000. The action was based on Dr. Potterf’s failure to comply in part with the requirement of his 2003 order that he have a licensed healthcare professional as a chaperone while examining adult patients. Dr. Potterf had complied with the requirement at his office, but had failed to comply with this requirement while seeing patients at two hospitals.

PURYEAR, Billy Houston, D.O., Lic. #D6314, Fort Worth, TX

On June 27, 2008, the Board and Dr. Puryear entered into an Agreed Order of Voluntary Surrender whereby Dr. Puryear permanently surrendered his license in lieu of further disciplinary action. The action was based on his failure to comply with the terms and conditions of a five-year 2007 Agreed Order, and his stated desire to stop practicing medicine.

RANELLE, John Barry, D.O., Lic. #E9349, Watauga, TX

On May 19, 2008, The Board issued an indefinite Automatic Suspension order against Dr. Ranelle’s medical license. The action was based on a violation of his 10-year probation under a 1999 Agreed Order and related 2006 order, which specifically provided for an automatic suspension for a violation of the 1999 order. As of this suspension date, Dr. Ranelle has been in violation of the 1999 order for failing to pay $1,378 for drug testing, due since November 2007.

WELDON, Bill E., D.O., Lic. #F4669, Fort Worth, TX

On August 29, 2008, the Board and Dr. Weldon entered into an Agreed Order Modifying Prior Order. Dr. Weldon was under a 2005 Agreed Order that suspended his license, stayed the suspension and placed him on a five-year probation with terms and conditions related to inappropriate prescribing and inadequate medical records. This order modifies the 2005 order to a 10-year term, commencing from the date of the entry of the original 2005 order. In addition, this order requires Dr. Weldon to submit, within 30 days, a written plan outlining how he will implement recommendations made by the Board’s physician chart monitor ordered in the 2005 order. It also provides for a new chart monitor and for a new yearly requirement of 10 hours of continuing medical education in pain management in addition to the yearly requirements already set forth in the 2005 order. The action was based on Dr. Weldon’s failure to adequately comply with his 2005 order by not implementing numerous recommendations made by the Board’s physician chart monitor.

WHITE, Robert Frank, M.D., Lic. #C7159, Mount Vernon, TX
On June 27, 2008, the Board and Dr. White entered into an Agreed Order Denying Termination and Granting Modification of Prior Agreed Order that requires Dr. White to obtain 50 hours of continuing medical education in the area of pain management. Dr. White’s termination request was denied. In exchange for the CME requirement, Dr. White will no longer be required to shadow a rheumatologist as set forth in his 2005 order (as amended by a 2006 order). Although Dr. White is in substantial compliance with the 2005 order, the basis for this order is the Board chart monitor’s concerns that issues regarding the prescription of narcotics remain to be fully addressed.

TERMINATION OF SUSPENSION

MICHAEL DEAN SMITH, M.D., LIC. #F4545, HOUSTON, TX

On October 10, 2008, the Board and Dr. Smith entered into a Mediated Agreed Order that terminated the suspension of his license and placed him on probation, subject to the following terms, for 15 years: he shall abstain from consumption of prohibited substances; participate in the Board’s drug testing program; continue treatment with his psychiatrist; continue to participate in AA and a county medical society physician health and rehabilitation committee; not treat his immediate family; limit his practice to his current employment setting; limit his practice to no more than 45 hours a week; and perform 60 hours of community service. The action was based on a provision in his suspension order allowing him to request termination of suspension provided he could present evidence that he is competent to safely practice medicine.

ACTIONS BASED ON OTHER STATES

SRIDHARAN, PALUR V., M.D., LIC. #H7236, RAWLINS, WY

On October 10, 2008, the Board and Dr. Sridharan entered into an Agreed Order requiring that he comply with all provisions of an order issued by the Wyoming Board of Medicine and report any modifications or termination of the order to the Texas board. The action was based on an order entered by the Wyoming board that found Dr. Sridharan failed to meet the standard of care in an aorta-femoral bypass graft surgery.

TIEMANN, WILLIAM, M.D., LIC. #T-M00124, HOUMA, LA

On October 10, 2008, the Board and Dr. Tiemann entered into an Agreed Order requiring that he comply with all provisions of orders issued by the Kentucky and Georgia licensing boards and report any other state board’s action related to substance abuse, and requiring him to pay an administrative penalty of $1,000 within 180 days. The action was based on actions taken in Kentucky, Georgia and Missouri based on his arrest for DUI and subsequent charges of reckless operation of a vehicle in New Orleans, LA.

TRUITT, JOHN SAMUEL, M.D., LIC. #J5501, HEREFORD, AZ

On June 27, 2008, the Board and Dr. Truitt entered into an Agreed Order requiring that Dr. Truitt’s medical records be subject to quarterly reviews by a Board chart monitor for a period of two years from the effective date of the order. The action is based upon a public reprimand issued by the Arizona Medical Board for unprofessional conduct related to his diagnosis and subsequent treatment of a patient for cancer when the patient’s condition was actually non-cancerous.

INADEQUATE MEDICAL RECORDS
ALONSO, RAMIRO, M.D., LIC. #D4598, McAllen, TX

On August 29, 2008, the Board and Dr. Alonso entered into an Agreed Order requiring that he attend 10 hours of continuing medical education in medical record-keeping within one year in addition to regular annual requirements and pay an administrative penalty of $500. The action was based on Dr. Alonso's failure to document who administered the injection, the site of the injection, and the actual dose of the injection that was provided to a patient.

BENSON, ROYAL HENRY III, M.D., LIC. #H0175, Bryan, TX

On August 29, 2008, the Board and Dr. Benson entered into a Mediated Agreed Order requiring that he attend 10 hours of continuing medical education in medical record-keeping within one year. Thereafter, upon completion of the CME, a physician monitor will review Dr. Benson's medical charts for a period of six months. The action was based on Dr. Benson's failure to provide adequate documentation in support of treatments and procedures provided to three OB/GYN patients.

CALDWELL, JODY GREEN, M.D., LIC. #G3409, Conroe, TX

On August 29, 2008, the Board and Dr. Caldwell entered into a Mediated Agreed Order requiring that she have a physician monitor her charts for one year; maintain adequate medical records on her patients; attend the University of California Physician Assessment and Clinical Education (PACE) course in medical record-keeping within one year; attend 10 hours of continuing medical education in dermatology within one year; and pay an administrative penalty of $500. The action was based on Dr. Caldwell's failure to document the characteristics of findings, family history, pertinent positives and negatives, subjective assessments and impressions, or assessment and treatment plan with regard to a patient who presented with a cough and scratchy throat, and a skin lesion that was removed and destroyed.

CONTE, MAURICE S., M.D., LIC. #E7036, Houston, TX

On August 29, 2008, the Board and Dr. Conte entered into a Mediated Agreed Order wherein Dr. Conte voluntarily and permanently surrendered his license. The Board found that in two cases, Dr. Conte failed to adequately document supervision of nurse practitioners and physician assistants in clinical settings.

FOGEL, GUY RUTLEDGE, M.D., LIC. #J5322, San Antonio, TX

On August 29, 2008, the Board and Dr. Fogel entered into a Mediated Agreed Order requiring Dr. Fogel to attend 10 hours of continuing medical education in medical record-keeping within one year and pay an administrative penalty of $1,000. The action was based on Dr. Fogel's failure to adequately document indications for surgery performed and treatment provided to three spinal surgery patients.

HARDWICK, JACK FRANKLIN, M.D., LIC. #C6352, Fort Worth, TX

On June 27, 2008, the Board and Dr. Hardwick entered into a Mediated Agreed Order requiring that Dr. Hardwick obtain 30 hours of continuing medical education including 20 hours in oncology and 10 hours in medical record-keeping. In addition, Dr. Hardwick shall pay an administrative penalty of $5,000. The action was based on Dr. Hardwick's failure to document a differential diagnosis on a patient.

KAREH, VICTOR, M.D., LIC. #H9023, Conroe, TX
On October 10, 2008, the Board and Dr. Kareh entered into an Agreed Order requiring that he obtain eight hours of continuing medical education in medical record-keeping and eight hours in CPT coding. The action was based on his failure to sufficiently document the billing code for a procedure.

**KUSHWAHA, Vivek, M.D., LIC. #K3290, BELLAIRE, TX**

On June 27, 2008, the Board and Dr. Kushwaha entered into a Mediated Agreed Order requiring that Dr. Kushwaha attend the University of California at San Diego Physician Assessment and Clinical Education (PACE) course in medical record-keeping and pay an administrative penalty of $5,000. The action was based on Dr. Kushwaha having medical record deficiencies in the pre- and post-operative reports, as well as other records, of a patient who had received extensive spine surgery.

**MAHONEY, James Joseph, D.O., LIC. #H0591, SOUTHLAKE, TX**

On June 27, 2008, the Board and Dr. Mahoney entered into a Mediated Agreed Order requiring that Dr. Mahoney attend the University of California at San Diego Physician Assessment and Clinical Education (PACE) course in medical record-keeping and have a Board chart monitor review for a six-month period. The action was based on Dr. Mahoney’s failure to document adequate medical record information for concurrent providers of a patient he was treating with complementary and alternative therapies for a variety of health-related matters.

**MCMEANS, Pat Mason, M.D., LIC. #G8916, BEAUMONT, TX**

On August 29, 2008, the Board and Dr. McMeans entered into an Agreed Order requiring that he obtain 10 hours of continuing medical education in medical record-keeping and 10 hours of continuing medical education in risk management within one year (in addition to annual requirements) and pay an administrative penalty of $3,000. The action was based on Dr. McMeans’ failure to maintain adequate medical record documentation in the treatment of five weight loss patients.

**MCNALLY, Lawrence B., M.D., LIC. #G2780, DALLAS, TX**

On August 29, 2008, the Board and Dr. McNally entered into a Mediated Agreed Order requiring Dr. McNally to attend 10 hours of continuing medical education in medical record-keeping within one year and to maintain adequate medical records on his patients. The action was based on Dr. McNally’s loss of a medical record transcription concerning a minor in-office surgical procedure performed on a patient.

**RAJ, Jhansim, M.D., LIC. #G8735, FORT WORTH, TX**

On August 29, 2008, the Board and Dr. Raj entered into an Agreed Order requiring that Dr. Raj pay an administrative penalty of $500. The action was based on Dr. Raj’s failure to document an adequate medical record on a patient.

**RAO, Gullapalli R. Krishna, M.D., LIC. #F2868, VICTORIA, TX**

On June 27, 2008, the Board and Dr. Rao entered into an Agreed Order requiring that Dr. Rao attend the University of California at San Diego Physician Assessment and Clinical Education (PACE) course in medical record-keeping, obtain an audit by the Texas Medical Liability Trust within six months and provide a copy of the audit report to the Board. The action was based on errors and deficiencies in the
medical records for a patient, and the Board’s concerns regarding the electronic medical records system in use at Dr. Rao’s practice.

RIOS, LUIS MANUEL JR., M.D., LIC. #J0221, EDINBURG, TX

On June 27, 2008, the Board and Dr. Rios entered into an Agreed Order requiring Dr. Rios to pay an administrative penalty of $2,000. The action was based on Dr. Rios’ failure to adequately document office visits related to his care and treatment of a patient through two plastic surgery procedures.

SRIVATHANAKUL, SURAPHANDHU, M.D., LIC. #E7288, VICTORIA, TX

On August 29, 2008, the Board and Dr. Srivathanakul entered into an Agreed Order Modifying Prior Order. The action was based on Dr. Srivathanakul’s failure to complete all requirements of a five-year 2005 order which placed him on probation with terms and conditions related to nontherapeutic prescribing and inadequate medical records. The 2008 order added an additional administrative penalty of $3,000 and amended the 2005 order by exchanging a continuing medical education boundary course requirement for a CME pain management course requirement. The 2008 Agreed Action was based on Dr. Srivathanakul’s failure to attend the boundary course as required and for failing to notify the Board of the abandonment of his practice site, which interfered with the chart monitor requirement of the 2005 order.

IMPAIRMENT DUE TO ALCOHOL OR DRUGS OR MENTAL/PHYSICAL CONDITION

COLEMAN, BRENT J., D.O., LIC. #G3241, UVALDE, TX

On August 29, 2008, the Board and Dr. Coleman entered into an Agreed Order requiring that Dr. Coleman obtain an independent medical evaluation and follow any continuing care and treatment recommendations; abstain from alcohol and drugs and submit to random alcohol and drug screens; be prohibited from prescribing or treating himself or his family; be prohibited from prescribing controlled substances or dangerous drugs to patients except for hospital inpatient settings; be prohibited from supervising or delegating prescriptive authority to physician assistants or advance practice nurses; and be subject to quarterly medical record reviews by a physician monitor. The action was based on Dr. Coleman’s substance abuse and substance diversion related to the inappropriate prescription of controlled substances or dangerous drugs to himself.

CORNETTE, MARVIN CLIFFORD, M.D., LIC. #F9328, DALLAS, TX

On October 10, 2008, the Board and Dr. Cornette entered into an Agreed Order suspending his license for not less than one year, after which he may petition for reinstatement upon showing evidence that at a minimum, must include the following: one year of sobriety; a report from a treating psychiatrist that he can safely practice; regular participation in AA and similar recovery programs; regular independent negative drug screens; and that he comply with deferred adjudication terms set out by the court. The action was based on his unlawfully obtaining a controlled substance from a pharmacy, for which he was arrested and for which he received deferred adjudication.

GREEN, DEMETRIS ALLEN, M.D., LIC. #J4168, SPRING, TX

On August 29, 2008, the Board and Dr. Green entered into an Agreed Order Granting Modification of Prior Agreed Order. Dr. Green had been under a 2002 Agreed Order, as modified by a 2007 Agreed Order, that placed him on 10-year probation under certain terms and conditions related to substance
abuse. Dr. Green requested removal of the restriction on a residency-only practice and that it be replaced with a restriction to a group/institutional practice and to have his DEA/DPS prescribing privileges reinstated, if approved for a group/institutional practice. The Board granted these requests but added terms that he must have his patient charts reviewed by a physician monitor for one year and that he be restricted from prescribing to himself or his immediate family.

LONGMOOR, CHARLES ERLE, M.D., LIC. #J4307, DALLAS, TX

On October 10, 2008, the Board and Dr. Longmoor entered into an Agreed Order of Suspension. The action was based on Dr. Longmoor’s violation of a previous order requiring that he abstain from the use of prohibited substances and his failure to disclose relevant information to the board.

LOUIS, EDWARD EMILE, M.D., LIC. #D0953, DICKINSON TX

On May 28, 2008, a Disciplinary Panel of the Board issued an order of Temporary Suspension Without Notice of Hearing, which temporarily suspended Dr. Louis’ medical license after determining that Dr. Louis’ continuation in the practice of medicine presents a continuing threat to the public welfare. The temporary suspension was based on a finding Dr. Louis is impaired due to a deficient cognitive status and inability to apply basic medical principles in response to inquiries, which demonstrated a lack of fitness to practice. On June 19, 2008, a Disciplinary Panel of the Board issued an order of Temporary Restriction (with notice) which temporarily restricts Dr. Louis’ medical license after concluding that an inquiry was necessary to determine if Dr. Louis’ continuation in the practice of medicine is a continuing threat to the public welfare. The Board had concerns regarding Dr. Louis’ possible deficient cognitive status and ability to apply basic medical principles. This temporary restriction order supersedes the prior temporary suspension order of May 28, allowing Dr. Louis to return to practice subject to certain terms and conditions. These include an independent medical exam, a chart monitor retroactively and during the restriction period, continuing medical education, and passing the SPEX exam. After Dr. Louis completes the terms of the order, the Board will review his case for further appropriate action.

MARTINEZ, JORGE A., M.D., LIC. #H1801, MCALLEN, TX

On August 29, 2008, the Board and Dr. Martinez entered into an Agreed Order Modifying Prior Order. Dr. Martinez had been under a 2002 order placing him on 10-year probation with terms and conditions related to substance abuse. Dr. Martinez had requested a termination or a modification because of the impossibility of his complying with one condition in the 2002 order that was outside his control. The Board denied the termination, but modified the 2002 order to delete the requirement that Dr. Martinez have weekly visits with a psychologist and added the condition that in addition to quarterly reports from his treating psychiatrist, additional reports could be provided by the psychiatrist or requested by the Board.

MCCLURE, CLARENCE HAROLD, M.D., LIC. #D9561, LUFKIN, TX

On June 27, 2008, the Board and Dr. McClure entered into an Agreed Order of Voluntary Surrender whereby Dr. McClure voluntarily and permanently surrendered his license because of his inability to continue in the practice of medicine with reasonable skill and safety due to illness or a physical condition. Dr. McClure suffered severe injuries and disability after a 1995 motor vehicle accident, which later evolved to inability to practice medicine with reasonable skill and safety. Dr. McClure eventually stopped seeing patients and closed his practice in 2007.
RIGGS, PATRICK KELLY, M.D., LIC. #H0760, FORT WORTH, TX

On June 27, 2008, the Board and Dr. Riggs entered into an Agreed Order of Voluntary Surrender whereby Dr. Riggs voluntarily and permanently surrendered his license because of his inability to continue in the practice of medicine with reasonable skill and safety due to illness or a physical condition. Dr. Riggs closed his practice in 1997 and has not practiced medicine since that time.

ROBERTS, DENNIS DONALD, M.D., LIC. #M6362, KINGWOOD, TX

On April 28, 2008, a Disciplinary Panel of the Board temporarily suspended Dr. Roberts' medical license after determining that Dr. Roberts' continuation in the practice of medicine presents a continuing threat to the public welfare. The temporary suspension was based on a finding that Dr. Roberts revealed a substance abuse problem in 2007, and while making progress with initial steps toward recovery, had relapsed in 2008 while on duty as an emergency room physician. On June 27, 2008, the Board and Dr. Roberts entered into an Agreed Order following Dr. Roberts' automatic suspension in effect since March 18, 2008. The order stays the suspension and places Dr. Roberts on a 10-year probation with the following terms and conditions: abstinence from prohibited substances; random alcohol and drug screening; practice limited to primary care only, in a group or institutional setting; a limit of 45 working hours over five days per week; a restriction on supervising and delegating prescription authority to physician assistants or advance practice nurses; attendance at Alcoholics Anonymous; and continuing monitored treatment by both a psychiatrist and licensed chemical dependency counselor. The action was based on Dr. Roberts' substance abuse of drugs used in anesthesiology and his subsequent relapse while under a voluntary abstinence and drug screening agreement with Board.

SHIPPEL, ALLAN HENDLEY, M.D., LIC. #G6613, ROSWELL, GA

On August 29, 2008, the Board and Dr. Shippel entered into an Agreed Order Modifying Prior Order. Dr. Shippel was under a 2005 order, as modified in 2008, which required notice to the Board and a forensic psychiatric evaluation before he could return to practice in Texas. Dr. Shippel had originally been under a 2002 order due to disciplinary actions in Georgia and South Carolina that were related to substance abuse. The 2008 order modified the 2005 order to require that Dr. Shippel obtain an independent medical evaluation and submit the results to the Board for consideration of his fitness to return to practice in Texas. This order requires that Dr. Shippel abstain from alcohol and drugs, be subject to random alcohol and drug screens, and attend Alcoholics Anonymous at least twice weekly for three years. The action was based on Dr. Shippel having satisfactorily demonstrated to the Board that he is now able to practice medicine with reasonable skill and safety.

SMITH, MICHAEL DEAN, M.D., LIC. #F4545, HOUSTON, TX

On April 18, 2008, the Board issued an indefinite Automatic Suspension order against Dr. Smith's medical license. The action came as a result of a violation of his 10-year probation under a 2005 Agreed Order that was based on alcohol and drug abuse. The Board exercised a provision in the 2005 order to automatically suspend a license upon a positive alcohol or drug screen. On March 10, Dr. Smith tested positive for marijuana.

STOECKEL, MARK DAVID, M.D., LIC. #L3845, CEDAR PARK, TX

On June 27, 2008, the Board and Dr. Stoeckel entered into an Agreed Order of Suspension that suspended his license indefinitely and requires that he immediately cease the practice of medicine. The order also
provides that Dr. Stoeckel may petition the Board in the future, and upon a showing of clear and convincing evidence deemed satisfactory by the Board that he is competent to safely return to the practice of medicine, he may have the suspension stayed or lifted. The action was based on Dr. Stoeckel’s admission to the Board of substance abuse that could adversely impact patient safety, and his entry to an inpatient facility for treatment.

**STUBBS, GARRY WAYNE, M.D., LIC. #H8442, DENISON, TX**

On June 27, 2008, the Board and Dr. Stubbs entered into a 10-year Mediated Agreed Order requiring that Dr. Stubbs abstain from prohibited substances; be subject to random alcohol and drug screens; have a psychiatric evaluation and possible continuing treatment; have continuing psychotherapy; attend Alcoholics Anonymous; be prohibited from supervising physician assistants and advance practice nurses, except for nurse anesthetists in the operating room; and be subject to certain terms and conditions for up to six months if he elects to return to the practice of anesthesiology. The action was based on Dr. Stubbs’ diversion and use of fentanyl.

**WARR, ROBERT B., M.D., LIC. #H6977, TEXARKANA, TX**

On June 27, 2008, the Board entered an order Granting Termination of Suspension and Agreed Order. Dr. Warr’s license had been temporarily suspended on December 7, 2005, after a finding that he had a mental or physical condition that impaired his ability to safely practice medicine. These conditions included self-prescribing multiple medications and his failure to report his treatment for depression to the Board. On December 22, 2005, the Board and Dr. Warr entered into an Agreed Order that suspended his license until such time as he could demonstrate that he could competently practice medicine. On February 28, 2008, Dr. Warr presented evidence to the Board that included the results of a forensic psychiatric exam, a neuro-psychological evaluation, and a physical exam. Based on these results, the Board granted Dr. Warr’s request for termination of the suspension, and placed Dr. Warr under terms and conditions for five years that include a chart and practice monitor; continued, monitored, psychiatric treatment, and additional continuing medical education.

**WHITE, STEPHEN CURTIS, M.D., LIC. #L3183, LONGVIEW, TX**

On August 29, 2008, the Board and Dr. White entered into an Agreed Order suspending Dr. White’s license for an indefinite period until such time as he petitions the Board and provides clear and convincing evidence to show that he is competent to safely return to medical practice. The action was based on Dr. White’s use of cocaine and his three arrests for possession of illegal drugs.

**NONTherAPEUTIC PRESCRIBING**

**DUNN, DAVID TODD, M.D., LIC. #M0709, BURLESON, TX**

On October 10, 2008, the Board and Dr. Dunn entered into an Agreed Order requiring that, within one year of the order, he obtain 15 hours of continuing medical education in pain management and drug seeking behavior and 10 hours in medical record-keeping. The action was based on his writing a prescription for hydrocodone for a patient without a physical examination after the patient’s four-month absence from a treatment program.

**FINDLAY, DAVID JOHN, M.D, LIC. #L1847, WEATHERFORD, TX**
Effective August 6, 2008, the Board and Dr. Findlay entered into an Agreed Order requiring the following for two years: that a physician monitor Dr. Findlay’s medical records and written practice protocols for chronic pain prescribing; and that Dr. Findlay attend 10 hours of continuing medical education in pain management each year (in addition to annual requirements). The action was based on Dr. Findlay’s failure to meet the standard of care in prescribing narcotics, failure to observe pain prescription protocols, and failure to keep adequate medical records of narcotics prescriptions for two patients.

LAUNIUS, JOHN A., M.D., LIC. #H2149, LEWISVILLE, TX

On October 10, 2008, the Board and Dr. Launius entered into an Agreed Order requiring that he take and pass the Special Purpose Examination within one year; that he have a chart monitor; and that within one year he take the physician prescribing course offered by the University of California-San Diego Physician Assessment and Clinical Education (PACE) program or an equivalent course. The action was based on Dr. Launius’ prescribing Adipex, Adderal and Armour Thyroid to patients when such medications were not indicated.

LE, NHI P., M.D., LIC. #K9105, PORT LAVACA, TX

On October 10, 2008, the Board and Dr. Le entered into an Agreed Order requiring that, within one year of the order, she obtain 10 hours of continuing medical education in ADHD and 10 hours on chronic pain and that she have a physician monitor designated by the board who will review patient records. The action was based on violations regarding documentation and prescription of stimulants.

MATWJIW, IGOR, M.D., LIC. #J4910, WEBSTER, TX

On October 10, 2008, the Board and Dr. Matwijiw entered into an Agreed Order requiring that, within one year of the order, he obtain eight hours of continuing medical education in medical record-keeping or risk management. The action was based on Dr. Matwijiw’s failure to document properly that he dispensed a sample of Apidra to a patient, and failure to document warnings and instructions that he gave the patient regarding its use.

SHAUGHNESSY, DENNIS M., M.D., LIC. #F7913, MIDLAND, TX

On October 10, 2008, the Board and Dr. Shaughnessy entered into a five year Agreed Order of public reprimand requiring that Dr. Shaughnessy have a practice monitor and that, within one year, he obtain 25 hours of continuing medical education in assessing, diagnosing and treating substance abuse. The action was based on Dr. Shaughnessy’s failure to take appropriate action in response to a patient’s aberrant behavior related to pain medication prescribed by Dr. Shaughnessy.

WOLF, GARY DUKE, D.O., LIC. #E9029, MANSFIELD, TX

On June 27, 2008, the Board and Dr. Wolf entered into a five-year Agreed Order requiring that Dr. Wolf be publicly reprimanded; be subject to quarterly chart reviews; and attend the University of California at San Diego Physician Assessment and Clinical Education (PACE) course in medical record-keeping within two year of the order’s effective date. The action was based on Dr. Wolf’s nontherapeutic prescribing of several pain medications, and inadequate related documentation, over a several-year period on a patient that Dr. Wolf knew, or should have known, was exhibiting addictive behavior.

FAILURE TO PROPERLY SUPERVISE OR DELEGATE
BOECKER, ANNA MARIE, M.D., LIC. #K1162, NEW BRAUNFELS, TX

On October 10, 2008, the Board and Dr. Boecker entered into an Agreed Order requiring that within one year Dr. Boecker take and pass the medical jurisprudence examination within three attempts and pay an administrative penalty of $2,000. The action was based on Dr. Boecker’s allowing an unlicensed physician to practice medicine in her office.

REDDY, SRILATHA A., M.D., LIC. #L3089, GRAND PRAIRIE, TX

On October 10, 2008, the Board and Dr. Reddy entered into an Agreed Order requiring that she pay an administrative penalty of $2,000 within 180 days. The action was based on Dr. Reddy’s allowing a Women’s Health Care Nurse Practitioner, whose license limited her treatment to women, to treat a male patient.

SCHNEE, MARK J., M.D., Lic. #E9392, Houston, TX

On August 29, 2008, the Board and Dr. Schnee entered into an Agreed Order requiring that Dr. Schnee institute corrective actions within 30 days to ensure that his employees follow his written protocols; that he attend eight hours of continuing medical education in medical record-keeping and eight hours in risk management within one year (in addition to annual requirements); and pay an administrative penalty of $2,500. The action was based on Dr. Schnee’s failure to ensure that a delegate employee followed his protocol on prescription refills provided to a patient.

VOLUNTARY SURRENDERS

BISHOP, ROBERT T., M.D., LIC. #C7545, DALLAS, TX

On August 29, 2008, the Board and Dr. Bishop entered into an Agreed Order of Voluntary Surrender wherein Dr. Bishop voluntarily and permanently surrendered his license in lieu of Board disciplinary action related to violations concerning a felony indictment for delivery of a controlled substance without a medical purpose in the course of professional practice.

BOHORQUEZ, JULIO CESAR, M.D., LIC. #F3414, HOUSTON, TX

On August 29, 2008, the Board and Dr. Bohorquez entered into an Agreed Order of Voluntary Suspension wherein Dr. Bohorquez voluntarily agreed to the suspension of his license and practice of medicine. The action was based on Dr. Bohorquez’s current inability to practice medicine due to a serious illness and his ongoing treatment for that illness.

COHEN, RICHARD, M.D., LIC. #D3187, EL PASO, TX

On October 10, 2008, the Board and Dr. Cohen entered into an Agreed Order of Voluntary Surrender. The action was based on the board’s finding that Dr. Cohen failed to properly interpret an abdominal computerized tomography scan, resulting in a significant delay in diagnosis and treatment of malignant fibrous histiocytoma.

KIM, MICHAEL D., M.D., LIC, #F0544, HOUSTON, TX
On October 10, 2008, the Board and Dr. Kim entered into an Agreed Order of Revocation of his medical license. The action was based on Dr. Kim’s having been found guilty on 17 counts of healthcare fraud relating to false or fraudulent certificates for motorized wheelchairs.

**MOORE, CHARLES THOMAS, M.D., LIC. #E4539, AUSTIN, TX**

On August 29, 2008, the Board and Dr. Moore entered into an Agreed Order of Voluntary Surrender wherein Dr. Moore voluntarily and permanently surrendered his license in lieu of Board disciplinary action related to a violation concerning failure to comply with the chart monitor requirement set forth in a 2005 Board order.

**ROTHENBERG, GAYLE ANNE, M.D., LIC. #F3341, HOUSTON, TX**

On October 10, 2008, the Board and Dr. Rothenberg entered into an Agreed Order of Revocation of her medical license. The action was based on her felony convictions for conspiracy, mail fraud, misbranding a drug for sale and lying to federal agents.

**ROX, AIMEE KATHRYN, M.D., PIT PERMIT NO. BP10026370, DALLAS, TX**

On August 29, 2008, the Board and Dr. Rox entered into an Agreed Voluntary Surrender Order wherein Dr. Rox voluntarily surrendered her permit in lieu of Board disciplinary action related to violations concerning substance abuse and her resignation from an anesthesiology/pain management residency program.

**SHEEHAN, VALERIE AGATHA, M.D., LIC. #C5876, DALLAS, TX**

On August 29, 2008, the Board and Dr. Sheehan entered into an Agreed Order of Voluntary Surrender wherein Dr. Sheehan voluntarily and permanently surrendered her license in lieu of Board disciplinary action related to violations concerning her continued prescribing of controlled substances to a patient after expiration of her DEA registration.

**WEINER, BENJAMIN, M.D., LIC. #C8018, ANGLETON, TX**

On October 10, 2008, the Board and Dr. Weiner entered into an Agreed Order of Voluntary Surrender. The action was based on health issues that preclude him from practicing medicine.

**WERNER, PETER W., M.D., LIC. #D6559, AUSTIN, TX**

On October 10, 2008, the Board and Dr. Werner entered into an Agreed Order of Voluntary Surrender. The action was based on his failure follow pain guidelines in prescribing narcotics to several patients.

**CRIMINAL CONVICTIONS**

**ANDERSON, NANCY LOUISE, M.D., LIC. #F7350, HOUSTON, TX**

On June 27, 2008, the Board and Dr. Anderson entered into a Mediated Agreed Order requiring that Dr. Anderson, for a period of 10 years, abstain from prohibited substances; be subject to random alcohol and drug screens; have a psychiatric evaluation and possible continuing treatment; and attend Alcoholics
Anonymous. The action was based on Dr. Anderson’s three convictions between 2000 and 2006 for driving while intoxicated.

MILLER, STEPHEN, M.D., LIC. #G9623, BEAUMONT, TX

On June 27, 2008, the Board and Dr. Miller agreed to the entry of a Voluntary Revocation order that indefinitely revoked his license to practice. The action was based on Dr. Miller’s conviction on a federal felony charge of income tax evasion.

THEAGENE, SAMUEL MICHAEL, M.D., LIC. #J7690, SAN ANTONIO, TX

On June 17, 2008, The Board issued an automatic order of suspension against Dr. Theagene’s medical license. The action was based on his incarceration in federal prison. On September 26, 2007, Dr. Theagene was found guilty of bribery of a public official in the United States District Court for the Western District of Texas San Antonio. On February 8, 2008, Dr. Theagene began serving a federal prison sentence of 97 months, and he is currently incarcerated in the Federal Correctional Institute in Three Rivers, Texas.

VU, KHANH NGUYEN, D.O., LIC. #L0676, TITUSVILLE, PA

On May 28, 2008, a Disciplinary Panel of the Board issued an order of Temporary Suspension Without Notice of Hearing, which temporarily suspended Dr. Vu’s medical license, after determining that Dr. Vu’s continuation in the practice of medicine presents a continuing threat to the public welfare. The temporary suspension remains in effect until a hearing is held before a Disciplinary Panel of the Board. The temporary suspension was based on Dr. Vu being criminally convicted and sent to prison in Pennsylvania on convictions for three counts of indecent assault involving fourteen female patients.

ORDER MODIFICATION

SPINKS, DAVID WAYNE, D.O., LIC. #F4557, DEER PARK, TX

On August 29, 2008, the Board and Dr. Spinks entered into an Agreed Order Modifying Prior Order. Dr. Spinks was under a 2005 order, modified and extended by two years in 2007, that was issued for inappropriate prescribing, engaging in a personal relationship with a patient, and inadequate medical records. This order further modifies and adds to the 2005 order and requires that Dr. Spinks obtain 10 hours of continuing medical education in medical record-keeping and 10 hours in other subject areas to be completed no later than October 7, 2009, and that Dr. Spinks take and pass the medical jurisprudence examination not later than October 7, 2010. This order further clarifies that Dr. Spinks’ 2005 order will not terminate sooner than October 7, 2009. The action was a response to Dr. Spinks encountering difficulty in obtaining all 20 hours of continuing medical education in medical record-keeping, as originally ordered in 2005. Otherwise, Dr. Spinks has been in compliance with the 2005 order but the problem with the educational requirement presented the potential for a non-compliance violation. As such, the action was designed to assist Dr. Spinks, ensure his compliance, and carry out the Board’s educational intent set forth in the requirements of the 2005 order.

TEMPORARY SUSPENSION ORDERS

CRANDALL, DORA BUSBY, M.D., LIC. #G5884, NEW BRAUNFELS, TX
On July 31, 2008, a Disciplinary Panel of the Board issued an Order of Temporary Suspension With Notice of Hearing, which temporarily suspended Dr. Crandall’s medical license after determining that Dr. Crandall’s medical practice was a continuing threat to the public. The length of the temporary suspension is indefinite and remains in effect until the Board takes further action. The temporary suspension was initiated after the Board investigated Dr. Crandall’s treatment practices in 13 patient cases. Due to Dr. Crandall’s failure to properly evaluate the patients, failure to document physical examinations, failure to appropriately prescribe medications, and failure to provide medical justifications for numerous narcotic prescriptions, Dr. Crandall was found to present a continuing threat to public safety.

MASSEY, CHARLES R. JR., M.D., LIC. # G5341, FREDERICKSBURG, TX

On June 13, 2008, a Disciplinary Panel of the Board issued an Order of Temporary Suspension Without Notice of Hearing, which temporarily suspended Dr. Massey’s medical license after determining that Dr. Massey’s continuation in the practice of medicine presents a continuing threat to the public. The length of the temporary suspension is indefinite and remains in effect until the Board takes further action. The temporary suspension was initiated after the Board attempted to investigate if Dr. Massey was prescribing human growth hormone without medical necessity. When the Board subpoenaed medical records from Dr. Massey, he refused to produce them. Based on Dr. Massey’s intentional obstruction of a Board investigation, he was found to present a continuing threat to public safety. On August 15, 2008, a Disciplinary Panel of the Board issued an Order of Temporary Suspension With Notice which temporarily suspended his license after concluding that his continuation in the practice of medicine is a continuing threat to the public health and safety. The Order of Temporary Suspension shall remain in effect until superseded by further order of Board. The Board had concerns regarding Dr. Massey’s alleged prescribing and administering of human growth hormone and other substances to patients upon their request and without medical justification. When the Board issued investigative subpoenas for Dr. Massey’s records, he repeatedly interfered with the investigation and refused to produce any records. The Disciplinary Panel’s decision was based on Dr. Massey’s unprofessional conduct in obstructing the Board’s investigation and refusing to recognize the Board’s authority.

CEASE AND DESIST ORDERS

BRUNKEN, ROBERT BYRT, M.D., LIC. #C3593, DALLAS, TX

On October 10, 2008, the Board and Robert Byrt Brunken, M.D., who voluntarily and permanently surrendered his medical license on May 8, 2007, entered into an Agreed Cease and Desist Order. The Action was based on Dr. Brunken having written five prescriptions for controlled substances and two prescriptions for dangerous drugs between June 1 and June 27, 2007. Dr. Brunken also ordered a dangerous drug and syringes eight times between December 18, 2007, and July 11, 2008. Dr. Brunken agreed to the order, which requires him to immediately halt all such activity.

CARROLL, DERRICK LYNN, M.D., HOUSTON, TX

On June 27, 2008, the Board and Dr. Carroll, who does not hold a current license to practice medicine in Texas, entered into an Agreed Cease and Desist Order. The action was based on Dr. Carroll’s representing himself to be a physician and writing a prescription at a medical care facility in Porter, Texas. The order requires Dr. Carroll to immediately halt all such activity.
GONZALEZ, JESSICA, M.D., MCALLEN, TX

On June 27, 2008, the Board and Dr. Gonzalez, who does not hold a current license to practice medicine in Texas, entered into an Agreed Cease and Desist Order. The action was based on Dr. Gonzalez’s performance of physical examinations and medical evaluations that were the basis for medical treatments provided to patients at a clinic in Alamo, Texas. The order requires Dr. Gonzalez to immediately halt all such activity.

OSEI, JOSEPH, PH.D., FORT WORTH, TX

On October 10, 2008, the Board and Dr. Osei, who does not hold a license to practice medicine in Texas, entered into an Agreed Cease and Desist Order. The action was based on Dr. Osei’s alleged representation of himself as a medical doctor in advertisements in the public domain, and his alleged treatment of patients as a physician in Fort Worth. Dr. Osei denied the allegations but agreed to the order, which requires him to immediately halt all such activity.

ADMINISTRATIVE ORDERS/MINIMAL STATUTORY VIOLATIONS

Fifty-nine licensees agreed to enter into administrative orders with the Board for minimal statutory violations.

CORRECTED ORDER (Nunc Pro Tunc)

KONJOYAN, THOMAS RICHARD, M.D., LIC. #G2173, GROVES, TX

On June 27, 2008, the Board issued a Nunc Pro Tunc order that added language to his February 2008 order, permitting Dr. Konjoyan to supervise, and delegate prescription authority to, physician assistants and advanced practice nurses.

PHYSICIAN ASSISTANTS

The Texas Physician Assistant Board has taken action against the following physician assistants:

BENTON, FLOYD H., P.A., LIC. NO. PA00039, STERLING CITY, TX

On July 25, 2008, the Board and Mr. Benton entered into a 12-month Agreed Order requiring Mr. Benton to abstain from alcohol and drugs and undergo the Board’s random drug screening for such prohibited substances. The action was based on Mr. Benton’s February 2007 placement on four years deferred adjudication community supervision for felony possession of marijuana that he was growing and providing to a terminal cancer patient.

FRYDENDALL, VERN RAYMOND, P.A., Lic. No. PA00081, Abilene, TX

On July 25, 2008, the Board and Mr. Frydendall entered into an Agreed Order of Voluntary Surrender whereby Mr. Frydendall voluntarily and permanently surrendered his license. The Board’s acceptance of this surrender resulted from Mr. Frydendall’s self-report and concern regarding a medical disability that could adversely impact his ability to care for future patients. As a result, Mr. Frydendall chose to retire from practice.