legislation passed in the 2009 legislative session expanded physicians’ ability to delegate prescribing to physician assistants and advance practice nurses. The following is an overview of statutes and regulations relating to prescriptive delegation, including recent changes.

Under the Medical Practice Act, Texas Occupations Code, and Chapter 193 of the Board rules, physicians may delegate prescriptive authority to PAs and APNs. This authority includes prescribing dangerous drugs and Schedules III, IV and V controlled substances.

As the delegating physician you remain responsible for the acts of those to whom you delegate. Physician supervision shall conform to what a reasonable, prudent physician would find consistent with sound medical judgment. The physician shall provide continuous supervision, but constant physical presence is not required. The physician’s authority to delegate is limited to four PAs or APNs or their full-time equivalents. This provision, included in Senate Bill 532, increases the previously allowed limit of three and went into effect September 1.

Practice settings and the various requirements for delegation in each type of setting are laid out in Chapter 193 of the board rules:

- Primary practice site, defined as the location where the physician spends more than 50 percent of his or her time and is physically present with the PA or APN.
- Alternate practice site, where services are similar to those provided at the primary practice site within 75 miles of the primary site. (This distance increased from 60 miles under SB 532.) The delegating physician must be on site at least 10 percent (down from 20 percent) of the time; must review at least 10 percent of the charts of patients seen by PAs or APNs (including electronic records, new under SB 532); and must be available through direct telecommunication for consultation, patient referral or assistance with a medical emergency.
- Facility-based practice state, such as a licensed hospital or long-term care facility. A physician may delegate if the physician is the medical director, chair of the facility’s credentialing

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Mission Statement
Our Board’s mission is to protect and enhance the public’s health, safety and welfare by establishing and maintaining standards of excellence used in regulating the practice of medicine and ensuring quality health care for the citizens of Texas through licensure, discipline and education.

Licensees must keep the board informed of their current address. Change of address forms are at http://www.tmb.state.tx.us/professionals/hcpsres/changeaddress.php

Other provisions of statute and rule physicians need to know about prescriptive delegation:

- Physicians must document delegation of prescriptive authority.
- If the delegating physician is unavailable, arrangements must be made for another physician to provide supervision.

Waivers: The Board may waive or modify supervision requirements under certain conditions. Waivers may include increasing the number of PAs and APNs to six and may also be granted on mileage limits between primary and alternate practice sites. Before granting waivers, the Board must determine that the types of care provided by the PAs and APNs are limited in nature and duration, within the scope of delegated authority, and that patient care will not be adversely affected.

Waiver requests may be made through the TMB web site at http://www.tmb.state.tx.us/professionals/np/pdwreqs.php.

An additional new provision under SB 532 is the extension of the period of the prescriptions for Schedules III, IV and V, including refills, from 30 to 90 days.

Registration by physicians of delegated prescriptive authority to PAs or APNs is required, effective January 31, 2010. Physicians who have already notified TMB that they supervise PAs or APNs will be provided registration information prior to that date.

For more information about prescriptive delegation changes, and registration forms, go to: http://www.tmb.state.tx.us/professionals/physicians/dellegatingPrescriptiveAuthority.php
Since the Spring 2009 issue of the Medical Board Bulletin, the Board has taken disciplinary action on 280 physicians and eight physician assistants. The Board issued three cease and desist orders for unlicensed practice. The following is a summary of those actions.

QUALITY OF CARE VIOLATIONS
Aggarwal, Ajay, M.D., Lic. #J7879, Bay City TX
On May 1, 2009, the Board and Dr. Aggarwal entered into a five-year Agreed Order of public reprimand requiring that, for each year of the order, Dr. Aggarwal obtain 50 hours of continuing medical education in assessing, diagnosing and treating substance abuse; that he have a practice monitor; that he request modification of his DEA and DPS controlled substance registration to eliminate Schedule II, limiting his prescribing of controlled substances to the remaining schedules, and that he not obtain controlled substance registration without board approval. The action was based on Dr. Aggarwal’s failure to meet the standard of care in his prescribing, monitoring, follow-up care, treatment plan and management of a pain patient and failing to heed multiple red flags for nontherapeutic controlled substance abuse by the patient, who died of acute Methadone intoxication.

Babcock, Chad, M.D., Lic. #L8269, Austin TX
On August 21, 2009, the Board and Dr. Babcock entered into an agreed order requiring that within one year he obtain five hours of continuing medical education in ethics; that within one year he complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and that within 90 days he pay an administrative penalty of $2,000. The action was based on Dr. Babcock’s prescribing several medications, x-rays and tests to a friend without maintaining medical records or written justification and neglecting to secure written informed consent or advise the friend of foreseeable side effects.

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Bailey, Charles F. Jr., M.D., Lic. #C6859, Snyder TX
On November 6, 2009, the Board and Dr. Bailey entered into an agreed order requiring that within one year he obtain 24 hours of continuing medical education as follows: eight hours of diagnosis and management of dementia, eight hours of evaluation and treatment of head injuries in family medicine, and eight hours of medical recordkeeping. The action was based on Dr. Bailey's failure to perform neurological and mental status examinations on a patient who presented after a fall with a high risk for a CVA or intracranial bleed. Although the subsequent MRI was negative for evidence of a CVA or intracranial bleed, Dr. Bailey failed to safeguard against potential complications given the patient's clinical presentation.

Bang, Richard, M.D., Lic. #L6280, Rockwall TX
On August 21, 2009, the Board and Dr. Bang entered into an agreed order requiring that he have a practice monitor for three years; that within one year he obtain 10 hours of continuing medical education in risk management and 10 hours of CME in medical recordkeeping; that he complete the physician prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and that within 60 days he pay an administrative penalty of $5,000. The action was based on Dr. Bang's prescribing excessive amounts of medications to a known drug abuser, who died of a drug overdose.

Battle, Robert M., M.D., Lic. #D2355, Houston TX
On November 6, 2009, the Board and Dr. Battle entered into a mediated agreed order requiring the following: that within 180 days Dr. Battle obtain 10 hours of continuing medical education in medical recordkeeping and 10 hours CME in family practice; he maintain adequate medical records; and within one year his charts will be subject to a one-time monitor; within 90 days he create an informed consent form to be provided to complementary and alternative medicine patients to be approved by TMB's executive director; and he provide his patients with a brochure or handout of estimated costs of his treatments. The action was based on Dr. Battle's use of tests and treatments not generally recognized in traditional medical practice, and on his inadequate medical records.

Berwind, Robert T., M.D., Lic. #E5481, Kingwood TX
On August 21, 2009, the Board and Dr. Berwind entered into an agreed order requiring that within one year he obtain 30 hours of continuing medical education, including 20 hours in urogynecology and 10 hours in medical recordkeeping; and that within 90 days he pay an administrative penalty of $1,000. The action was based on Dr. Berwind's failure to properly evaluate and perform surgery on a patient with a vaginal prolapse, requiring the patient to undergo a second surgical procedure.

Black, James Nelson, M.D., Lic. #G1282, Temple TX
On August 21, 2009, the Board and Dr. Black entered into an agreed order of public reprimand requiring that within three years he take and pass the examination promulgated by the International Board of Heart Rhythm Examiners and that within 90 days he pay an administrative penalty of $3,000. The action was based on Dr. Black's improper placement of a lead when implanting a pacemaker in a patient.

Branch, Rudolph E., M.D., Lic. #D6378, Dallas TX
On August 21, 2009, the Board and Dr. Branch entered into an agreed order of public reprimand suspending his license and staying the suspension under the following conditions: that within one year he obtain 10 hours of continuing medical education in ethics and 10 hours in medical recordkeeping; that within 90 days he pay an administrative penalty of $2,500; and that he become familiar with state and federal regulations regarding prescribing dangerous drugs and controlled substances, as well as Texas Medical Board Rule 174.4; and that he make patient records available for inspection by the Board. The action was based on Dr. Branch's prescribing weight-loss medications to two patients via the Internet.

Breeling, Charles, M.D., Lic. #F9232, Corpus Christi TX
On November 6, 2009, the Board and Dr. Breeling entered into an agreed order requiring that within one year Dr. Breeling complete 10 hours of continuing medical education in medical recordkeeping and 15 hours in coronary artery disease and that he have a practice monitor for two years. The action was based on Dr. Breeling's failure to provide appropriate follow-up care for a patient who had received an aorta repair by graft and who died of internal bleeding 10 days after surgery.

Caddell, James D., D.O., Lic. #F6497, Dallas TX
On November 6, 2009, the Board and Dr. Caddell entered into an agreed order requiring that within one year he obtain four hours each of continuing medical education in medical recordkeeping, treatment of cardiovascular diseases, and coding and documentation, and pay an administrative penalty of $1,000 within 90 days. The action was based on Dr. Caddell's failure to use proper diligence in treating a patient's hypertension.
Board Approves Revised Tanning Advisory Statement

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

WARNING

TANNING IS ONE OF THE LEADING CAUSES OF SKIN CANCER.

TANNING MAY CAUSE SEVERE BURNS, BLISTERING AND SCARRING.

- The U.S. Department of Health and Human Services has declared ultraviolet radiation (UV) to be a cancer causing substance.

- Both indoor and outdoor tanning expose a person to ultraviolet radiation because UV radiation can come from the sun and artificial sources, such as tanning beds and sun lamps.

- The amount of UV radiation received during indoor tanning is similar to the amount received from the sun, and in some cases may be stronger.

- People who tan greatly increase their risk of developing skin cancer.

- Numerous medical studies have shown that exposure to UV radiation, from tanning outside or with indoor tanning devices, is associated with an increased risk of skin cancer.

- The number of skin cancers has been rising over the past several years due to increasing exposure to UV radiation from the sun, tanning beds, and sun lamps.

- In the United States, a person dies every 62 minutes from melanoma, the deadliest form of skin cancer.

- Exposure to UV radiation from indoor tanning devices can also lead to premature skin aging, eye damage, and damage to the immune system.

- The effects of UV radiation are cumulative and may show up several years after the exposure.

- The adverse effects of UV radiation are increased when a person is exposed during their twenties, teens, or even younger.

- PHYSICIANS, THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES AND OTHER HEALTH ORGANIZATION RECOMMEND THAT A PERSON, ESPECIALLY CHILDREN UNDER 18, REDUCE THEIR EXPOSURE TO ULTRAVIOLET RADIATION FROM INDOOR TANNING DEVICES TO HELP PREVENT SKIN CANCER.
and hypercholesterolemia and his failure to provide sufficient documentation to support coding.

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

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

Cantu, David A., M.D., Lic. #J1073, Fredericksburg TX

On May 29, 2009, the board and Dr. Cantu entered into an agreed order requiring that he complete 10 hours of continuing medical education in risk management. The action was based on Dr. Cantu’s prescribing an adult-strength dose of Ambien for a seven-year-old patient; neglecting to eliminate 11 refills for the drug that his electronic system provided; and failing to follow up or monitor the effectiveness of the drug on the patient and her 13-year-old sister, to whom he had also prescribed Ambien.

Carrasco-Santiago, Manuel, M.D., Lic. #J5275, Big Spring TX

On May 29, 2009, the board and Dr. Carrasco-Santiago entered into a mediated agreed order requiring that he obtain 10 hours each of continuing medical education in pre-operative evaluation of patients and general cardiology and that he pay an administrative penalty of $1,500 within 90 days. The action was based on Dr. Carrasco-Santiago’s failure to make appropriate efforts to follow up on an EKG and further evaluate a patient’s cardiovascular status prior to clearing the patient for knee surgery, after which the patient suffered an acute myocardial infarction complicated by pulmonary edema and died.

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

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

Crawford, Debbie A., D.O., Lic. #J8973, Brownwood TX

On August 21, 2009, the Board and Dr. Crawford entered into an agreed order requiring that within one year she obtain 10 hours of continuing medical education in medical recordkeeping and 10 hours in ethics; the order also requires that she submit a written statement of corrective action taken. The action was based on Dr. Crawford utilizing a Florida company for administration and interpretation of Electromyography (EMG) and Nerve Conduction Velocity Studies, and that employees who administered and interpreted the studies were not licensed Texas health care providers as required.

Dake, Theodore Jr., M.D., Lic. #E9594, San Marcos TX

On August 21, 2009, the Board and Dr. Dake entered into an agreed order requiring that within one year Dr. Dake obtain 10 hours of continuing medical education in medical recordkeeping. The action was based on Dr. Dake’s failure to adequately document his testing and workup in the process of evaluating and diagnosing a patient.

Daugherty, Brian, M.D., Lic. #K2325, Huffman TX

On August 21, 2009, the Board and Dr. Daugherty entered into an agreed order requiring that he have a practice monitor for one year; that within one year he obtain 10 hours of continuing medical education in medical recordkeeping and 10 hours of CME in prescribing for pain management; and that within 180 days he pay an administrative penalty of $1,000. The action was based on Dr. Daugherty’s failure to do a thorough evaluation and examination of a patient he treated for pain, relying on the patient’s statements, and his failure to request the patient’s medical records to verify the patient’s statements.

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

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

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

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

**Findley, Michael S., M.D., Lic. #H1279, Waco TX**

On May 29, 2009, the board and Dr. Findley entered into an agreed order requiring that he complete 10 hours of continuing medical education in prescribing for pain management. The action was based on Dr. Findley’s failure to properly document neurological and physical examinations; his prescribing excessive amounts of narcotics; and his failure to recognize narcotics abuse in one patient.

**Granado, Elma Gonzales, M.D., Lic. #G9744, Fort Worth TX**

On August 7, 2009, the Board and Dr. Granado entered into an agreed order requiring that within one year Dr. Granado obtain 10 hours of continuing medical education in risk management, 10 hours in pharmacology, and 10 hours in medical recordkeeping. The action was based on Dr. Granado’s failure to use reasonable diligence regarding a patient’s prior documented allergies when she administered Haldol to a patient who was allergic to Haldol, and her failure to properly document her concerns about possible contraindicated medications administered to the patient.

**Grant, James S., M.D., Lic. #E7096, Texarkana TX**

On August 21, 2009, the Board and Dr. Grant entered into a three-year agreed order prohibiting him from engaging in the practice of pain management; limiting his practice to a group or institutional setting; requiring that within one year he take and pass the Texas Medical Jurisprudence Examination; that within 180 days he take the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and that he have a practice monitor. The action was based on Dr. Grant’s failure to appropriately treat seven patients for health issues including diabetes, hypertension, and chronic pain. Additionally, Dr. Grant failed to appropriately document care provided to the patients.

**Haney, Peter M., M.D., Lic. #K4911, Houston TX**

On May 29, 2009, the board and Dr. Haney entered into an agreed order requiring that, within two years, Dr. Haney obtain 30 hours of continuing medical education of at least 10 hours each in medical recordkeeping, pediatric GI diseases and physician-patient communication and that he pay an administrative penalty of $2,000 within 30 days. The action was based on Dr. Haney’s failure to communicate with an infant’s parents to their satisfaction; failure to explicitly document his concerns regarding a possible diagnosis of malrotation; and failure to order an upper GI study to rule out malrotation in a timely manner.

**Hill, Welton E., M.D., Lic. #F6746, Bellville TX**

On May 29, 2009, the board and Dr. Hill entered into a two-year agreed order requiring that he have a practice monitor; that he obtain 10 hours of continuing medical education in medical recordkeeping for each year of the order; and that he pay an administrative penalty of $1,000 within 90 days. The action was based on Dr. Hill’s inadequate documentation in treatment of multiple patients with dementia, ADD and depression.

**Hinshaw, Luke, M.D., Lic. #L8077, Great Falls MT**

On August 21, 2009, the Board and Dr. Hinshaw entered into an agreed order requiring that within one year Dr. Hinshaw obtain 10 hours each of continuing medical education in pharmacology, with emphasis on the use of antibiotics, and in management of hospital acquired infections. The action was based on Dr. Hinshaw’s prescribing gentamicin to a hospitalized patient in excessive quantities.

**Kendall, Kevin, M.D., Lic. #J8620, Katy TX**

On August 21, 2009, the Board and Dr. Kendall entered into an agreed order requiring that he have a practice monitor for one year; that within one year he obtain 10 hours of continuing medical education in each of the following areas: pain management, medical recordkeeping and pediatric ambulatory care; and that he pay an administrative penalty of $2,500 within 60 days. The action was based on Dr. Kendall’s failure to notify hospital staff of his transfer of a patient to the patient’s primary physician, and his prescribing non-therapeutic doses of controlled substances in treating chronic pain in three patients.
Key, James D. Sr., M.D., Lic. #E3339, Brownsville TX
On August 21, 2009, the Board and Dr. Key entered into a five-year agreed order requiring that he obtain a second opinion from a board certified orthopedic surgeon with a spine specialty or neurosurgeon prior to performing any spinal surgeries or procedures; that he have a practice monitor; and that within 30 days he contact the Texas A&M Health Science Center Rural and Community Health Institute (K-STAR) or the University of California San Diego Physician Assessment and Clinical Education (PACE) program to schedule an assessment of his practice. The action was based on Dr. Key’s failure to meet the standard of care in treating a surgical patient because of inadequate follow-up on a post-operative complication, and his inadequate documentation in the medical record of that patient.

Khan, Muhammad A., M.D., Lic. #J4878, McKinney TX
On August 21, 2009, the Board and Dr. Khan entered into a one-year agreed order requiring that he have a practice monitor; that within one year he obtain 30 hours of continuing medical education in the following areas: 10 hours in medical recordkeeping; 10 hours in interventional cardiology related to cardiology; and 10 hours in interventional cardiology, non-cardiac specific; and that he obtain a written consultation from a licensed Texas physician who is board certified in vascular surgery or interventional neuro-radiology prior to performing carotid arteriograms, vertebral arteriograms, and/or any endovascular interventions. The action was based on Dr. Khan’s failure to meet the standard of care in performing cardiac procedures on 29 patients and his failure perform and/or document a history or physical examination in these patients, who did not meet the criteria for such invasive and risky procedures.

Klein, Amy W., D.O., Lic. #K7781, Gainesville TX
On August 21, 2009, the Board and Dr. Klein entered into an agreed order requiring that within one year she obtain eight to 10 hours of continuing medical education in obstetric ultrasound or fetal monitoring; 10 hours in high-risk obstetrics and 10 hours in medical recordkeeping. The action was based on Dr. Klein’s failure to meeting the standard of care of a patient and her baby during final stages of labor in not recognizing the severity of fetal distress and not timely addressing fetal strip abnormalities.

Lackey, James M., M.D., Lic. #L5014, San Antonio TX
On November 6, 2009, the Board and Dr. Lackey entered into a two-year agreed order requiring that his practice be monitored; that within one year Dr. Lackey obtain 10 hours each of continuing medical education in medical recordkeeping, risk management and treatment of chronic pain; and that within 90 days he pay an administrative penalty of $1,000. The action was based on Dr. Lackey’s failure to meet the standard of care and failure to maintain adequate medical records in the treatment of a pain patient.

Le, David E., M.D., Lic. #F6356, Houston TX
On August 21, 2009, the Board and Dr. Le entered into an agreed order requiring that he have a practice monitor for one year; that within 30 days he obtain 10 hours of continuing medical education in medical recordkeeping; and that within 30 days he pay an administrative penalty of $500. The action was based on Dr. Le’s failure to meet the standard of care and/or properly document care and treatment of two patients, and on his failure to notify the board of his change of address within 30 days as required.

Li, Lucy Quan, M.D., Lic. #L6496, Frisco TX
On August 21, 2009, the Board and Dr. Li entered into an agreed order restricting her from performing solo cosmetic blepharoplasty surgery until she receives board approval; requiring that she obtain additional surgery training in cosmetic blepharoplasty; and requiring that she obtain six hours of continuing medical education in risk management. The action as based on Dr. Li’s failure to meet the standard of care by performing blepharoplasty surgery without adequate training.

Liggett, Scott, M.D., Lic. #F8766, Marble Falls TX
On August 21, 2009, the Board and Dr. Liggett entered into an agreed order requiring that within one year Dr. Liggett obtain eight hours each of continuing medical education in medical recordkeeping, diagnosis and treatment of diabetes and physician-patient communication. The action was based on Dr. Liggett’s failure to adequately document in the medical record of a new-onset type 2 diabetic: hydration status; any fingerstick results; and a plan for follow-up and monitoring. Although Dr. Liggett obtained a urinalysis indicating an abnormal urine glucose level, performed a physical exam, prescribed Glipizide, a glucometer and diabetic supplies, ordered a consult for diabetes and nutrition counseling, instructed the patient to check her blood sugar twice daily and record the results, and ordered a laboratory workup, which would be available the next morning, to confirm the patient’s elevated blood sugar, Dr. Liggett did not remember whether he obtained a fingerstick blood sugar test on the patient in his office.
**Luna, Sergio, M.D., Lic. #J7058, Austin TX**

On August 21, 2009, the Board and Dr. Luna entered into an agreed order requiring that he have a practice monitor for one year and that within one year he obtain 10 hours of continuing medical education in medical recordkeeping, 10 hours in child and adolescent psychiatry, and 10 hours in child and adolescent psychopharmacology. The action was based on Dr. Luna’s failure to meet the standard of care in the treatment of an eight-year-old boy with bipolar disorder to whom Dr. Luna prescribed multiple psychotropic drugs.

**Malone, Timothy F., D.O., Lic. #K1540, Dallas TX**

On May 29, 2009, the board and Dr. Malone entered into an agreed order of public reprimand suspending Dr. Malone’s licensing, staying the suspension, placing him on probation for 10 years and requiring the following: Dr. Malone may not delegate prescribing of Schedule II and III drugs to physician assistants or advanced practice nurses; he must surrender his DEA and DPS prescribing certificates for Schedule II and III drugs; he may not prescribe controlled substances until he receives authorization from the Board; he must have a female chaperone present when examining female patients; he must have a practice monitor for the first three years of the order; within one year he must take and pass the Texas Medical Jurisprudence Examination; within one year he must complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE); within one year he must complete the “maintaining proper boundaries” course offered by Santé Center for Healing; that he attend the 26th Annual Scientific Meeting of the American Academy of Cosmetic Surgery in Orlando, Florida, January 27-31, 2010; that within two years Dr. McGonagle obtain 20 hours of continuing medical education offered by Audio-Digest Foundation in wound care, infectious disease, and antibiotic therapy; and that he pay an administrative penalty of $2,000 within 180 days. The action was based on Dr. Malone’s responsibility for disorganized and incomplete medical records and his failure to update his physician profile as required.

**McGonagle, Martin, M.D., Lic. #G6563, Brownwood TX**

On August 21, 2009, the Board and Dr. McGonagle entered into a 2½ year mediated agreed order requiring his invasive cosmetic surgery practice be monitored; that within one year he complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; that within one year he complete the “maintaining proper boundaries” course offered by Santé Center for Healing; that he accept the 26th Annual Scientific Meeting of the American Academy of Cosmetic Surgery in Orlando, Florida, January 27-31, 2010; that within two years Dr. McGonagle obtain 20 hours of continuing medical education offered by Audio-Digest Foundation in wound care, infectious disease, and antibiotic therapy; and that he pay an administrative penalty of $2,000 within 180 days. The action was based on Dr. McGonagle’s failure to meet the standard of care in treatment of several patients who received cosmetic procedures, including lip implant, face lift, breast augmentation and blepharoplasty, as it related to the treatment of postoperative wound infections and the use of antibiotic therapy, and his entering into an inappropriate financial relationship with an employee.

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

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

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Morrill, Thomas, D.O., Lic. #H2620, Garland TX
On November 6, 2009, the Board and Dr. Morrill entered into an agreed order of public reprimand requiring the following: that within one year he complete a professional boundaries course; within one year he obtain 20 hours of continuing medical education, including 10 hours in medical recordkeeping and 10 hours in treatment and prescribing for chronic pain; and within 180 days he pay an administrative penalty of $10,000. The action was based on his providing frequent and inappropriately large doses of narcotics without proper documentation to a patient with whom he had a sexual relationship.

Muzza, Hugo, M.D., Lic. #D4239, San Antonio TX
On August 21, 2009, the Board and Dr. Muzza entered into an agreed order requiring that within one year Dr. Muzza obtain 12 hours of continuing medical education offered by the American Academy of Disability Evaluating Physicians that includes evaluating workers’ compensation cases and four hours CME in peripheral vs. radiculopathy workups. The action was based on Dr. Muzza’s failure to meet the standard of care regarding appropriate documentation, diagnoses, treatment plan, and medical advice for a patient for whom he ordered nerve conduction velocity studies, and his failure to document medical reasoning and rationale for the NCV testing.

Olive, Trevelyn J., M.D., Lic. #M1992, Arlington TX
On August 21, 2009, the Board and Dr. Olive entered into an agreed order requiring that within one year Dr. Olive obtain 10 hours of continuing medical education in medical recordkeeping; 10 hours CME in high-risk obstetrics; and 10 hours in gynecological and obstetrical emergencies. The action was based on Dr. Olive’s improper diagnosis of an ectopic pregnancy, her failure to document a pelvic examination, and her injecting Methotrexate into a patient whose later sonogram showed viable embryos, which the patient subsequently miscarried, in her uterus.

Parikh, Navinchandra C., M.D., Lic. #E1697, Grand Prairie TX
On August 21, 2009, the Board and Dr. Parikh entered into an agreed order of public reprimand requiring that he limit his practice to a group or institutional setting; that he have a practice monitor; that within seven days he eliminate from his DEA and DPS permits Schedule II prescribing; that within one year he take and pass the Special Purpose Examination (SPEX); and that within one year he take the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The action was based on Dr. Parikh’s failure to maintain even minimally adequate medical documentation, failure to adequately examine or document a patient who suffered a deep vein thrombosis; failure to perform any diligent steps regarding continuing management of Warfarin prescribed for the patient after he was diagnosed with a DVT and a pulmonary embolism, and nontherapeutically prescribing Vicodin.

Patel, Vikramkumar D., M.D., Lic. #G6987, Houston TX
On May 29, 2009, the board and Dr. Patel entered into an agreed order of public reprimand requiring that he have a practice monitor or, within two years, obtain recertification from the American Board of Obstetrics and Gynecology; that, within two years, he obtain 10 hours each of continuing medical education in medical recordkeeping and risk management; and that he pay an administrative penalty of $5,000 within 90 days. The action was based on Dr. Patel’s failure to properly manage the care and treatment of a patient on hormone replacement therapy who required a hysterectomy after developing endometrial adenocarcinoma.

Pickrell, Michael B., M.D., Lic. #H7807, Austin TX
On May 29, 2009, the board and Dr. Pickrell entered into a 15-year agreed order requiring that he abstain from consuming prohibited substances; participate in the board’s drug-testing program; submit to an independent medical examination by a psychiatrist; participate in AA; have a practice monitor; and, within one year, obtain 15 hours of continuing medical education in chronic pain. The action was based on Dr. Pickrell’s prescribing narcotics and other drugs to multiple patients without adequate documentation or laboratory work and on his abuse of alcohol, steroids and other drugs.

Rainey, Dennis C., M.D., Lic. #J3583, Beaumont TX
On May 29, 2009, the board and Dr. Rainey entered into an agreed order requiring that, within one year, he complete 10 hours of continuing medical education in the pharmacology of emergency medicine. The action was based on his failure to meet the standard of care by transferring a medically unstable patient to a psychiatric facility rather than have her monitored.

Raj, Jhansi M., M.D., Lic. #G3785, Fort Worth TX
On November 6, 2009, the Board and Dr. Raj entered into an agreed order requiring that within one year Dr. Raj obtain eight hours of continuing medical education in psychopharmacology and four hours in risk

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

**Chapter 162, Supervision of Medical School and Physician Assistant Students:** amendments to §162.1, Supervision of Medical School Students.

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

**Chapter 165, Medical Records:** amendments to §165.3, Patient Access to Diagnostic Imaging Studies in Physician’s Office.

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

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

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

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

**Chapter 173, Physician Profiles:** amendments to §173.1, relating to Profile Contents; and §173.4, relating to Updates to the Physician’s Profile Due to Board Action.

**Chapter 175, Fees, Penalties, and Forms:** amendments to §175.1, Application Fees; §175.2, Registration and Renewal Fees; §175.5, Payment of Fees or Penalties, increasing certain application and renewal fees, establishing fees for the approval of continuing acupuncture courses, and providing circumstances under which application and renewal fees may be refunded; and repeal of §175.4, relating to Application Form.

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

**Chapter 180, Physician Health Rehabilitation Program:** repeal of §180.1, Rehabilitation Orders; new §§180.1-180.7 establishing the Texas Physician Health Program for the purpose encouraging the wellness of licensees and applicants pursuant to the Medical Practice Act (“Act”), Tex. Occ. Code Ann. §§167.001-.011 (emergency adoption); amendments to proposed new rule §180.1, relating to Rehabilitation Orders; §180.2, relating to Definitions; §180.3, relating to Texas Physician Health Program; and proposed new rule §180.7, relating to Rehabilitation Orders; §180.4, Operation of Program (emergency adoption).

**Chapter 183, Acupuncture:** amendments to §183.14, Acudetox Specialists, removing duplicative language regarding fees for acudetox certification.

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

**Chapter 190, Disciplinary Guidelines:** amendments to §190.8(1)(L) relating to the prescribing of controlled substances/dangerous drugs for the partners of patients that have been diagnosed with sexually transmitted diseases; §190.2, relating to Board’s Role; and new rule §190.14, relating to Disciplinary Sanction Guidelines.

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

*continued on page 12*
management. The action was based on Dr. Raj’s failure to adequately monitor serum lithium levels or to obtain thyroid or renal function tests for a patient with bipolar and schizoaffective disorders.

**Restrepo, Margo K., M.D., Lic. #E2815, Houston TX**

On August 21, 2009, the Board and Dr. Restrepo entered a two-year agreed order requiring that, for each year of the order, she obtain 12 hours of continuing medical education in suicide risk management, and that within 60 days she pay an administrative penalty of $5,000. The action was based on Dr. Restrepo’s admitting and discharging a psychiatric patient without conducting a face-to-face evaluation, mental status examination, or risk assessment. The patient committed suicide within 24 hours of being discharged from the psychiatric unit at St. Joseph’s Medical Center.

**Salas, David S., M.D., Lic. #H6944, Paris TX**

On May 29, 2009, the board and Dr. Salas entered into an agreed order requiring that, within one year, he obtain at least four hours of continuing medical education in risk management and pay an administrative penalty of $1,000 within 60 days. The action was based on Dr. Salas’ prescribing an excessive dose of Bactrim-DS to an 11-year-old patient who suffered edema, conjunctival hemorrhage, rash, nausea and vomiting as a result of the excessive dose.

**Sands, Larry R., M.D., Lic. #G0884, Zapata TX**

On May 29, 2009, the board and Dr. Sands entered into an agreed order requiring that he complete five hours of continuing medical education in medical recordkeeping. The action was based on Dr. Sands’ failure to properly document informing an 82-year-old patient of the sedative effects of an injection and to determine whether the patient had someone to drive her home.

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

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

**Schmiege, Gustav R. Jr., M.D., Lic. #F5036, Pasadena TX**

On August 21, 2009, the Board and Dr. Schmiege entered into an agreed order requiring that Dr. Schmiege limit his practice to a group or institutional setting; that for one year he have a practice monitor; and that within one year he obtain 10 hours of continuing medical education in medical recordkeeping. The action was based on his failure to adequately document the basis of his diagnoses and justification for the use of the medications prescribed to two patients.

**Schnider, Geoffrey, M.D., Lic. #E8887, Houston TX**

On May 29, 2009, the board and Dr. Schnider entered into an agreed order of public reprimand. The action was based on Dr. Schnider’s performing a tubal ligation on a surgical patient, subsequent to emergency surgery for abdominal bleeding, without her informed consent.

**Sharp, Thomas L., D.O., Lic. #L2003, Greenville TX**

On August 21, 2009, the Board and Dr. Sharp entered into an agreed order requiring that within 90 days Dr. Sharp pay an administrative penalty of $1,000. The action was based on Dr. Sharp’s failure to adequately inform a patient’s family or other providers that a patient had been advised to transfer to another hospital or that the seriousness and risks of the situation had been explained to the patient, and his failure to accurately document the patient’s refusal to transfer with an appropriate “against medical advice” form.

**Singstad, Charles P., M.D., Lic. #K4251, San Antonio TX**

On August 21, 2009, the Board and Dr. Singstad entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in risk management and within 60 days he pay an administrative penalty of $500. The action was based on Dr. Singstad’s failure to adequately document a
discharge medication treatment plan and his failure to contact a patient's primary care physician and ensure agreement on a treatment plan to be followed upon the patient's transfer to a nursing home.

**Smith, George N., D.O., Lic. #E5251, West TX**

On May 29, 2009, the board and Dr. Smith entered into a two-year agreed order requiring that he complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; that he have a practice monitor for the duration of the order; that, within one year, he obtain 10 hours of continuing medical education in medical recordkeeping and 10 hours in addiction medicine; that he obtain 15 hours per year of CME in pain management; and prohibiting him from prescribing narcotic schedule II or III drugs except as provided in the order. The action was based on Dr. Smith's failure to meet the standard of care in prescribing IM morphine and Demerol to two chronic pain patients.

**Smith, Howard B., M.D., Lic. #J2341, Dallas TX**

On August 21, 2009, the Board and Dr. Smith entered into an agreed order requiring that within one year Dr. Smith take the medical recordkeeping and physician prescribing courses offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The action was based on Dr. Smith’s failure to properly follow up and document treatment of a patient with complaints of alcohol dependency, generalized anxiety disorder and Attention Deficit Hyperactivity Disorder whom he treated with Levitra, which is not consistent with FDA guidelines.

**Spencer, James B., M.D., Lic. #D4315, Jasper TX**

On August 21, 2009, the Board and Dr. Spencer entered into an agreed order requiring that within one year Dr. Spencer obtain 10 hours of continuing medical education in risk management and within 180 days he pay an administrative penalty of $2,000. The action was based on Dr. Spencer’s failure to diagnose a gangrenous gall bladder in a patient who presented to the emergency room.

**Sreshta, Dominic G., M.D., Lic. #L0617, Houston TX**

On August 21, 2009, the Board and Dr. Sreshta entered into an agreed order requiring that within one year Dr. Sreshta obtain 10 hours in each of continuing medical education in risk management and medical recordkeeping. The action was based on Dr. Shreshta’s improperly transferring a 94-year-old patient to a nursing home and inadequately documenting his reasons for doing so and communicating to the patient’s family.

**Standefer, John, M.D., Lic. #F2038, Dallas TX**

On August 21, 2009, the Board and Dr. Standefer entered into a three-year mediated agreed order of public reprimand requiring that Dr. Standefer have a practice monitor; that within one year he obtain 10 hours each of continuing medical education in medical recordkeeping, ethics, and physician-patient communications and, for each year of the order thereafter, 15 hours of ethics; that he comply with Chapter 192 of the board rule on office-based anesthesia; that he monitor his practice’s web site annually to assure it doesn’t contain false or misleading statements; that he document that he has explained procedures to patients; that he see each patient before surgery and receive written consent; that he indicate which surgeon will perform procedures; and that within 90 days he pay an administrative penalty of $20,000. The action was based on Dr. Standefer’s failure to see patients prior to cosmetic procedures; misleading advertising; failure to meet the standard of care in obtaining informed consent from cosmetic procedure patients; and his purchase and use of unapproved botox.

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

On November 6, 2009, the Board and Dr. Syed entered into a mediated agreed order requiring that within one year he complete the patient prescribing

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**Don't forget! Texas Law Requires Electronic Death Registration**

House Bill 1739 mandates electronic death registration for funeral homes and medical certifiers. Section 193.005 requires that medical certifiers on a death certificate submit the medical certification and attest to its validity using an electronic process.

To register, go to the Texas Department of State Health Services’ electronic death registry page at [www.texasvsu.org](http://www.texasvsu.org)
course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) and that he have a one-time practice monitor. The action was based on Dr. Syed’s failure to meet the standard of care in follow-up for a patient experiencing side effects from prescribed medication.

**Thakkar, Harish N., M.D., Lic. #K1096, Houston TX**

On June 29, 2009, the Board and Dr. Thakkar entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in the treatment of high-risk patients. The action was based on Dr. Thakkar’s failure to order appropriate diagnostic studies, to recognize the gravity of the patient’s condition, or to advise emergency room evaluation or hospital admission for a patient with respiratory symptoms who suffered a cardiopulmonary arrest and subsequently died.

**Taveau, H. Sprague IV., D.O., Lic. #J0696, Killeen TX**

On July 2, 2009, the Board and Dr. Taveau entered into an agreed order requiring that his practice be monitored; that he notify the board within 20 days if he is not seeing patients; that within one year he obtain 10 hours of continuing medical education in endocrinology; and that he pay an administrative penalty of $1,000 within 60 days. The action was based on his ordering extensive lab tests for a patient without discussing them with her; his pursuing secondary and tertiary testing before primary tests were done; and his prescribing medications such as thyroid and B12 that were not warranted.

**Tomaszek, David E., M.D., Lic. #K9191, Conroe TX**

On August 21, 2009, the Board and Dr. Tomaszek entered into an agreed order requiring that within one year Dr. Tomaszek obtain eight hours of continuing medical education and 16 hours in minimally invasive spine surgery; that within 180 days he pay an administrative penalty of $2,000. The action was based on Dr. Tomaszek’s failure to get an updated MRI and failure to document why he did not think it was necessary to get an updated MRI for a patient on whom he performed a cervical discectomy.

**Tressler, Samuel D. III, M.D., Lic. #E8978, San Antonio TX**

On May 29, 2009, the board and Dr. Tressler entered into an agreed order requiring that he pay an administrative penalty of $1,000 within 60 days. The action was based on Dr. Tressler’s failure to meet the standard of care in prescribing Auralgan for a 16-month-old patient with tympanostomy tubes (PE tubes), which is contraindicated for patients with PE tubes. The patient did not exhibit any adverse effects from the Auralgan.

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

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

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

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

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

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

**Williams, Embry W. III, M.D., Lic. #F4689, Richardson TX**

On August 21, 2009, the Board and Dr. Williams entered into an agreed order requiring that he have an independent psychiatric evaluation and that he pay an administrative penalty of $500 within 90 days. The action was based on Dr. Williams’ failure to respond to calls and pages from nursing and hospital staff when his patients needed his attention. In two instances, other physicians were required to deliver his patients’ babies.
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.

… “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.

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<th>Name</th>
<th>License No.</th>
<th>Date filed</th>
<th>Allegations</th>
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<tr>
<td>Robert Tate Angel, M.D.</td>
<td>C8881</td>
<td>8/25/09</td>
<td>Failure to meet the standard of care; nontherapeutic prescribing; failure to maintain adequate medical records; action by peers.</td>
</tr>
<tr>
<td>Manohar R. Angirekula, M.D.</td>
<td>L2101</td>
<td>8/18/09</td>
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<td>William H. Atkinson, M.D.</td>
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<td>Gary R. Burman, M.D.</td>
<td>J1204</td>
<td>5/29/09</td>
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<tr>
<td>Lauri B. Campagna, M.D.</td>
<td>J9993</td>
<td>9/1/09</td>
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<tr>
<td>Sheila F Calderon, M.D.</td>
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<tr>
<td>June Williams Colman, M.D.</td>
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<td>5/19/09</td>
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</tr>
<tr>
<td>Marshall James Dyke, M.D.</td>
<td>D1619</td>
<td>8/18/09</td>
<td>Failure to comply with a Board order.</td>
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<tr>
<td>Michael Scott Escobedo, M.D.</td>
<td>K0463</td>
<td>6/12/09</td>
<td>Misleading or deceptive advertising.</td>
</tr>
</tbody>
</table>
David A. Fairweather, M.D. ... L7373 .... 9/1/09 ...... Failure to properly respond to a patient's communications; failure to use professional diligence.

Jennifer Joanne Few, M.D. .. BP10023537 ..... 8/25/09 ...... Failure to respond to a board subpoena; providing false information to the board.

Olie Ray Garrison, D.O. .............. G5081 ...... 9/3/09 ...... Failure to meet the standard of care; failure to maintain adequate medical records.

Howard Grant, M.D. ................. F2265 ..... 9/19/09 ...... Inappropriate delegation; aiding and abetting the unlicensed practice of medicine; violation of board rule regarding pain treatment; failure to maintain adequate medical records; writing false or fictitious prescriptions; nontherapeutic prescribing.

Walter R. Hawkins, M.D. ............... D2684 ..... 8/21/09 ...... Failure to practice medicine in an acceptable professional manner; failure to maintain adequate medical records.

Robert D. Healing, M.D. .............. G2986 ..... 10/23/09 ...... Failure to meet the standard of care; negligence in performing medical service; failure to respond when on call.

Joel R. Hendricks, M.D. .......... G9596 ..... 7/30/09 ...... Failure to meet the standard of care.

Jose Luis Hinojosa, M.D. ............. H0450 ..... 12/3/09 ...... Failure to meet the standard of care; failure to maintain adequate medical records; failure to use diligence in medical practice; and non-therapeutic prescribing and/or treatment.

Donald G. Holmes, PA-C ............ PA02171 ... 10/7/09 ...... Default on THECB student loan; unprofessional conduct.

Paul Edward Jackson, M.D. .... Temporary .. 5/29/09 ...... Failure to meet the standard of care; providing unnecessary services; failure to maintain adequate medical records; improper prescribing.

Wayne C. Jones, M.D. ............... D6049 .... 9/27/09 ...... Unprofessional conduct; nontherapeutic prescribing; failure to maintain adequate medical records.

Sang Bai Joo, M.D. ................. E9252 ...... 7/7/09 ...... Dispensing drugs to a known abuser; nontherapeutic prescribing; failure to maintain adequate medical records; failure to meet the standard of care.

Mark H. Kett, PA-C ............... PA00431 ... 10/15/09 ...... Impairment; action by peers.

Naeem Ullah Khan, M.D. ............ L6235 ..... 5/13/09 ...... Failure to meet the standard of care; failure to obtain informed consent; nontherapeutic prescribing, dishonorable conduct.

Alan D. Koenigsberg, M.D. .... G7837 ...... 9/2/09 ...... Failure to cooperate with the board; failure to respond to board subpoenas.

Naila S. Malik, M.D. ................. L4552 ..... 5/6/09 ...... False, misleading or deceptive advertising.

Fernando Mallou, M.D. .............. D1711 ...... 5/14/09 ...... Conviction of felony sexual assault.

Joseph F. McWherter, M.D. ........ E8713 ..... 8/12/09 ..... Failure to meet the standard of care; failure to maintain adequate medical records; nontherapeutic prescribing.

Rahul K. Nath, M.D. ............... K4969 ..... 8/28/09 ..... Unprofessional conduct; improper billing; false or deceptive advertising; failure to maintain adequate medical records.

Long Phan Nguyen, M.D. .......... G7293 ..... 9/2/09 ..... Nontherapeutic prescribing; violation of board's guidelines for prescribing for pain; prescribing to a known abuser.

Anthony P. Nikko, M.D. .......... K5639 ..... 8/21/09 ..... Unprofessional conduct; improper billing.

Christopher E. Olson, M.D. ...... L2521 ..... 10/7/09 ..... Failure to meet the standard of care.

Cynthia B. Paulis, D.O. .......... J7622 ..... 8/12/09 ..... Failure to practice consistent with public health and welfare; nontherapeutic prescribing; failure to maintain adequate medical records; unprofessional conduct.

Raul Adrian Pena, M.D. .......... L0504 ..... 9/3/09 ..... False or misleading advertising.

John E. Perry III, M.D. .......... L1430 ..... 8/26/09 ..... Unprofessional conduct; failure to practice consistent with public health and welfare; failure to maintain adequate medical records; violation of board rule regarding treatment of pain; dispensing drugs to known abusers; writing false or fictitious prescriptions; nontherapeutic prescribing; improper billing; adequate supervision; improper delegation.

Greggory K. Phillips, M.D. ..... H6511 ..... 10-23-09 ..... Failure to meet the standard of care; nontherapeutic prescribing; failure to maintain adequate medical records.

Shirley P. Pigott, M.D. .......... F7054 ..... 5/8/09 ..... Impairment; unprofessional conduct; violation of a board order.

M. Atif Rahi, M.D. .......... K3411 ..... 8/13/09 ..... Unprofessional conduct; failure to practice consistent with public health and welfare; disciplinary action by peers.

Randy Ramahi, D.O. ............... J4462 ..... 8/25/09 ..... Impairment; intemperate use; failure to comply with a Board order; nontherapeutic prescribing.

Arnold Ravdel, M.D. .......... E8838 ..... 5/7/09 ..... Failure to timely respond when on-call; peer action; relinquishing privileges while under investigation.

William John Reeves Jr., M.D. .. D6523 ..... 7/16/09 ..... Dispensing drugs to a known abuser; nontherapeutic prescribing; failure to maintain adequate medical records; failure to meet the standard of care.
Lisa Carole Routh, M.D. ............... H2742 ...... 5/13/09 ....... Failure to meet the standard of care; unprofessional conduct; nontherapeutic prescribing.

Mouin F. Sabbagh, M.D. ............... J6229 ...... 8/31/09 ....... 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.

Shahrokh Safarimaryaki, M.D. ...... K7092 ...... 8/12/09 ...... Failure to meet the standard of care; nontherapeutic prescribing; failure to maintain adequate medical records.

Michael G. Sargent, M.D. ............... F7910 ...... 8/19/09 ...... 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.

Mohsin Mazhar Syed, M.D. .......... K2295 ...... 5/22/09 ...... Failure to meet the standard of care; providing medically unnecessary services; improper billing.

Naeem K. Tareen, M.D. ................. F9038 ...... 10-16-09 ...... Failure to pay child support.

Daniel C Voglewede, M.D. ........... G2504 ...... 10-22-09 ...... Failure to meet the standard of care; nontherapeutic prescribing.

Jennifer Andrea Weatherly, D.O. .. L3871 ...... 6/3/09 ...... Improper billing; providing unnecessary services.

Bill E. Weldon, D.O. ................. F4669 ...... 8/25/09 ...... Failure to comply with a Board order.

Michael D. Williams, D.O. .......... H2907 ...... 8/25/09 ...... Failure to comply with a Board order. ♦

Continued from page 17

**Williams, Lucia, M.D., Lic. #G9013, Jacksonville TX**

On August 21, 2009, the Board and Dr. Williams entered into a mediated agreed order requiring that within one year Dr. Williams obtain 16 hours of continuing medical education in operative laparoscopic surgery and that she pay an administrative penalty of $5,000 within 90 days. The action was based on Dr. Williams’ failure to meet the standard of care in the management of a surgical patient.

**Wills, Matthew J., M.D., Lic. #K8576, Topeka KS**

On August 21, 2009, the Board and Dr. Wills entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in medical errors. The action was based on Dr. Wills’ performing four wrong-site surgeries between 1999 and 2006.

**Wilson, Hugh H. Jr., M.D., Lic. #D6212, Lubbock TX**

On August 21, 2009, the Board and Dr. Wilson entered into an agreed order of public reprimand requiring that Dr. Wilson have a practice monitor for one year; that within one year he take and pass the Special Purpose Examination (SPEX); that within one year he obtain 20 hours of continuing medical education in the following areas: five hours in medical recordkeeping, five hours in risk management, five hours in general prescribing practices, and five hours in the diagnosis and evaluation of kidney diseases; and that within 90 days he pay an administrative penalty of $1,000. The action was based on Dr. Wilson’s failure to recognize acute renal failure and refer a patient to a nephrologist or admit the patient to the intensive care unit.

**Winton, Kenneth R., D.O., Lic. #H0955, Kermit TX**

On August 21, 2009, the Board and Dr. Winton entered into an agreed order requiring that for three years he have a practice monitor; that within one year he obtain 10 hours of continuing medical education...
in medical recordkeeping and 10 hours in emergency room medicine; and that within 60 days he pay an administrative penalty of $500. The action was based on Dr. Winton's failure to do adequate ER workups prior to discharging five patients; failure to correct a billing discrepancy for one patient; and failure to update his TMB physician profile.

Ybarra, Benjamin, D.O., Lic. #K3883, Mansfield TX
On March 2, 2009, the Board and Dr. Ybarra entered into a three-year agreed order requiring that he have a practice monitor, and that, within the first year of the order, he obtain eight hours of continuing medical education in medical recordkeeping and eight hours of CME in pain management. The action was based on Dr. Ybarra's failure to meet the standard of care for one patient by failing to fully and properly assess the patient's medical condition prior to initiating treatment; failing to adequately document prescriptions and the rationale for prescribing decisions in the patient's treatment; failing to thoroughly review relevant patient records during the course of the patient's treatment; and by continuing to prescribe high dose narcotics to the patient after the patient's hospitalization for an overdose.

Yueh, Hwai C., M.D., Lic. #J8175, Bedford TX
On August 21, 2009, the Board and Dr. Yueh entered into an agreed order requiring that within one year Dr. Yueh obtain 10 hours of continuing medical education in management of internal medicine emergencies and the course entitled “Annual High Risk Emergency Medicine” offered by the Center for Emergency Medicine Education. The action was based on Dr. Yueh's failure consult an emergency room patient's primary care physician to verify her baseline renal function, and on his discharging the patient although laboratory tests indicated a possible state of infection or stress.

Zegarrundo, Rolando, M.D., Lic. #E8244, Houston TX
On August 21, 2009, the Board and Dr. Zegarrundo entered into an agreed order of public reprimand requiring that within one year Dr. Zegarrundo take and pass the Texas Medical Jurisprudence Examination; that within one year he obtain 10 hours of continuing medical education in ethics; and that within 60 days he pay an administrative penalty of $5,000. The action was based on Dr. Zegarrundo’s failure to properly supervise physician assistants in a weight-loss clinic; his applying incorrect protocols in the treatment of patients in the clinic; and his inadequate documentation of the evaluation, treatment, and follow-up care provided to the patients.

UNPROFESSIONAL CONDUCT VIOLATIONS
Alvear, Joel, M.D., Lic. #L1514, Katy TX
On August 21, 2009, the Board and Dr. Alvear entered into a three-year mediated agreed order requiring that Dr. Alvear have a practice monitor; that within six months he complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and that he complete 50 hours of continuing medical education as follows: 10 hours in pain management for each of the three years of the order, and 10 hours in medical recordkeeping and 10 hour in ethics to be completed by the end of the second year of the order. The action was based on Dr. Alvear's having a sexual relationship with a subordinate in a clinic whom he had also seen as a patient, and on Dr. Alvear's lack of documentation and pain contracts in the treatment of multiple patients.

Benson, Royal H. III, M.D., Lic. #H0175, Bryan TX
On August 21, 2009, the Board and Dr. Benson entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in physician-patient relationships and within 180 days he pay an administrative penalty of $2,500. The action was based on Dr. Benson's verbal communications in a restaurant to a former patient in reaction to a complaint she filed; the comments appeared to be for the purpose of intimidation.

Blackwell, Michael, M.D., Lic. #J3695, Tomball TX
On May 29, 2009, the board and Dr. Blackwell entered into an agreed order requiring that he pay an administrative penalty of $1,000 within 90 days. The action was based on Dr. Blackwell's yelling at hospital staff in the presence of a patient, family members and staff when he was informed his scheduled surgical case would be delayed because of an emergency.

Bracamontes, Francisco I., M.D., Lic. #J5264, McAllen TX
On August 21, 2009, the Board and Dr. Bracamontes entered into an agreed order requiring that within one year Dr. Bracamontes successfully complete the anger management course at the Anger Management Institute of Texas and that within 90 days he pay an administrative penalty of $1,000. The action was based on Dr. Bracamontes' yelling and cursing at nurses and ICU staff after an incident in which he was not notified about a patient's deteriorating condition in a timely manner.

Campbell, Odette L., M.D., Lic. #H9609, Denton TX
On May 29, 2009, the board and Dr. Campbell entered into an agreed order requiring that, within 180 days,
she pay a $3,000 administrative penalty. The action was based on her failure to respond to a board subpoena and her violation of a 2007 agreed order.

Chase, C.C., M.D., Lic. #K5080, Corpus Christi TX
On November 6, 2009, the Board and Dr. Chase entered into an agreed order in which a $500 administrative penalty already paid to the board will be applied to the order. The action was based on his initial refusal to refund payment for an unused portion of a Meso-therapy package.

Chen, Eugene Y., M.D., Lic. #H4231, Las Vegas NV
On August 21, 2009, the Board and Dr. Chen entered into an agreed order requiring that within one year Dr. Chen obtain eight hours of continuing medical education in CPT coding. The action was based on Dr. Chen being found guilty of violation of the False Claims Act in U.S. District court for double-billing Medicare.

Chumak, Bogdan A., M.D., Lic. #H1053, La Grange TX
On April 3, 2009, the board and Dr. Chumak entered into an agreed order requiring that, within one year, he obtain 40 hours of continuing medical education, with at least eight hours each in the following areas: risk management, boundary violations, medical recordkeeping, and identifying drug-seeking behavior; and that he pay an administrative penalty of $2,500 within 90 days. The action was based on Dr. Chumak's prescribing large quantities of medications, including controlled substances, to a patient with whom he had a romantic relationship, and prescribing over-the-counter medications to her children.

Cochran, Phillip D., M.D., Lic. #L0092, Midland TX
On November 6, 2009, the Board and Dr. Cochran entered into a mediated agreed order of public reprimand requiring the following: that within two years he complete the Professional/Problem-Based Ethics (ProBE) course in physician ethics; within one year he take and pass the Texas Medical Jurisprudence Examination; and within one year he pay an administrative penalty of $1,000. The action was based on Dr. Cochran's providing prescriptions to a patient with whom he had a sexual relationship, and providing prescriptions to the patient's spouse, without documented medical justification.

Davenport, Donald, D.O., Lic. #L0118, Odessa TX
On November 6, 2009, the Board and Dr. Davenport entered into an agreed order requiring that within one year he obtain four hours of continuing medical education in medical recordkeeping. The action was based on Dr. Davenport's failure to properly document vital signs for a patient's post-operative visits after a Roux-en-Y gastric bypass; his failure to document blood work for a post-operative visit; and his failure to document the patient's noncompliance with an order for lab work.

Dunham, Jocelyn B., M.D., Lic. #J1979, Flower Mound TX
On November 6, 2009, the Board and Dr. Dunham entered into an agreed order requiring that within one year Dr. Dunham obtain 16 hours of continuing medical education, including eight hours in medical recordkeeping and eight hours in physician-patient communication. The action was based on Dr. Dunham's failure to properly communicate and discuss MRI results with a patient.

Dayian, Ara R., M.D., Lic. #K2443, Dallas TX
On November 6, 2009, the Board and Dr. Dayian entered into an agreed order requiring that within one year Dr. Dayian obtain 12 hours of continuing medical education, including eight hours in medical recordkeeping and four hours in ethics; and that within 90 days he pay an administrative penalty of $2,000. The action was based on his office inappropriately withholding medical and billing records from a patient because of an outstanding balance.

Echols, Ben H., M.D., Lic. #F6227, Houston TX
On November 6, 2009, the Board and Dr. Echols entered into an agreed order of public reprimand requiring that within one year he take and pass the Texas Medical Jurisprudence Examination and that within 90 days he pay an administrative penalty of $5,000. The action was based on Dr. Echols' allowing his staff to falsify records in order for a patient to continue to receive workers' compensation benefits.

Fenton, Barry, M.D., Lic. #G1005, Dallas TX
On August 21, 2009, the Board and Dr. Fenton entered into an agreed order of public reprimand requiring that within one year he complete the Vanderbilt University Medical Center for Professional Health's professional boundaries course; that he have a chaperone when treating female patients until he has completed the Vanderbilt course; and that within 180 days pay an administrative penalty of $5,000. The action was based on Dr. Fenton's having a personal romantic relationship with a psychiatric patient.

Gadasalli, Suresh N., M.D., Lic. #J5765, Odessa TX
On November 6, 2009, the Board and Dr. Gadasalli entered into an agreed order requiring the following: that within one year he take and pass the Texas Medical Jurisprudence Examination; within one year he...
obtain five hours of continuing medical education in medical ethics; and within 180 days he pay an administrative penalty of $10,000. The action was based on Dr. Gadasalli’s interpersonal communication difficulties with hospital staff and his inadequate maintenance of a patient’s medical record.

Gibson, Donald II, M.D., Lic. #H5209, Houston TX
On August 21, 2009, the Board and Dr. Gibson entered into an agreed order requiring that within one year Dr. Gibson take and pass the Texas Medical Jurisprudence Examination and within 90 days he pay an administrative penalty of $1,000. The action was based on Dr. Gibson’s writing prescriptions for Adderall, a controlled substance, for a family member in the absence of immediate need, without taking a history or physical and without creating or maintaining any medical records.

Halberdier, John E., M.D., Lic. #D9476, Conroe TX
On November 6, 2009, the Board and Dr. Halberdier entered into an agreed order of public reprimand prohibiting Dr. Halberdier from treating or dispensing drugs to his immediate family; requiring that within one year he complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) and within one year he complete the professional boundaries course offered by the PACE program; and that he obtain 10 hours of continuing medical education in medical ethics. The action was based on Dr. Halberdier’s failure to keep records for a patient with whom he developed a romantic relationship and eventually married; and when the couple became estranged he committed a third degree felony by violating a protective order related to family violence.

Holt, Janie E., M.D., Lic. #H7429, College Station TX
On May 29, 2009, the board and Dr. Holt entered into an agreed order requiring that, within one year, he complete 100 hours of community service with one or more nonprofit charitable organizations. The action was based on Dr. Holt’s failure to provide medical records to four patients in a timely manner after the closing of her practice and her failure to report her address change to the board in 30 days as required by law.

House, Janelle K., D.O., Lic. #K9083, Rockdale TX
On August 21, 2009, the Board and Dr. House entered into an agreed order requiring that within one year she obtain 15 hours of continuing medical education, including at least 12 hours in prescribing for pain and three hours of ethics. The action was based on Dr. House’s failure to recognize drug-seeking behavior in a patient.

Kilianski, Joseph R., M.D., Lic. #H4463, Keller TX
On May 29, 2009, the board and Dr. Kilianski entered into an agreed order prohibiting him from authorizing ultrasound exams without a physician’s order; mandating that he comply with state and federal laws regarding ultrasounds; and imposing an administrative penalty of $2,000 to be paid within 90 days. The action was based on Dr. Kilianski’s allowing staff at a prenatal obstetric ultrasound center to perform ultrasounds on five patients without a physician’s order, in violation of federal and state regulations.

Lane, Randall B., M.D., Lic. #E2667, Dallas TX
On November 6, 2009, the Board and Dr. Lane entered into an agreed order requiring that within one year he obtain 25 hours of continuing medical education as follows: 10 hours of medical recordkeeping, 10 hours of CPT coding, and five hours of ethics; and that he pay an administrative penalty of $5,000 in a series of payments to be completed by April 15, 2010. The action was based on Dr. Lane’s inadequate medical records and incorrect CPT coding for four patients.

Majczenko, Tricia, M.D., Lic. #BP10031893, El Paso TX
On November 6, 2009, the Board and Dr. Majczenko entered into an agreed order of public reprimand. The action was based on Dr. Majczenko’s submitting forged and falsified documents for her physician-in-training permit.

Maxwell, Rebecca H., M.D., Lic. #L6519, Houston TX
On November 6, 2009, the Board and Dr. Maxwell entered into a mediated agreed order of public reprimand requiring that within one year she submit documentation of her already having completed the course in maintaining professional boundaries at the Vanderbilt University Center for Professional Health and that she continue care and treatment from her current psychiatrist. The action was based on Dr. Maxwell’s having a personal relationship with a patient for whom she continued to prescribe medications, and attempting to conceal the relationship, for which she pled no contest to a Class A Misdemeanor and received deferred adjudication.

McDonald, Deward D., M.D., Lic. #C5174, Longview TX
On May 29, 2009, the board and Dr. McDonald entered into an agreed order of public reprimand requiring that, within one year, Dr. McDonald obtain five hours each of continuing medical education in ethics and boundary violations; and that he pay an administrative penalty of $1,000 within 90 days. The action
was based on Dr. McDonald’s having an inappropriate sexual relationship with a patient on whom he performed a breast biopsy.

**Messer, Dale L., M.D., Lic. #D2740, Alvin TX**

On May 29, 2009, the board and Dr. Messer entered into an agreed order requiring that he complete the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The action was based on Dr. Messer’s making an inappropriately inappropriate remark to a patient.

**Pearce, Jay, D.O., Lic. #H4608, Fulton TX**

On May 29, 2009, the board and Dr. Pearce entered into an agreed order requiring that, within one year, he take and pass the Texas Medical Jurisprudence Examination. The action was based on Dr. Pearce’s inappropriate behavior toward a hospital staff member.

**Rappe, Brian D., D.O., Lic. #J4981, Carlsbad TX**

On August 21, 2009, the Board and Dr. Rappe entered into a five-year agreed order of public reprimand, suspending his license, staying the suspension and placing him on probation for five years under the following terms and conditions: within 90 days he undergo an independent psychiatric exam; within one year he take and pass the Texas Medical Jurisprudence Examination; that he have a practice monitor; and that he not treat or prescribe to members of his family. The action was based on Dr. Rappe’s failure to properly notify patients of closing his practice; failure to undergo a psychiatric evaluation requested by the board, and failure to appear at hearings requested by the board.

**Saran, Nisha M., D.O., Lic. #L5894, Arlington TX**

On May 29, 2009, the board and Dr. Saran entered into an agreed order of public reprimand. The action was based on suspension of her DEA certificate because of its unauthorized use by a member of her family.

**Scaff, Bruce E., M.D., Lic. #G0065, Athens TX**

On August 21, 2009, the Board and Dr. Scaff entered into an agreed order requiring that within 60 days he obtain a physician-in-training permit.

**Shah, Zille H., M.D., Lic. #BP10022448, Irving TX**

On August 21, 2009, the Board and Dr. Shah entered into an agreed order requiring that within 90 days Dr. Shah pay an administrative penalty of $3,000. The action was based on Dr. Shah’s striking his hand on a toddler’s forehead when the child was flailing during an exam. The patient was not harmed.

**Smith, Barlow, M.D., Lic. #F9026, Marble Falls TX**

On June 29, 2009, the Board and Dr. Smith entered into an agreed order of public reprimand requiring that, within one year, he complete the University of California San Diego Physician Assessment and Clinical Education (PACE) program or the Vanderbilt Center for Professional Health and that he pay an administrative penalty of $2,500 within 90 days. The action was based on Dr. Smith’s repeated sexual contact with a psychiatric patient who had a history of being sexually abused, and on his telling his fiancée, who called the patient and insulted her.

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

On November 6, 2009, the Board and Dr. Taube entered into an agreed order of public reprimand requiring that she complete 10 hours of continuing medical education in ethics and that she pay an administrative penalty of $2,500 within 90 days. The action was based on Dr. Taube’s allowing an unlicensed person to use her medical license wall certificate to order, prescribe, dispense and sell herbal supplements that were acquired with Dr. Taube’s Texas medical license.

**Warren, Kelly J., M.D., Lic. #K8565, Dallas TX**

On August 21, 2009, the Board and Dr. Warren entered into an agreed order requiring Dr. Warren to pay an administrative penalty of $8,000 within 45 days. The action was based on Dr. Warren’s failure to respond to a board subpoena for records.

**Young, James R., M.D., Lic. #K4616, Nacogdoches TX**

On May 29, 2009, the board and Dr. Young entered into a mediated agreed order of public reprimand requiring that he pay an administrative penalty of $5,000 within 30 days. The action was based on his abusive behavior toward other physicians and staff during an effort to stabilize a post-operative patient at Nacogdoches Memorial Hospital and the suspension of his privileges from that hospital.

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

On November 6, 2009, the Board and Dr. Zamora-Quezada entered into a two-year agreed order of public reprimand requiring that his practice be monitored; that within 90 days he have an independent audit of his billing practices; that within one year he obtain 10 hours each of continuing medical education in medical recordkeeping, ethics and appropriate billing and coding; and that within one year he pay an adminis-
New Physician Licenses Issued, June-November 2009

The Texas Medical Board issued or reissued licenses to 2,065 physicians between May 28 and November 6, 2009. The board congratulates the following new Texas licensed physicians:

Abanto, Pedro Ruben, MD * Abay, Demsas G.Hawariat, MD * Abboud, Lucien Naji, MD * Abbud-Mendez, Cesar Alejandro, MD * Abduri, Madhava S, MD * Abiodun, Oluyotayin Arike, MD * Abo-Auda, Waal Saleem Mustafa, MD * Abou Haidar, Ziad Emil, MD * Abraham, Asha, DO * Abramsky, Mitchel Jay, MD * Achor, Timothy Stuart, MD * Acosta, Indrani Enid, MD * Addeji, Adekunle Adedayo, MD * Adejana, Adegbeyega Ibukunolu, MD * Adelman, David Matthew, MD * Adeniyi, Muniur Olakunle, MD * Aderinboye, Omolara Violet, MD * Adesanya, Olubukunola, MD * Adkins, Samantha Rae, MD * Afshar, Sam, MD * Agha, Syed Abbas, MD * Agloria, Malika, MD * Agmon, Emelike Uchechi, MD * Agrawal, Deepak, MD * Agwu, Ngozi Chinyere, MD * Agyeman, Kwanze Boakye, MD * Akuwujie, Raj, MD * Ahmad, Kaashif, MD * Ahmad, Umad, MD * Ahmad, Sobia, MD * Ahmed, Ammar, MD * Ahmed, Nage Hassan, MD * Ahmed, Meer Rafiuddin, MD * Ahmed, Mubbasheer, MD * Ahsan, Syed Kamran, MD * Ahuero, Jason Samuel, MD * Ahuja, Naresh Kumar, MD * Aidinian, Gilbert, MD * Akhilgir, Mohsen, MD * Akin, Laura Desporte, MD * Akiyemi, Emmanuel Olusesan, MD * Akintoye, Adenike Esther, MD * Akman, Cigdem Inan, MD * Akram, Muhammad, MD * Alam, Ehsan, MD * Al-Bataineh, Mohammad Ali Abdullah, MD * Alejandro, Karla C, MD * Ali, Zahra Karam, MD * Ali, Osman Mohammed, MD * Ali, Haris, MD * Ali, Abbas Khider, MD * Ali, Malik Mohnis, DO * Ali, Deeba Nohi, MD * Aliu, Valarie Adesuwa, MD * Al-Kali, Abir, MD * Al-Khoury, Georgies Elie, MD * Allen, Lisa Leanne, MD * Alley, Joshua Benjamin, MD * Allison, Nanette, DO * Allocco, Frances, MD * Almeda, Jose Luis, MD * Almeida, Francisco Aecio Guedes, Jr, MD * Almusaddi, Moussab, MD * Aloba, Maria Chona Briones, MD * Alonso, Wilfred Jerome, MD * Al-Rajaiah, Jaafar Mo’azz M D’aisee, MD * Alurkar, Ajey Shashikant, MD * Alvarez, Karen Alexander, DO * Alvarez, Allen Albert, MD * Alves, Patrice, MD * Alves, Tahira Palmer, MD * Amauiz, Nneka S, MD * Ama, Sheila Madhavi, MD * Amaya Hellman, Diana Stella, MD * Ambaw, Samson M, MD * Ambay, Raj S, MD * Ambay, Aparna R., MD * Amiel, Gilad Eliyahu, MD * Ammar, Neal, MD * Ammar, Sherif, MD * Amoro, Florence Bosibori, MD * Anaya, Candido Javier, MD * Anaya, Carlos, MD * Anderson, Devry Calvin, MD * Anderson, C Erik, MD * Anderson, Kyle Preston, MD * Anderson, Christine Marcelletta, MD * Anderson, April Lauren, MD * Angier, Greggory Nabil, MD * Annam, Aparna, DO * Ansari, Safdar Abbas, MD * Ansari, Mary Mahalakshmi, MD * Anthony, Kerri M’do Taiseer, MD * Ara, Mary Margaret, MD * Arain, Faisal Akhtar, MD * Archibong, Emma Virginia, MD * Archie, Patrick Hinton, MD * Argumedo, Steven, MD * Aristizabal-Oritz, Andres, MD * Arizaca Dileo, Patricia Karina, MD * Armstrong, Christopher Steven, MD * Arnaout, Diane, MD * Arnold, Haydn L, III, MD * Aronson, Andrew A, MD * Aronson, Daniel Job, MD * Arreaza Graterol, Maria Margarita, MD * Arrieta, Omar Steven, MD * Arshad, Syed Talal, MD * Arshad, Muhammad, MD * Arya, Basant, MD * Aryangat, Ajikumar V, MD * Arze, Annelise Ximena, MD * Asghar, Sheba, MD * Ashley, William Wallace, Jr, MD * Ashton, Daniel Joshua, MD * Asis, Antonio, MD * Aslam, Nadeem, MD * Asoma, Kichionmon, MD * Auler, Mark Alfred, MD * Awab, Ahmed, MD * Ayala, Natalie, MD * Ayala Garcia, Lilliam Enid, MD * Ayanbule, Funmi, MD * Ayoub, Joseph Samy, MD * Azam, Raheen, MD * Aziz, Khadija, MD * Aziz, Fatima, MD * Bachmann, Justin Matthew, MD * Backardjiey, George, MD * Badawy, Mohamed Karim, MD * Badi, Anurkumar Narayansy, MD * Bagree, Ameena, MD * Bain, Harris Rehan, MD * Baijal, Rahul Geetendra, MD * Baird, Christopher Wallace, MD * Bakdaleiy, Yahya, MD * Baker, Jagwiana Samia, MD * Balakrishnan, Preetha Lakshmi, MD * Balay, Kimberly Sierra, MD * Balch, Glen Charles, MD * Balker, Shemsu Detamo, MD * Ball, Valdesha Lechante’, MD * Ballard, Luke Justin, MD * Ballard, Geneva Randall, MD * Ball-Brummett, Debra Anne, MD * Ballestas, Carlos Enrique, MD * Ballestas, Carmen Sofia, MD * Ballesteros, Alfonso Guadalupe, MD * Ban, Kathryn Elizabeth, MD * Bandela, Srikantan, MD * Banerjee, Kakoli, MD * Banerjee, Suman Kumar, MD * Banki, Farzaneh, MD * Banks, Kristine Elizabeth, MD * Bansal, Kanti Lal, MD * Bansal, Mohit, MD * Bansal, Mohit, MD * Bareket, Henry Zvi, MD * Barker, Emily Chism, MD * Barker, Gregory Mark, MD * Barker, Colin Macleod, MD * Barko, Holly Ann, MD * Barr, Jeffrey Vincent, MD * Barrera, Tres Aaron, MD * Barrera, Jose Enrique, MD * Barrow, Bridget Ann, MD * Bart, Charisse, MD * Barton, Amy Leigh, MD * Baskaran, Visveshwara, MD * Bassett, Aaron Kyle, DO * Bassham, Brian Scott, MD * Baston, Robert Kirk, MD * Batchu, Vishalakshmi, MD * Batra, Dipesh, MD * Battiste, James Douglas, MD * Bauer, Brent J, MD * Baugh, Andrew Clawson, MD * Baum, Lawrence Owen, III, MD * Bava, Eric David, MD * Beadie, Sarah May, MD * Beals, Chandra Nicole, MD * Bear, Russell Robertson, DO * Beardwood, Gordon Alan, MD * Beaucharg, Brandy Lashay, MD * Beaver, Richard Leigh, MD * Bechert, Charles, MD * Becker, Mark Oliver, MD * Beijiani, Sandhya, MD * Bellantoni, Christine, MD * Bellera, Ricardo V., MD * Benavides, David Rene, MD * Bentley, Karl C., MD * Berens, Bruce Melvin, MD * Bergbauer, Robin, MD * Berger, Mark William, MD * Bergin, Colleen Joan, MD * Berios, Ioannis, DO * Berkey, Bryan Douglas, MD * Berlin, Alexander Leon, MD * Berliner, Jeffrey Craig, DO * Berlingeris Ramos, Alma Criseida, MD * Berman, Blake Morris, MD * Bernardi, Ronald John, MD * Bernstein, Linda Melanie, MD * Berro, Joseph Benjamin, MD * Berry, Laura Mcrea, MD * Best, Sara Lynn, MD * Betanco, Jorge Antonio, MD * Bhadirajraj, Padmini, MD * Bhakta, Neeta Soorya, MD * Bhardwaj, Jatin, MD * Bhati, Gurdip Singh, MD * Bhati, Leah Shawn, MD * Bhati, Amol Madhav, MD * Bhatt, Nayan Kumar, MD * Bhattacharjee, Sagorika, MD * Bhattacharjee, Suman Kumar, MD * Bheda, Rahul Geetendra, MD * Bhella, Paul Singh, MD * Bhoda, Raja Sekhar Reddy, MD * Bhongir, Rahul, MD * Bhullar, Parampal Singh, MD * Bias, Travis Gaujot, DO * Bidyasar, Savita, MD * Biggers, Jason Scott, MD * Bigos, Stanley James, MD * Bilah, Shahreen, MD * Birnbaum, Lee Albert, MD * Birt, Bradley Blair, MD * Bischoff, Carl Julius, MD * Blackmwlker, John Timothy, MD * Blackwell, Sean Cyle, MD * Blaylock, Heather Dell, MD * Bleivins, John Ray, MD * Blonsky, Jeffery J, MD * Blount, Benroe Wayne, MD * Blum, Jared Julius, MD * Blum Mariduen, Mariela Anabel, MD * Boggaram, Bhagyalakshmi Gopal, MD * Bohn, Andrew Paul, MD * Boling, Christy Linnette, MD * Bolz, Angela Dene, DO * Bond, Ninetta Marie, MD * Boon, John Reynolds, MD *
On November 6, 2009, the Board and Dr. Zuzukin entered into an agreed order requiring that within one year he complete the anger management course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE); and that within 60 days he pay an administrative penalty of $2,500. The action was based on Dr. Zuzukin's unprofessional behavior towards hospital staff.
NONThERAPEUTIC PRESCRIBING VIOLATIONS

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

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

Avila, Fernando T., M.D., Lic. #G2899, San Antonio TX

On August 21, 2009, the Board and Dr. Avila entered into an agreed order requiring that within two years he obtain 20 hours of continuing medical education in pain management and that within one year Dr. Avila complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The action was based on Dr. Avila's nontherapeutic prescribing of pain medications and other drugs to two patients and his failure to properly document his prescribing.

Burgin, William W. Jr., M.D., Lic. #E1998, Corpus Christi TX

On August 21, 2009, the Board and Dr. Burgin entered into an agreed order requiring that within one year he obtain 20 hours of continuing medical education in pain management; five hours in physician/patient relationships; and five hours in risk management; and that within 60 days he pay an administrative penalty of $2,000. The action was based on Dr. Burgin's inappropriate prescribing practices with patients with whom he had personal relationships.

Burleson, James D., M.D., Lic. #H1932, Gatesville TX

On August 21, 2009, the Board and Dr. Burleson entered into a five-year agreed order of public reprimand requiring that he limit his practice to a group or institutional setting; that he eliminate Schedule II and III drugs from his DEA and DPS controlled substance registrations; that he have a practice monitor for the term of the order; that within one year he take and pass the Special Purpose Examination (SPEX) and the Texas Medical Jurisprudence Examination; and for each of the five years he obtain 10 hours of continuing medical education in pain management and 10 hours in medical recordkeeping. The action was based on Dr. Burleson's prescribing high doses of narcotics to 17 patients without adequate documentation; prescribing high doses of methadone in violation of FDA restrictions; and other documentation and prescribing issues for multiple patients.

Emeju, Herbert M., M.D., Lic. #E4320, Port Arthur TX

On May 29, 2009, the board and Dr. Emeju entered into a three-year agreed order requiring that his practice be monitored; that, within one year and for each year of the order he obtain 20 hours of continuing medical education in pain management and 10 hours in medical recordkeeping; and within one year take and complete the medical recordkeeping 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. Emeju's poor recordkeeping and prescribing practices.

Harris, Sabrina D., M.D., Lic. #J2057, San Antonio TX

On August 21, 2009, the Board and Dr. Harris entered into an agreed order requiring that within one year she take and pass the Texas Medical Jurisprudence Examination; that within one year she obtain 10 hours of continuing medical education in risk management, five hours of CME in physician-patient relationships, and five hours of CME in ethics. The action was based on nontherapeutically prescribing to patients of a weight-loss clinic and failing to respond to initial board subpoenas and requests for documents.

King, Charles F., M.D., Lic. #K6628, Commerce TX

On May 29, 2009, the board and Dr. King entered into a three-year agreed order requiring that his practice be monitored and that, within one year, he take and complete the physician prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The action was based on his nontherapeutically prescribing Xanax and Soma to one patient.

Lugo-Miro, Victor I., M.D., Lic. #H6890, Kingwood TX

On August 21, 2009, the Board and Dr. Lugo-Miro entered into an agreed order requiring that within one year he obtain 30 hours of continuing medical education, including 10 hours in medical recordkeeping and 20 hours in chronic pain and pain management. The action was based on Dr. Lugo-Miro's failure to properly evaluate, diagnose, and treat a patient for a chronic pain condition.

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

On November 6, 2009, the Board and Dr. O'Neill entered into an agreed order prohibiting him from prescribing Schedule II, III, IV and V drugs and prohibiting him from accepting new patients. The action continued on page 32
was based on Dr. O’Neill’s inappropriately prescribing weight-loss and anti-anxiety drugs to one patient.

Polasek, Jerry W., M.D., Lic. #M5885, Houston TX
On August 21, 2009, the Board and Dr. Polasek entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in risk management and 10 hours in endocrinology. The action was based on Dr. Polasek’s prescribing potentially dangerous medications to five weight-loss patients.

Roy, Lisa Marie, M.D., Lic. #M0892, San Angelo TX
On August 21, 2009, the Board and Dr. Roy entered into an agreed order requiring that within one year Dr. Roy take and pass the Texas Medical Jurisprudence Examination and that within one year she obtain 10 hours of continuing medical education in medical recordkeeping and 10 hours of CME in common psychiatric conditions. The action was based on Dr. Roy’s failure to properly treat, prescribe to, and document her treatment and prescribing to a patient who was also a friend.

Simmons, Donald R., M.D., Lic. #L2010, Linden TX
On August 21, 2009, the Board and Dr. Simmons entered into an agreed order requiring that he have a practice monitor for two years; that within one year he obtain 10 hours of continuing medical education in medical recordkeeping and 15 hours in prescribing for and treating chronic pain. The action was based on Dr. Simmons’ prescribing methadone, baclofen, Klonopin and other medications to a patient who previously had been hospitalized for overdoses.

Soumahoro, Zainab H., M.D., Lic. #M2231, Humble TX
On August 21, 2009, the Board and Dr. Soumahoro entered into an agreed order requiring that within one year Dr. Soumahoro take and pass the Texas Medical Jurisprudence Examination and within one year she obtain five hours of continuing medical education in ethics. The action was based on her prescribing non-therapeutically to four patients in a weight-loss clinic.

Su, Alex Min-Chang, M.D., Lic. #K7912, Houston TX
On November 6, 2009, the Board and Dr. Su entered into a two-year agreed order requiring that Dr. Su have a practice monitor and that within six months he obtain 10 hours of continuing medical education in medical recordkeeping and 15 hours in prescribing for and treating chronic pain. The action was based on Dr. Su’s prescribing methadone, baclofen, Klonopin and other medications to a patient who previously had been hospitalized for overdoses.

Ybarra, Benjamin, D.O., Lic. #K3883, Mansfield TX
On August 21, 2009, the Board and Dr. Ybarra entered into an agreed order of public reprimand requiring that within 180 days Dr. Ybarra pay an administrative penalty of $5,000. The action was based on Dr. Ybarra’s prescribing multiple opioid to a family member without performing necessary physical examinations, documenting a medical history or maintaining contemporaneous medical records.

INADEQUATE MEDICAL RECORDS

Acosta, Carlos, M.D., Lic. #F3681, Arlington TX
On November 6, 2009, the Board and Dr. Acosta entered into an agreed order requiring that he obtain 10 hours of continuing medical education in medical recordkeeping within one year and pay an administrative penalty of $1,000 within 90 days. The action was based on Dr. Acosta’s failure to maintain medical records showing proper indications for two spinal surgeries on one patient.

Bertino, Michael, M.D., Lic. #D4928, San Antonio TX
On August 21, 2009, the Board and Dr. Bertino entered into a two-year mediated agreed order requiring that Dr. Bertino have a practice monitor and that within six months he obtain 10 hours of continuing medical education in medical recordkeeping. The action was based on Dr. Bertino’s failure to adequately document an appropriate indication for sinus surgery before performing invasive procedures on multiple pediatric patients, and his records did not adequately document the patients’ medical histories or whether an appropriate trial of maximal medical therapy, evaluation or antibiotic therapy was first conducted to resolve the patients’ symptoms before proceeding to surgery.

Caruth, Jeffrey, M.D., Lic. #H6102, Plano TX
On November 6, 2009, the Board and Dr. Caruth entered into an agreed order requiring that he pay an administrative penalty of $1,000 within 90 days. The action was based on Dr. Caruth’s failure to adequately document physical examinations prior to surgery and/or specific medications that were prescribed for weight-loss management for eight patients. None of the patients experienced any complications.

Caterbone, Philip W., D.O., Lic. #J9995, Pflugerville TX
On November 6, 2009, the Board and Dr. Caterbone entered into an agreed order requiring that he pay an administrative penalty of $1,000 within 60 days. The action was based on his failure to properly document one patient’s visit.
On August 21, 2009, the Board and Dr. Khan entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in medical recordkeeping. The action was based on Dr. Ferguson’s failure to properly document his diagnosis of constipation for a patient who presented to the hospital with lower back and groin pain.

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

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

**Fontanier, Charles E., D.O., Lic. #F3960, Houston TX**

On August 21, 2009, the Board and Dr. Fontanier entered into an agreed order requiring that within one year Dr. Fontanier obtain 10 hours of continuing medical education in medical recordkeeping and that within 180 days he submit a plan indicating how he intends to improve coordination of care methods, including methods of external and internal communication, including how he will communicate his assessments, treatment plans, and concerns with his colleagues who are also involved in the care of his patients. The action was based on Dr. Fontanier’s medical records that failed to provide a clear and coherent overview of the care provided to a patient from multiple providers and that failed to clearly indicate whether medications were filled or changed by Dr. Fontanier or other providers.

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

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

**Horndeski, Gary M.D., Lic. #G2390, Sugar Land TX**

On May 29, 2009, the board and Dr. Horndeski entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in medical recordkeeping and that he pay an administrative penalty of $2,000 within 90 days. The action was based on Dr. Horndeski’s failure to properly document a patient assessment and physical examination, patient expectations for surgery, an operative plan for initial surgery and for a revision, and, for the revision, a reason for the change in the proposed procedure on the day of the surgery, for a liposuction patient.

**Khan, Zohra R., M.D., Lic. #H0074, Euless TX**

On August 21, 2009, the Board and Dr. Khan entered into an agreed order requiring that within one year she obtain eight hours of continuing medical education in medical recordkeeping. The action was based on Dr. Khan’s failure to properly document care and treatment of nine psychiatric patients.

**Louis, Edward E., M.D., Lic. #D0953, Dickinson TX**

On May 29, 2009, the board and Dr. Louis entered into an order requiring that he have a practice monitor for two years. The action was based on concerns over documentation of five patients’ charts that led to a temporary restriction on Dr. Louis’ practice in June, 2008.

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

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

**Phipps, Wendy D., M.D., Lic. #L4648, El Paso TX**

On August 21, 2009, the Board and Dr. Phipps entered into an agreed order requiring that within one year she obtain five hours of continuing medical education in medical recordkeeping. The action was based on Dr. Phipps’ failure to properly document and communicate lab results to a patient.

**Roach, Dee A., M. D., Lic. #G5542, Colorado City TX**

On May 29, 2009, the board and Dr. Roach entered into an agreed order requiring that, within one year, he take and complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The action was based on Dr. Roach’s failure to maintain adequate medical records on one patient.

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

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

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

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

Schmidt, Rebecca S., M.D., Lic. #K2118
On August 21, 2009, the Board and Dr. Schmidt entered into an agreed order requiring that within 90 days Dr. Schmidt pay an administrative penalty of $500. The action was based on Dr. Schmidt’s failure to properly document the treatment of a patient receiving Mesotherapy, a fat reduction technique.

Serna, Samuel, M.D., Lic. #M0562, Edinburg TX
On August 21, 2009, the Board and Dr. Serna entered into an agreed order requiring that within one year Dr. Serna obtain eight hours of continuing medical education in medical recordkeeping. The action was based on Dr. Serna’s prescribing thyroid medication to a colleague without keeping any prescription or any other medical records.

Shah, Pankaj K., M.D., Lic. #H9712, Houston TX
On August 21, 2009, the Board and Dr. Shah entered into an agreed order requiring that Dr. Shah obtain 30 hours of continuing medical education in each of the following areas: 10 hours in medical recordkeeping; 10 hours of ethics; and 10 hours of physician-patient communication. The action was based on Dr. Shah’s poor records and poor communications relating to scheduling pre-operative tests for a patient on whom elective surgery was performed prior to some of the tests and without Dr. Shah’s clearance for the surgery.

Sirinek, Kenneth R., M.D., Lic. #F5377, San Antonio TX
On August 21, 2009, the Board and Dr. Sirinek entered into an agreed order requiring that within 90 days Dr. Sirinek pay an administrative penalty of $1,000. The action was based on Dr. Sirinek’s writing prescriptions for Vicodin and Darvocet for a family member who suffered from migraine headaches without maintaining any documentation.

Smith, Theodore D., D.O., Lic. #L1465, Austin TX
On May 29, 2009, the board and Dr. Smith entered into an agreed order requiring that, within one year, he complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program and pay an administrative penalty of $1,000 within 90 days. The action was based on Dr. Smith’s failure to properly document his clinical testing and evaluation to show justification for his diagnostic conclusions and recommended treatment for two patients in his neurology practice.

Walker, McDonald H., M.D., Lic. #F7658, Plano TX
On May 29, 2009, the board and Dr. Walker entered into an agreed order requiring that, within one year, he complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program and pay an administrative penalty of $2,000 within 90 days. The action was based on Dr. Walker’s failure to adequately document the medical record of a three-year-old emergency room patient with regard to the wound, the prescribed antibiotics, his observations of the patient, and complete discharge instructions for a possible snakebite.

Webster, A. Ross, M.D., Lic. #F1301, Houston TX
On August 21, 2009, the Board and Dr. Webster entered into an agreed order requiring that within one year Dr. Webster obtain 10 hours of continuing medical education in medical recordkeeping and within 90 days pay an administrative penalty of $1,000. The
action was based on Dr. Webster's illegible medical records for a patient who had undergone a hemorrhoidectomy and his inadequate documentation regarding effective communication with the patient.

**Weeks, David, M.D., Lic. #L4165, Austin TX**
On August 21, 2009, the Board and Dr. Weeks entered into an agreed order requiring that within one year he complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The action was based on Dr. Weeks’ failure to document justifications for tests he provided.

**Wong, Ronald E., M.D., Lic. #J5950, San Antonio TX**
On August 21, 2009, the Board and Dr. Wong entered into an agreed order requiring that within one year he complete 10 hours of continuing medical education in medical recordkeeping. The action was based on medical record documentation that was illegible and incomplete for a patient he treated in the emergency room.

**Yudovich, Martin, M.D., Lic. #E3806, Houston TX**
On August 21, 2009, the Board and Dr. Yudovich entered into a two-year agreed order of public reprimand requiring that Dr. Yudovich’s practice be monitored; that within one year he take the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and that for each year of the order he obtain five hours of continuing medical education in medical billing. The action was based on Dr. Yudovich’s failure to adequately and fully document his treatment, examinations and rationale for diagnoses for multiple pediatric patients and on his failure to meet the minimum requirements set by a state program for adequate records to support the charges for medical services billed to the state program.

**FAILRE TO PROVIDE MEDICAL RECORDS**
**Valdez, Marcos J., M.D., Lic. #L2721, McAllen TX**
On November 6, 2009, the Board and Dr. Valdez entered into an agreed order requiring that within 60 days he pay an administrative penalty of $2,000. The action was based on Dr. Valdez’s failure to provide medical records for several patients in a timely manner.

**IMPAIRMENT DUE TO ALCOHOL OR DRUGS**
**Goen, Tracy H., M.D., Lic. #K3579, College Station TX**
On May 29, 2009, the board and Dr. Goen entered into an agreed order suspending his license until such time as the board finds clear evidence that Dr. Goen is able to safely practice medicine. The action was based on Dr. Goen’s inability to practice because of addiction to prescription medicine.

**Mullen, John B., M.D., Lic. #G1123, Mount Pleasant TX**
On August 21, 2009, the Board and Dr. Mullen entered into a five-year agreed order requiring that he abstain from prohibited substances; that he establish a physician-patient relationship and undergo a complete examination by both a board-certified internal medicine physician and board-certified cardiologist approved by the Executive Director, and if continuing care is recommended Dr. Mullen shall undergo continuing care and treatment by either or both of the physicians for the treatment of any condition that, without adequate treatment, could adversely affect his ability to safely practice medicine; that he obtain an independent medical evaluation from an evaluating psychiatrist; that he continue seeing his counselor; and that he participate in AA at least six times a month. The action was based on Dr. Mullen’s treatment of an emergency room patient while he was intoxicated, resulting in his inability to intubate a patient in respiratory distress. After three unsuccessful attempts the patient died. In addition, Dr. Mullen has serious cardiac issues he has been treating himself.

**Turner, Richard T., M.D., Lic. #G9237, Valley Mills TX**
On August 21, 2009, the Board and Dr. Turner entered into an agreed order of restriction by which Dr. Turner agrees not to resume the practice of medicine until he appears before the board and presents evidence that he is competent to practice medicine. The action was based on his inability to practice because of a physical condition and his abuse of alcohol.

**ACTIONS BY ANOTHER STATE OR ENTITY**
**Hurley, Regina S., M.D., Lic. #L4454, Clearwater FL**
On May 29, 2009, the board and Dr. Hurley entered into an agreed order requiring that she pay an administrative penalty of $2,000 within 90 days. The action was based on action by the Florida Department of Health after Dr. Hurley left a guide wire in a patient after the insertion of a central line catheter.

**McCarthy, James M., M.D., Lic. #H3118, Lafayette LA**
On May 29, 2009, the board and Dr. McCarthy entered into an agreed order requiring that he comply with his consent order with the Louisiana State Board of Medical Examiners; that he ask the Louisiana Board to provide reports to the Texas board; and that within 60 days he pay an administrative penalty of $500. The action was based on Dr. McCarthy’s five-year consent order with the Louisiana Board requiring

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that he participate in the Louisiana Physician’s Health Program and its drug-testing program, maintain abstinence and notify employers of the order.

**Meharry, Leroy I., M.D., Lic. #F4955, Umatilla OR**

On May 29, 2009, the board and Dr. Meharry entered into an agreed order in which Dr. Meharry voluntarily surrendered his license. The action was based on Dr. Meharry’s health problems and his desire to surrender his Texas medical license in lieu of further disciplinary proceedings regarding allegations he violated a 2006 order of the Oregon Medical Board.

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

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

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

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

**Woodward, Robert A., M.D., Lic. #G8518, Plano TX**

On May 29, 2009, the board and Dr. Woodward entered into a 10-year agreed order of public reprimand requiring that he not treat himself or his family; that he abstain from the consumption of prohibited substances; that he attend AA or a similar program at least three times a week; that within 90 days he get an independent evaluation from a psychiatrist; and that within one year he take and pass the Texas Medical Jurisprudence Examination. The action was based on Dr. Woodward’s failure to report the suspension of his Louisiana medical license to the board and on his writing prescriptions for his wife and diverting them for his own use.

**SUPERVISION OR DELEGATION VIOLATIONS**

**Gressler, Volker, M.D., Lic. #J5775, Richardson TX**

On August 21, 2009, the Board and Dr. Gressler entered into a three-year agreed order requiring that he employ a registered nurse or midlevel practitioner certified in chemotherapy administration; that his practice be monitored; and that within one year he obtain 10 hours of continuing medical education in prevention of medication errors. The action was based administration of an overdose of Taxol to a prostate cancer patient that contributed to the patient’s death.

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

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

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

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

**Muñoz, Jesus A., M.D., Lic. #J6184, Humble TX**

On May 29, 2009, the board and Dr. Muñoz entered into an agreed order requiring that, within one year, he obtain 10 hours of continuing medical education in supervising delegates or, if he is unable to find such a course, in risk management, and pay an administrative penalty of $3,000 within 60 days. The action was based on Dr. Muñoz’s allowing nursing staff to diagnose, order tests, and write prescriptions for his patients without appropriate qualifications.

**To, Brandon Nghia, M.D., Lic. #L5929, Katy TX**

On August 21, 2009, the Board and Dr. To entered into an agreed order requiring him to pay an administrative penalty of $1,000 within 90 days. The action was based on Dr. To’s failure to be present at an alternate practice site at least 20 per cent of the time and his failure to adequately supervise providers practicing under his supervision.

**ACTIONS BASED ON CRIMINAL CONVICTIONS**

**Berry, Jennifer Y., M.D., Lic. #L3920, Bay City TX**

On August 21, 2009, the Board and Dr. Berry entered into an agreed order of public reprimand revoking Dr. Berry’s license, staying the revocation and placing
her on probation for 10 years; requiring that within one year she obtain 20 hours of continuing medical education in ethics or risk management; that she comply with all terms and conditions of her federal probation; that within two years she take and pass the Texas Medical Jurisprudence Examination; and that within 30 days she retain the services of a professional billing/auditing services and follow its recommendations. The action was based on Dr. Berry’s conviction on one count of Medicare fraud in Mississippi.

Gunn, John Christian, M.D., Lic. #L9039, San Antonio TX
On July 7, 2009, the Board entered an Order of Suspension of Dr. Gunn’s Texas medical license. The action was based on Dr. Gunn’s incarceration in a federal correctional institution.

Hoang, Thu Anh, M.D., Lic. #K2925, Houston TX
On August 21, 2009, the Board and Dr. Hoang entered into an agreed order requiring that within one year Dr. Hoang take and pass the Texas Medical Jurisprudence Examination and that within one year she obtain 22 hours of continuing medical education, including 10 hours each in risk management and medical recordkeeping and two hours in ethics. The action was based on Dr. Hoang’s pleading guilty to a federal class A misdemeanor for one count of misbranding drugs while working for a company that distributed controlled substances via the Internet.

Klem, Jeffrey, M.D., Lic. #L2379, Beaumont TX
On August 21, 2009, the Board and Dr. Klem entered a 15-year agreed order of public reprimand in which Dr. Klem’s license was suspended, the suspension was stayed and Dr. Klem was placed under the following conditions: Dr. Klem may not have direct or indirect contact with patients under the age of 21; when treating patients 21 and older, Dr. Klem must have a chaperone present; he must practice in a group or institutional setting; within 30 days he must submit names of treating psychiatrists to be approved for care and treatment; within one year he must take and pass the Texas Medical Jurisprudence Examination; within one year he must complete the professional boundaries course offered by Vanderbilt University Medical Center for Professional Health or the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within 180 days he pay an administrative penalty of $5,000; and that he comply with the terms of his plea agreement in Criminal District Court in Harris County.

Olmsted, William R., M.D., Lic. #J1550, Georgetown TX
On August 21, 2009, the Board and Dr. Olmsted entered into an agreed order of public reprimand revoking his license, staying the revocation and placing him on probation for 10 years under the following terms and conditions: that he have an independent psychiatric evaluation; that he limit his practice to a group or institutional setting; that within one year he complete the professional boundaries courses offered by Vanderbilt University Medical Center for Professional Health or the University of California San Diego Physician Assessment and Clinical Education (PACE) program; that within 180 days he pay an administrative penalty of $5,000; and that he comply with the terms of his plea agreement in Criminal District Court in Dallas County, including paying a fine, registering as a sex offender, obtaining counseling, performing community service and ceasing contact with children except his own. The action was based on Dr. Olmsted’s nolo contendere plea of indecency with a child by contact, a second degree felony.

ADVERTISING VIOLATION
Manrique de Lara, Carlos, M.D., Lic. #K3794, Edinburg TX
On August 21, 2009, the Board and Dr. Manrique de Lara entered into a one-year agreed order under which his advertisements will be monitored by the board’s compliance division; requiring that within one year Dr. Manrique de Lara obtain eight hours of continuing medical education in ethics; and that within 60 days he pay an administrative penalty of $5,000. The action was based on Dr. Manrique de Lara’s false, misleading or deceptive advertising of his LASIK surgery procedures.

PEER REVIEW ACTIONS
Bourgeois, Sebastian, M.D., Lic. #BP30027420, Houston TX
On May 29, 2009, the board and Dr. Bourgeois entered into a mediated agreed order of public
reprimand. The action was based on Dr. Bourgeois’ suspension from a general surgery residency program at Baylor Medical School for making an inappropriate sexual remark to a female surgery resident.

Grant, Paul A., M.D., Lic. #E7608, Fort Worth TX
On May 29, 2009, the board and Dr. Grant entered into an agreed order requiring that, within one year, he obtain 10 hours of continuing medical education in risk management or ethics and that he successfully complete the professional boundaries course offered by the Vanderbilt Center for Professional Health. The action was based on Dr. Grant’s giving up privileges at Baylor Surgical Hospital after an investigation into his making inappropriate sexual remarks and contact with staff members at the hospital.

Lauer, Scott D., D.O., Lic. #K9102, Grapevine TX
On August 21, 2009, the Board and Dr. Lauer entered into an agreed order requiring that within one year he obtain 15 hours of continuing medical education in medical recordkeeping. The action was based on Dr. Lauer’s being subject to peer action at North Hills Hospital for issues regarding inadequate/poor communication and delinquent prenatal records.

Ravdel, Arnold, M.D., Lic. #E8838, Houston TX
On November 6, 2009, the Board and Dr. Ravdel entered into a mediated agreed order requiring that within one year he take and pass the Texas Medical Jurisprudence Examination and that within 90 days he pay an administrative penalty of $2,500. The action was based on Dr. Ravdel’s resigning his privileges at Triumph Health Care while under, or to avoid, an investigation related to professional competence.

Ross, H. Dudley, M.D., Lic. #F7120, Houston TX
On August 21, 2009, the Board and Dr. Ross entered into an agreed order of public reprimand requiring that within one year he take and pass the Texas Medical Jurisprudence Examination and that within 180 days he pay an administrative penalty of $5,000. The action was based on Dr. Ross’ suspension of privileges at Mesquite Community Hospital for submitting a falsified medical malpractice insurance certificate.

Sadana Amit, M.D., Lic. #L9880, Portland OR
On August 21, 2009, the Board and Dr. Sadana entered into an agreed order requiring that he pay an administrative penalty of $2,000 within 90 days. The action was based on the suspension of Dr. Sadana’s privileges until he completed all delinquent medical records at Trinity Clinic in Tyler, and his failure to notify the board of his address change when he moved to Oregon.

Wade, Andrew L., M.D., Lic. #H8962, Sherman TX
On August 21, 2009, the Board and Dr. Wade entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in medical recordkeeping and within 180 days he pay an administrative penalty of $500. The action was based on Dr. Wade’s being the subject of peer review action by Wilson N. Jones Medical Center in Sherman because of problems with his documentation of patient care.

VIOLATION OF PROBATION OR PRIOR ORDER

Bukhari, Rizwan H., M.D., Lic. #J1900, Dallas TX
On November 6, 2009, the Board and Dr. Bukhari entered into a 10-year agreed order making his previous nonpublic rehabilitation order public and requiring that within 90 days he pay an administrative penalty of $1,000. The action was based on Dr. Bukhari’s failure to submit letters from up to three board-certified psychiatrists willing to treat him, in violation of his previous order.

Cantu, Phillip M., M.D., Lic. #K2865, Orange TX
On August 21, 2009, the Board and Dr. Cantu entered into an agreed order of public reprimand extending his 2006 agreed order by three years and requiring that within 180 days he pay an administrative penalty of $3,000. The action was based on Dr. Cantu’s failure to comply with provisions of the 2006 agreed order.

Green, Demetris, M.D., Lic. #J4168, Houston TX
On August 21, 2009, the Board and Dr. Green entered into an agreed order modifying his required payments to a drug testing company. The action was based on his lack of progress in paying down his debt to the drug testing company.

Koch, Justin L., M.D., Lic. #M7339, Dallas TX
On November 6, 2009, the Board and Dr. Koch entered into an eight-year agreed order requiring the following: that Dr. Koch abstain from prohibited substances; participate in the board’s drug-testing program; within 30 days begin care and treatment with an approved psychiatrist; continue care with his treating psychotherapist; and continue to participate in AA or a similar program. The action was based on Dr. Koch’s violation of an abstinence requirement of his 2007 Agreed Licensure Order.

Patt, Richard B., M.D., Lic. #J5440, Pasadena TX
On May 29, 2009, the board and Dr. Patt entered into an agreed order requiring that he pay an administrative penalty of $250 within 30 days. The action was based on Dr. Patt’s failure to submit specimens for drug-testing as required by a 2007 board order.
Zimmerman, Erica I., M.D., Lic. # J6829, Austin TX
On May 29, 2009, the board and Dr. Zimmerman entered into an agreed order requiring that, within 180 days, she obtain at least five hours of continuing medical education in either psychopharmacology or the treatment of depression. The action was based on Dr. Zimmerman’s failure to obtain sufficient CME required by a previous order.

ORDER MODIFYING PRIOR ORDER
Bailey, Charles F. Jr., M.D., Lic. #C6859, Snyder TX
On November 6, 2009, the Board and Dr. Bailey entered into an agreed order modifying his order of February 8, 2008, from a requirement that he practice only in a prison setting to a requirement that he practice in a group or institutional setting. The action was based on Dr. Bailey’s compliance with the 2008 order and his desire to seek employment outside the Texas Department of corrections.

Head, Philip A., M.D., Lic. #J5097, Houston TX
On May 29, 2009, the board and Dr. Head entered into an agreed order modifying prior order requiring that within six months he obtain a position in a residency/fellowship program of not less than one year; that he continue with AA attendance; and that he submit reports from the TMA drug-testing program prior to starting the board’s drug-testing program, which will occur when he enters a residency program. The action was based on Dr. Head’s difficulty in finding a mini-residency as required by the 2008 order.

Lorentz, Rick G., M.D., Lic. #J2169, Spring TX
On August 21, 2009, the Board and Dr. Lorentz entered into an agreed order modifying a prior order by extending Dr. Lorentz’s February 8, 2006, order by six months; requiring that his choice of treating psychiatrists be limited to the Harris County area; and requiring that he begin treatment within 30 days of approval of a treating psychiatrist and follow the psychiatrist’s recommendations. The action was based on Dr. Lorentz’s noncompliance with provisions of his 2006 order and his difficulty in finding a treating psychiatrist.

Loya, Juan F., M.D., Lic. #J4039, El Paso TX
On November 6, 2009, the Board and Dr. Loya entered into an agreed order modifying his order of April 7, 2006, to require him to submit names of treating psychiatrists for approval and that he see the treating psychiatrist at least quarterly or on an as-needed basis; and adding a practice monitor for one year. The action was based on Dr. Loya’s request for a modification to remove the requirement for an evaluating psychiatrist and on concerns over charting.

Sarkar, Ankur, M.D., Lic. #K3450, Houston TX
On August 21, 2009, the Board and Dr. Sarkar entered into an agreed order modifying his April 11, 2008, order to state that if he receives two consecutive favorable chart monitor reports that do not include findings that Respondent has failed to follow the recommendations of the chart monitor, he may submit a request to terminate the order. The action was based on Dr. Sarkar’s inability to comply with previous requirements because of loss of employment and patients.

AUTOMATIC SUSPENSION
Carlin Grant Bartschi, M.D., Lic. #J0916, Gilbert, AZ
On October 6, 2009, the Board entered an automatic Order of Suspension against Dr. Bartschi due to his incarceration in a federal penitentiary following a felony conviction in Arizona for tax evasion and fraud. The suspension is for an indefinite period, and may be terminated at such time as Dr. Bartschi appears before the Board and demonstrates his physical and mental competence to practice medicine, and that he is otherwise safe to return to practice.

REVERSAL OF TEMPORARY SUSPENSION
Odette Louise Campbell, M.D., License #H9609, Denton, TX
On October 16, 2009, a Disciplinary Panel of the Board entered an Order Denying Temporary Suspension or Restriction of Texas Medical License (With Notice of Hearing), in the matter of the license of Odette Louise Campbell, M.D. Based on the evidence presented, the Disciplinary Panel was unable to determine that Dr. Campbell presented a continuing threat to the public welfare from acts or omissions as alleged by the Board. Following an evidentiary hearing, the Board’s Application for Temporary Suspension or Restriction of License of Dr. Campbell’s medical license was denied. This action by the Board supersedes and reverses the previous Order of Temporary Suspension (Without Notice of Hearing) that had been entered on August 19. Dr. Campbell’s license is no longer temporarily suspended as a result.

REVOCATIONS
Crain, Daniel A., D.O., Lic. #J4063, Bridge City TX
On August 21, 2009, the Board entered a Default Order against Daniel A. Crain, D.O, revoking his

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Texas medical license. On March 17, 2009, the Board filed a Complaint with the State Office of Administrative Hearings (SOAH) in case no. 503-09-3212 which alleging Dr. Crain closed his practice in December 2007 without advising his patients he was terminating their care; failed to follow-up with numerous patient requests for medical records; failed to notify the Board of an address change; and abandoned hazardous waste at his former practice site. After responding to an initial contact by the Board, Dr. Crain subsequently failed to reply to any contact by the Board; failed to supply necessary information and records to the Board; and failed to respond to Board subpoenas. After filing of the SOAH Complaint, all notices were perfected and the Board issued a Determination of Default, and all other required deadlines passed without any response from Dr. Crain. As a result, all facts alleged in the Complaint were therefore deemed admitted, and Dr. Crain’s Texas medical license was revoked by Default Order.

**Littlejohn, William Donald, M.D., Lic. #D4203, Fort Worth TX**
On August 21, 2009, the Board entered a Default Order against William Donald Littlejohn, M.D., revoking his Texas medical license. On February 24, 2009, the Board filed a Complaint with the State Office of Administrative Hearings (SOAH) in case no. 503-09-2794 which alleged that Dr. Littlejohn is unable to practice safely due to a mental or physical condition; that he became personally or financially involved with a patient in an inappropriate manner; that he failed to maintain adequate medical records; and that failed to treat a patient according to the recognized standard of care. After filing of the SOAH Complaint, all notices were perfected and the Board issued a Determination of Default, and all other required deadlines passed without any response from Dr. Littlejohn. As a result, all facts alleged in the Complaint were therefore deemed admitted, and Dr. Littlejohn’s Texas medical license was revoked by Default Order.

**VOLUNTARY SURRENDERS, REVOCATIONS, SUSPENSIONS**

**Anderson, Robert Michael, M.D., Lic. #K6799, Lake Charles LA**
On August 21, 2009, the Board and Dr. Anderson entered into an agreed order of voluntary surrender of his license in lieu of further disciplinary proceedings.

**Aurignac, Fabian, M.D., Lic. #K3977, Miami FL**
On May 29, 2009, the board and Dr. Aurignac entered into an agreed order of voluntary revocation of Dr. Aurignac’s license. The action was based on Dr. Aurignac’s desire to avoid further investigations and hearings on pending cases before the board.

**Avery, Parnell, M.D., Lic. #D8849, Houston TX**
On November 6, 2009, the Board and Dr. Avery entered into an agreed order in which he voluntarily surrendered his Texas medical license because of a physical condition.

**Burman, Matthew, M.D., Lic. #E2155, Bloomfield Hills MI**
On November 6, 2009, the Board and Dr. Berman entered into an agreed order in which he voluntarily surrendered his Texas medical license. The action was based on a pending investigation based on physician misconduct in Michigan.

**Cohn, Cal K., M.D., Lic. #E4819, Houston TX**
On May 29, 2009, the board and Dr. Cohn entered into an agreed order in which Dr. Cohn voluntarily surrendered his license because of his medical condition.

**Coleman, Brent J., D.O., Lic. #G3241, South Padre Island TX**
On November 6, 2009, the Board and Dr. Coleman entered into an agreed order in which he voluntarily surrendered his Texas medical license in lieu of further disciplinary proceedings. The action was based on Dr. Coleman’s violation of his October 28, 2008, agreed order.

**Dotson, Rodney, M.D., Lic. #D9988, Canyon TX**
On November 6, 2009, the Board and Dr. Dotson entered into an agreed order in which he voluntarily surrendered his Texas medical license. The action was based on Dr. Dotson’s desire to retire from practice in lieu of disciplinary proceedings.

**Froberg, Larry M., M.D., Lic. #G5064, Little Rock AR**
On November 6, 2009, the Board and Dr. Froberg entered into an agreed order in which he voluntarily surrendered his Texas medical license because of a physical condition and his desire to retire from practice in lieu of disciplinary proceedings.

**Garza, Raul, M.D., Lic. #F3134, San Benito TX**
On August 21, 2009, the Board and Dr. Garza entered into an agreed order of voluntary surrender of his license in lieu of further disciplinary proceedings within 90 days, during which time he may not prescribe any Schedule II, III or IV controlled substances. Dr. Garza has decided to retire and asserts that he committed no violation of the Medical Practice Act.

**Glinkowski, Tadeusz, M.D., Lic. #E5090, Houston TX**
On August 21, 2009, the Board and Dr. Glinkowski entered into an agreed order of voluntary surrender
of his license in lieu of further disciplinary proceedings.

Hoblit, David L., M.D., Lic. #E0056, Dallas TX
On November 6, 2009, the Board and Dr. Hoblit entered into an agreed order in which he voluntarily surrendered his Texas medical license in lieu of further disciplinary proceedings.

McNutt, Steven S., M.D., Lic #L0413, Dover OH
On November 6, 2009, the Board and Dr. McNutt entered into an agreed order in which he voluntarily surrendered his Texas medical license. The action was based on Dr. McNutt’s failure to notify patients or the board when he moved and left no forwarding address and on his failure to provide requested records to a patient.

Roberts, Gary F., M.D., Lic. #J1371, Mesquite TX
On May 29, 2009, the board and Dr. Roberts entered into an agreed order in which he voluntarily surrendered his license. The action was based on allegations that Dr. Roberts made inappropriate sexual comments and touched a patient inappropriately.

Romack, Anthoni R., M.D., Lic. #G5553, Grand Saline TX
On November 6, 2009, the Board and Dr. Romack entered into an agreed order in which he voluntarily surrendered his Texas medical license. The action was based on Dr. Romack’s non-therapeutically prescribing addictive medications on multiple occasions.

Taylor, Judy G., M.D., Lic. #G5680, Irving TX
On August 21, 2009, the Board and Dr. Taylor entered into an agreed order of voluntary surrender of her Texas medical license. The action was based on Dr. Taylor’s inability to practice medicine due to a physical condition.

Wesson, Mae E., M.D., Lic. #F2103, Beaumont TX
On August 21, 2009, the Board and Dr. Wesson entered into an agreed order by which her license is suspended. The action was based on Dr. Wesson’s desire to suspend her practice of medicine due to a physical disability and his desire to avoid further litigation.

MINOR STATUTORY VIOLATIONS
The board took actions against 65 physicians for minor statutory violations (“fast-track orders”).

PHYSICIAN ASSISTANTS
Custodio, Israel David, Lic. #PA01549, San Antonio TX
On July 17, 2009, the Board and Mr. Custodio entered into an Agreed Order of public reprimand requiring that within one year he take and pass the Texas Physician Assistant Jurisprudence Examination; that within one year he obtain at least 10 hours of continuing medical education in ethics; and that within 180 days he pay an administrative penalty of $5,000. The action was based on Mr. Custodio’s failure to meet the standard of care in treating and prescribing medications to weight-loss patients, including failure to order appropriate lab tests, and prescribing thyroid medication for patients who did not have hypothyroidism.

Fields, John P., Lic. # PA03606, San Antonio TX
On July 17, 2009, the Board and Mr. Fields entered into an Agreed Voluntary Surrender order. The action was based on claims that Mr. Fields issued false or fictitious prescriptions for a schedule IV drug for his personal use using his supervising physician’s prescriptive privileges and DEA number. Mr. Fields neither admits nor denies the allegations.

Hopson, Lewis Bernard, Lic. #PA00835, Houston TX
On July 17, 2009, the Board and Mr. Hopson entered into an Agreed Order of public reprimand requiring that within one year he take and pass the Texas Physician Assistant Jurisprudence Examination; that within one year he obtain at least 10 hours each of continuing medical education in medical recordkeeping, endocrinology and ethics; and that within 180 days he pay an administrative penalty of $5,000. The action was based on Mr. Hopson’s failure to meet the standard of care in treating multiple patients, including inadequate examinations, diagnostic imaging and lab tests, and prescribing thyroid medication for patients who did not have hypothyroidism.

Houseman, Thad William, P.A., Lic. #PA01862, Whitney TX
On October 22, 2009, the Texas Physician Assistant Board entered an Automatic Order of Suspension suspending Mr. Houseman’s license. The action was based on the violation of an agreed order of March 22, 2005, requiring Mr. Houseman to abstain from consumption of alcohol, dangerous drugs or controlled substances.
substances, that he submit a list of prescribed medications to the board, and providing that if he tested positive for any prohibited substance his license would be immediately suspended. On June 9, 2009, Mr. Houseman submitted a random drug screen specimen that tested positive for a prohibited substance, Meprobamate, a tranquilizer. The length of the suspension is indefinite and it remains in effect until the board takes further action.

Kolman, Arnold Drew, Lic. #PA001185, Houston TX
On July 17, 2009, the Board and Mr. Kolman entered into an Agreed Order requiring that within 90 days he pay an administrative penalty of $2,000 and that within one year he take and pass the Texas Physician Assistant Jurisprudence Examination. The action was based on Mr. Kolman’s failure to meet the standard of care in prescribing medication to weight-loss patients and for inadequate medical records in the treatment of weight-loss patients.

Polasek, Adriana, Lic. #PA04738, Sugar Land TX
On July 17, 2009, the Board and Ms. Polasek entered into an Agreed Order requiring that within one year she obtain 10 hours each of continuing medical education in medical recordkeeping and endocrinology; and that within one year she take and pass the Texas Physician Assistant Jurisprudence Examination. The action was based on Dr. Polasek’s prescribing potentially dangerous medications without adequate justification to five weight-loss patients.

Shrout, Anita Dawn, Lic. # PA03854, Houston TX
On July 17, 2009, the Board and Ms. Shrout entered into an Agreed Order requiring that she have on-site physician supervision; that within one year she complete the Professional/Problem Based Ethics (PROBE) course offered by the Center for Personalized Education for Physicians; that she take and pass the Texas Physician Assistant Jurisprudence Examination; and that she pay an administrative penalty of $5,000. The action was based on Ms. Shrout’s prescribing scheduled drugs after her DEA license had lapsed; using the DEA number of a physician who was not listed on her profile or on the physician’s profile as her supervising physician; and nontherapeutic prescribing of Lortab and Xanax.

In addition, the Texas Physician Assistant Board took one action based on a minimal statutory violation.

CEASE AND DESIST ORDERS
Herrick, Brooke, PSY.D, (no license number) Waxahachie TX
On November 6, 2009, the Texas Medical Board and Brooke Herrick, Psy.D, who does not hold a current license to practice medicine in Texas, entered into an Agreed Cease and Desist Order. The order was based on Dr. Herrick’s unlicensed practice of medicine in Ellis County by holding herself out as a physician; using the title “doctor,” and writing prescriptions for one or more persons while using the authorizations of other licensed healthcare professionals, all of which Dr. Herrick denies. The order requires Dr. Herrick to immediately halt all such activity.

Flores, Idalia Rodriguez, (no license number) McAllen TX
On October 30, 2009, the Texas State Board of Acupuncture Examiners and Idalia Rodriguez Flores, who does not hold a current license to practice acupuncture in Texas, entered into an Agreed Cease and Desist Order. The order was based on Ms. Flores’ performance of acupuncture on one or more patients in Hidalgo County and holding herself out as a “Doctor of Chinese Medicine,” which Ms. Flores denies. The order requires Ms. Flores to immediately halt all such activity.

Shih, Lucy, (no license number) Colleyville TX
On October 30, 2009, the Texas State Board of Acupuncture Examiners and Lucy Shih, who does not hold a current license to practice acupuncture in Texas, entered into an Agreed Cease and Desist Order. The order was based on Ms. Shih’s administration of acupuncture treatments to one or more patients in Tarrant County. The order requires Ms. Shih to immediately halt all such activity.

CORRECTION
In the Spring 2009 issue of the Medical Board Bulletin, the summary for Victor Pallares, M.D., Lic. #J3867, should have been listed under Inadequate Medical Records.

DSHS Announces Changes to HIV/STD Reporting Requirements for 2010
For changes to HIV/STD reporting rules for healthcare providers and laboratories serving Texas, go to http://www.dshs.state.tx.us/hivstd/news/default.shtm#2010reporting