59 Doctors Disciplined
Since its last Board meeting in October, the Texas Medical Board has taken disciplinary action against 59 licensed physicians, who received one or more of the following actions: three temporary suspensions; 10 surrenders/revocations, with one stayed and probated; nine suspensions, with two stayed and probated; 20 restrictions; two public reprimands; and 24 administrative penalties totaling $54,700. The Texas Physician Assistant Board took action against two physician assistants at its November 4 meeting and assessed administrative penalties totaling $1,000.

New Licenses Issued
During its December 8-9 Board meeting, the Board approved the licensure applications of 381 physicians.

Rule Changes
The Board adopted the following proposed rule changes that were published in the Texas Register:
Chapter 161, General Provisions, to reflect statutory name changes and the composition of the board.
Chapter 163, Licensure, to include examination attempts and limits on time to complete an examination.
Chapter 172, Temporary Licenses, to include the addition of Faculty Temporary License.
Chapter 175, Fees, Penalties, and Forms
- Increased penalty fees for physician assistants and increased renewal and/or penalty fees for acupuncturists, surgical assistants, acudetox specialists, non-certified radiological technicians, and non-profit health organizations.
- Mandated Texas Online fee increase for physician and physician in training renewals.
- Fee requirements for Office Based Anesthesia site registration.
Chapter 178, Complaints, to include amendments to 178.2 Definitions, 178.4 Complaint Initiation, 178.5 Complaint Evaluation, 178.6 Complaint Filing, 178.7 Complaint Resolution, and 178.8 Appeals regarding the process for complaint initiation, preliminary investigation and filing.
Chapter 179, Investigations, to include amendments to 179.2 Definitions, 179.3 Confidentiality, 179.4 Request for Information and Records from Physicians, and 179.6 Time Limits, regarding clarification on response time for requests for medical records and time limits for completion of an investigation of a complaint.
Chapter 180, Rehabilitation Orders, regarding requirements and limitations on eligibility for rehabilitation orders.
Chapter 182, Use of Experts, to include 182.3 Definitions, 182.4 Use of Consultants, 182.5 Expert Panel, new 182.5.1 Expert Physician Reviewers, 182.7 regarding selection, use and removal of members of the Expert Panel.
Subchapter E, Proceedings Relating to Probationers, 187.43 Proceedings for the Modification/Termination of Agreed Orders and Disciplinary Orders, new 187.45 Probationer Appearances, and Subchapter F, Temporary Suspension Proceedings, 187.56 Convening a Disciplinary Panel regarding process and revised options for board orders, composition of ISC panel, roles of ISC participants, and revisions to reflect APA requirements.

Chapter 190, Disciplinary Guidelines, to include Subchapter B, Violation Guidelines, 190.8 Violation Guidelines; Subchapter C, Sanction Guidelines, 190.14 Disciplinary Sanction Guidelines, and 190.16 Administrative Penalties regarding clarification of disciplinary actions based on criminal actions and identification of administrative violations.

Chapter 193, Standing Delegation Orders 193.2 Definitions and 193.6 Delegation of the Carrying Out or Signing of Prescription Drug Orders to Physician Assistants and Advanced Practice Nurses, to include elimination of registration of prescriptive delegation with the board, the addition of documentation of prescriptive delegation by the physician, and the elimination of the Advisory Committee on Prescriptive Delegation Waiver requests.

Proposed Rule 172.13 Limited License for Practice of Administrative Medicine was withdrawn for further stakeholder input.


Disciplinary Actions
The following are summaries of the Board actions. The full text of the Board orders will be available on the Board’s web site at www.tmb.state.tx.us about 10 days after the Board meeting. The orders provide all information that is public regarding the facts of the case and violations of the law.

Open records requests for orders may be made to openrecords@tmb.state.tx.us; media contact Jill Wiggins at (512) 305-7018 or jill.wiggins@tmb.state.tx.us.

Disciplinary Actions
ALDAPE, ADOLFO ALEJANDRO, M.D., LAREDO, TX, Lic. #K9971
On December 9, 2005, the Board and Dr. Aldape entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. Aldape failed to respond to a Board subpoena for medical records.

ATLAS, JOE, M.D., HOUSTON, TX, Lic. #C1799
On December 9, 2005, the Board and Dr. Atlas entered into an Agreed Order in which Dr. Atlas voluntarily surrendered his medical license. The action resolves allegations that Dr. Atlas violated Board rule 165.5(b) that sets out a physician's duties when he retires from practice.

BAILEY, SHIRLEY, M.D., RUSK, TX, Lic. #D9330
On December 9, 2005, the Board and Dr. Bailey entered into an Agreed Order suspending Dr. Bailey's license until such time as she demonstrates she is physically, mentally, and otherwise competent to safely practice medicine. The action was based her present inability to practice medicine because of poor health.

BARRETT, DAVID BENJAMIN, M.D., ATHENS, TX, Lic. #G7987
On December 9, 2005, the Board and Dr. Barrett entered into an Agreed Order revoking Dr. Barrett's medical license. The action was based on allegations that Dr. Barrett failed to meet the standard of care in his treatment of 11 patients who were or may have been harmed by his actions.

BASPED, BEAUFORD JR., D.O., FORT WORTH, TX, Lic. #E3813
On December 9, 2005, the Board and Dr. Basped entered into a Mediated Agreed Order revoking Dr. Basped's license, staying the revocation and placing him on probation for 15 years under the following terms and conditions: Dr. Basped must surrender his controlled substances registration certificates; limit his practice to a
group or institutional setting approved in advance by the Executive Director of the Board; complete each year
10 hours of courses in ethics and 30 hours in risk management; have his practice monitored by another
physician; pass the Special Purpose Examination and the Medical Jurisprudence Examination within one year;
obtain a written assessment from the Center for Personalized Education for Physicians (CPEP); perform 50
hours of community service each year; and pay an administrative penalty of $10,000. Dr. Basped is not
permitted to supervise or delegate prescriptive authority to a physician assistant or advanced practice nurse.
The action is based on allegations that Dr. Basped prescribed narcotics without conducting a proper history or
physical examination to support the need for narcotics. The allegations arose after an undercover officer from
the narcotics task force posed as a patient and was prescribed drugs by Dr. Basped.

BURKS, WILLIAM RANDOLPH, M.D., MARGATE, FL, Lic. #F9257
On December 9, 2005, the Board and Dr. Burks entered into an Agreed Order assessing an administrative
penalty of $1,000. The action was based on action taken by the Florida Board of Medicine finding that Dr.
Burks had accidentally implanted the wrong intraocular lens in a cataract patient.

CANTU, GEORGE, M.D., RAYMONDVILLE, TX, Lic. #J5271
On December 9, 2005, the Board and Dr. Cantu entered into an Agreed Order assessing an administrative
penalty of $500. The action was based on allegations that Dr. Cantu failed to provide properly requested
medical records within 15 business days.

CAPLAN, BRIAN JEFFREY, M.D., MANSFIELD, TX, Lic. #F0142
On December 9, 2005, the Board and Dr. Caplan entered into an Agreed Order requiring Dr. Caplan to
complete within one year a course of at least 40 hours in coronary heart disease and a course of at least 10
hours in record-keeping/risk management, and to pay an administrative penalty of $2,500. The action was
based on allegations that, for one patient, Dr. Caplan failed to appropriately interpret an EKG, including failing
to timely diagnose congestive heart failure.

CARTER, KAYWIN MAHONEY, M.D., LUFKIN, TX, Lic. #H3992
On December 9, 2005, the Board and Dr. Carter entered into an Agreed Order requiring Dr. Carter to complete
a course of at least 10 hours in the area of gynecological surgery and to pay an administrative penalty of
$1,000. The action was based on allegations that Dr. Carter was not diligent in a patients’ care, misdiagnosing
her ectopic pregnancy.

CHANDRAN, RANGRAM, M.D., MODESTO, CA, Lic. #L2180
On December 9, 2005, the Board and Dr. Chandran entered into an Agreed Order assessing an administrative
penalty of $250. The action was based on action taken by the Florida Board of Medicine assessing an
administrative fine based on a finding that Dr. Chandran failed to disclose in his application for a Florida
license that he had repeated classes for his first year of medical school.

COMEAX, TAMYRA YVETTE, M.D., HOUSTON, TX, Lic. #L0096
On December 9, 2005, the Board and Dr. Comeaux entered into an Agreed Order requiring Dr. Comeaux to
provide satisfactory evidence that she is acting as medical director of a specified fetal ultrasound facility, that
another physician is providing supervision at the facility, or that the ultrasound equipment is no longer being
used; requiring her to complete 20 hours in courses or programs in ethics/risk management; and requiring her
to pay an administrative penalty of $5,000. The action was based on allegations that Dr. Comeaux failed to
supervise the use of a prescription medical device, specifically ultrasound equipment, leased under her name.

COTTER, JOHN KERN, M.D., SHREVEPORT, LA, Lic. #G5883
On December 9, 2005, the Board and Dr. Cotter entered into an Agreed Order suspending Dr. Cotter’s license
until such time as he appears before the Board and provides clear and convincing evidence and information
that, in the discretion of the Board, adequately indicates that he is physically, mentally, and otherwise
competent to safely practice medicine. The action was based on allegations of Dr. Cotter’s substance abuse. Dr.
Cotter was arrested and pled guilty to the third degree felony of unlawfully obtaining a controlled substance.
CRANDALL, DORA BUSBY, M.D., NEW BRAUNFELS, TX, Lic. #G5884
On December 9, 2005, the Board and Dr. Crandall entered into a five-year Mediated Agreed Order requiring Dr. Crandall to complete a course of at least two days in the area of appropriate prescribing of controlled substances; to complete 10 hours of continuing medical education in medical records; and requiring that her practice be monitored by another physician during the term of the order. The action was based on allegations that, with regard to three patients, Dr. Crandall's records were sparse, poorly kept, and did not contain adequate information.

CUNADO, CARLOS DOMINGO, M.D., PEARLAND, TX, Lic. #K6556
On December 9, 2005, the Board and Dr. Cunado entered into an Agreed Order extending his prior order by one year and requiring an additional 20 hours of continuing medical education in the area of evaluation, management, billing and documentation. The action was based on allegations that Dr. Cunado's coding for the purpose of billing was inadequate for the follow-up visits of nine patients given the general lack or scarcity of documentation.

DE WET, PIETER JUAN, M.D., TYLER, TX, Lic. #J0470
On December 9, 2005, the Board and Dr. De Wet entered into an Agreed Order assessing an administrative penalty of $1,000. The action was based on allegations that Dr. De Wet caused the dissemination of false, deceptive, or misleading advertising concerning the benefits of chelation therapy.

FRUGE, LLOYD MASON, M.D., ATLANTA, TX, Lic. #G5067
On December 9, 2005, the Board and Dr. Fruge entered into an Agreed Order requiring Dr. Fruge to complete a total of at least 20 hours of continuing medical education in emergency medicine and in record keeping/risk management. The action was based on allegations that Dr. Fruge's management of the treatment of one patient fell below the standard of care and that his documentation of the history and physical examination of that patient were inadequate.

GARDNER, JAMES FRANCIS III, M.D., SAN ANTONIO, TX, Lic. #G3382
On December 9, 2005, the Board and Dr. Gardner entered into an Agreed Order assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Gardner did not complete the required one hour of continuing medical education in ethics for the period of December 1, 2002, through November 30, 2003.

GARZA, GUMARO xxx, M.D., EDINBURG, TX, Lic. #E7943
On December 9, 2005, the Board and Dr. Garza entered into an Agreed Order suspending Dr. Garza's license, staying the suspension and placing him on probation for five years; requiring that he abstain from the consumption of drugs and alcohol; that he participate in testing for drugs and alcohol; that he continue to receive psychiatric care and treatment; that he refrain from treating or prescribing for his immediate family; and that he pay an administrative penalty of $5,000. The action was based on allegations that Dr. Garza failed to fully comply with a prior confidential rehabilitation order entered into with the Board on February 7, 2003, including testing positive on two occasions for ethylglucuronide, a bio-marker for alcohol use.

GOTTLIEB, LEWIS RAVENET, M.D., SPRING, TX, Lic. #G8538
On December 9, 2005, the Board entered a Final Order revoking Dr. Gottlieb's medical license. The action was based on Dr. Gottlieb's failure to respond to a complaint filed with the State Office of Administrative Hearings alleging that he was convicted of conspiracy to commit health care fraud on April 1, 2004. Dr. Gottlieb may file a Motion for Rehearing within 20 days of the Order. If a Motion for Rehearing is filed and the Board denies the motion, the Order is final. If a Motion for Rehearing is filed and the Board grants the motion, the Order is not final and a hearing will be scheduled.

ISERN, REUBEN A., M.D., BEAUMONT, TX, Lic. #E8585
On December 9, 2005, the Board entered a Final Order assessing an administrative penalty of $10,000. The action was based on a determination of Dr. Isern's failure to comply with the Board's subpoena of medical records; failure to correspond with the Board regarding the matter in question; failure to appear at an informal
settlement conference; failure to respond to a complaint filed with the State Office of Administrative Hearings; and apparent willful disregard for the Board's authority in that he is attempting to thwart the Board's ability to investigate and monitor him and ensure that he is safe to practice medicine. Continued non-cooperation by Dr. Isern may result in further disciplinary action by the Board. Dr. Isern may file a Motion for Rehearing within 20 days of the Order. If a Motion for Rehearing is filed and the Board denies the motion, the Order is final. If a Motion for Rehearing is filed and the Board grants the motion the Order is not final and a hearing will be scheduled.

**JANJUA, AAMER WALI, M.D., BEAUMONT, TX, Lic. #L8385**
On December 9, 2005, the Board and Dr. Janjua entered into an Agreed Order assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Janjua did not timely sign a death certificate.

**JONES, JAMES STEPHEN, M.D., LUBBOCK, TX, Lic. #M1806**
On December 9, 2005, the Board and Dr. Jones entered into an Agreed Order suspending his medical license for a minimum of 12 months and thereafter until he demonstrates to the Board that he is physically, mentally, and otherwise safe to practice medicine; requiring him to abstain from the consumption of alcohol and drugs and to participate in drug and alcohol screening during his suspension. The action was based on allegations that Dr. Jones abused Fentanyl and Sufentanly during his anesthesiology residency and that there was an incident involving the administration of a paralytic agent while he was impaired that may have caused harm to a patient. The Agreed Order superseded a Temporary Suspension Order Without Notice that was entered on October 21, temporarily suspending Dr. Jones' medical license based on evidence that his continuation in the practice of medicine would constitute a continuing threat to public welfare due to his abuse of controlled substances and resulting impairment.

**KLEIN, IRA, M.D., HOUSTON, TX, Lic. #E3574**
On December 9, 2005, the Board and Dr. Klein entered into an Agreed Order of Voluntary Surrender whereby Dr. Klein's voluntary surrender of his medical license was accepted by the Board. The action was based on Dr. Klein's belief that this order is the most efficient resolution to the continued probation and monitoring requirements required by a prior agreed order with the Board.

**KOPPERSMITH, DANIEL LEONCE, M.D., TIKI ISLAND, TX, Lic. #H3691**
On December 9, 2005, the Board and Dr. Koppersmith entered into an Agreed Order requiring Dr. Koppersmith to complete at least 10 additional hours of continuing medical education in medical record keeping. The action was based on allegations that Dr. Koppersmith did not adequately document his review, analysis, and consideration of symptoms supporting his diagnosis and rule-out diagnosis for one patient.

**KULUBYA, EDWIN S., M.D., LAREDO, TX, Lic. #L1100**
On November 21, 2005, the Board and Dr. Kulubya entered into an Agreed Order requiring Dr. Kulubya to complete an additional 10 hours of continuing medical education each year for three years and to comply with the terms and conditions placed on his practice by the California Medical Board. The action was based on action taken by the California Medical Board revoking Dr. Kalubya's medical license effective April 26, 2004, staying the revocation and placing Dr. Kulubya on probation for five years for gross negligence and incompetence.

**KURI, JOSE A., M.D., BROWNSVILLE, TX, Lic. #E3723**
On December 9, 2005, the Board and Dr. Kuri entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. Kuri failed to provide the properly requested medical records of one patient within 15 business days and requested a fee in excess of that permitted by Board rules.

**LEAHEY, EDWARD WILLIAM, M.D., BAYTOWN, TX, Lic. #E9763**
On December 9, 2005, the Board and Dr. Leahey entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. Leahey failed to provide properly requested medical records within 15 business days of receipt of the request.

**LEE, CYNTHIA JEANNE, M.D., COTATI, CA, Lic. #F6869**

On December 9, 2005, the Board entered a Final Order revoking Dr. Lee's medical license. The action was based on Dr. Lee's failure to respond to a complaint filed with the State Office of Administrative Hearings alleging that she has not complied with the requirements of an Agreed Order she entered into with the Board on April 5, 2002. Dr. Lee may file a Motion for Rehearing within 20 days of the Order. If a Motion for Rehearing is filed and the Board denies the motion, the Order is final. If a Motion for Rehearing is filed and the Board grants the motion, the Order is not final and a hearing will be scheduled.

**LINDE, STUART ALLEN, M.D., HOUSTON, TX, Lic. #F1750**

On December 9, 2005, the Board and Dr. Linde entered into an Agreed Order requiring Dr. Linde to complete a course of at least 10 hours in the area of medical records and to pay an administrative penalty of $2,500. The action was based on allegations that Dr. Linde administered Midazolam to a patient awaiting a surgical procedure whom he mistakenly believed to be under his care and failed to document his error or inform that patient's physician.

**LOUKAS, DEMETRIUS FRED, M.D., AUSTIN, TX, Lic. #D8329**

On December 9, 2005, the Board and Dr. Loukas entered into an Agreed Order requiring Dr. Loukas to prepare and submit to the Board a policy regarding procedures for having chest X-rays for his patients to be over-read by either a qualified physician or qualified radiologist. The action was based on allegations that a lesion on the lung of a patient that was revealed by X-rays taken in August and December of 2002 was missed by Dr. Loukas when he read the X-rays.

**MAY, LANCE A., M.D., APO, AP, Lic. #L5830**

On November 30, 2005, the Board and Dr. May entered into an Agreed Order suspending Dr. May's medical license until such time as he demonstrates that he is physically, mentally, and otherwise competent to safely practice medicine. The action was based on Dr. May's self-report of intemperate use of drugs or alcohol that could adversely affect his ability to practice medicine safely and on allegations of chemical dependency.

**MILLER, ROBERT MICHAEL, M.D., KEENE, TX, Lic. #J8317**

On December 9, 2005, the Board and Dr. Miller entered into an Agreed Order placing Dr. Miller on probation for eight years; requiring that his practice be monitored by another physician for the term of the order; that he provide to the Board a copy of the lab charges from the lab companies that he utilizes; and that he not charge patients more than 15 per cent above what the lab company charges or accept any additional compensation or payment of any kind from the lab companies. The requirements of the Agreed Order supersede and replace the requirements of the April 2, 2004, Agreed Order between the Board and Dr. Miller. The action was based on the following allegations that Dr. Miller ordered a multitude of laboratory tests for one patient without correlating the patient's history with the medical necessity, repeating, in some instances, these laboratory tests without a
finding of medical necessity being indicated in the records, and continuing to treat the patient when a referral to a consultant would have been appropriate.

**MUNOZ, ALEJANDRO, M.D., IOWA PARK, TX, Lic. #G8549**
On December 9, 2005, the Board and Dr. Munoz entered into an Agreed Order requiring Dr. Munoz to complete the course offered by the Vanderbilt Medical Center for Professional Health entitled A Continuing Education Course for Physicians Who Cross Sexual Boundaries, and to pay an administrative penalty of $2,000. The action was based on allegations that Dr. Munoz became personally involved in an inappropriate manner with a patient.

**NAAMAN, ADAM, M.D., HOUSTON, TX, Lic. #E3591**
On December 9, 2005, the Board and Dr. Naaman entered into a Mediated Agreed Order requiring Dr. Naaman to complete a course in medical record keeping of at least 10 hours and that he pay an administrative penalty of $1,200. The action was based on allegations that Dr. Naaman failed to adequately document treatment of postoperative care for one patient.

**NEEDLEMAN, LOUIS J., M.D., CORPUS CHRISTI, TX, Lic. #J1547**
On November 30, 2005, the Board and Dr. Needleman entered into an Agreed Order requiring Dr. Needleman to complete 25 hours of courses in ethics and to pay an administrative penalty of $1,000. The action was based on the action of the Massachusetts State Board of Medicine in entering into a Consent Agreement with Dr. Needleman that contained a reprimand and assessed a $5,000 fine for failing to respond to inquiries for additional information relating to his registration renewal.

**NGUYEN, SON KIM, M.D., HOUSTON, TX, Lic. #G9040**
On December 9, 2005, the Board and Dr. Nguyen entered into a two year Agreed Order requiring that Dr. Nguyen establish and adopt a pain management protocol complying with Board Rule 170; that his practice be monitored by another physician; that he obtain 20 hours of continuing medical education in record keeping; and that he pay an administrative penalty of $5,000. The action was based on allegations that Dr. Nguyen inadequately documented his treatment of one patient and thereby violated Board Rule 170 regarding the treatment of pain with respect to that patient.

**OLOFSSON, SHATHA M., M.D., CORPUS CHRISTI, TX, Lic. #J2459**
On December 9, 2005, the Board and Dr. Olofsson entered into an Agreed Order accepting the voluntary surrender of Dr. Olofsson's medical license. The action was based on Dr. Olofsson's desire to surrender her license because of her continued physical disability.

**O'NEAL, KENNETH W., M.D., ABILENE, TX, Lic. #D6119**
A Temporary Suspension Order Without Notice was entered on November 28, 2005, temporarily suspending Dr. O'Neal's license due to evidence that the physician's continuation in the practice of medicine would constitute a continuing threat to public welfare. The Temporary Suspension Order shall remain in effect until such time as it is superseded by a subsequent order of the Board. The action was based on allegations that Dr. O'Neal's treatment of three patients, who died immediately after receiving intravenous infusion of various mixtures from Dr. O'Neal, fell below the standard of care.

**ORZECK, ERIC A., M.D., HOUSTON, TX, Lic. #D6513**
On December 9, 2005, the Board and Dr. Orzech entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. Orzech charged a fee to provide medical records related to a social security claim for disability in violation of Board rules and state law.

**PEARCE, DAVID EARL, M.D., CORPUS CHRISTI, TX, Lic. #G9510**
On December 9, 2005, the Board and Dr. Pearce entered into an Agreed Order requiring Dr. Pearce to complete 10 hours of courses in each of the areas of medical record keeping and risk management. The action
was based on allegations involving the removal of a laparotomy pad by Dr. Pearce after an abscess formed after surgery and Dr. Pearce's lack of immediate notification to the patient or the patient's family.

**PETERSEN, WILLIAM ALPHONSE, M.D., CHARLESTON, WV, Lic. #G3687**

On December 9, 2005, the Board and Dr. Petersen entered into an Agreed Order assessing an administrative penalty of $250 and requiring Dr. Petersen to comply with any terms and conditions imposed by the Florida Board of Medicine. The action was based on the action of the Florida Board of Medicine in fining Dr. Petersen for failing to disclose on his licensing application that he had failed a final exam in medical school.

**REICH, STEPHANIE JILL, M.D., AUSTIN, TX, Lic. #H7340**

On December 9, 2005, the Board and Dr. Reich entered into an Agreed Order requiring Dr. Reich to obtain a total of 25 hours of continuing medical education in the areas of physician/patient relationships, ethics and record keeping; and that she pay an administrative penalty of $2,000. The action was based on allegations that Dr. Reich entered into a close personal relationship with a patient without appropriately terminating the physician-patient relationship and authorized prescriptions for two of the patient's minor children without maintaining a medical record for either child.

**ROUTH, LISA CAROLE, M.D., HOUSTON, TX, Lic. #H2742**

On December 9, 2005, the Board and Dr. Routh entered into a five-year Agreed Order publicly reprimanding Dr. Routh and requiring her to obtain an additional 50 hours of continuing medical education per year divided among the areas of physician/patient relationships, ethics and record keeping, and that she pay an administrative penalty of $5,000. The Agreed Order additionally requires Dr. Routh's practice to be monitored by another physician if she changes her area of practice from neuro-imaging to another area of practice. The action was based on allegations of unprofessional conduct by the submission of false or misleading information to the Alaska board; failure to maintain adequate medical records; and violating a regulation of the Alaska board by entering into a dual (financial) relationship with a patient. Dr. Routh reached an agreement with the Alaska board that the allegations would be dismissed if she agreed not to ever reapply for an Alaska license (which had lapsed) and to pay a fine of $10,000.

**RUMSEY, BRUCE G., M.D., PLANO, TX, Lic. #G6007**

On December 9, 2005, the Board and Dr. Rumsey entered into an Agreed Order suspending Dr. Rumsey's medical license until such time as he demonstrates that he is physically, mentally, and otherwise competent to safely practice medicine. The action was taken based on allegations that Dr. Rumsey used alcohol in an intemperate manner that could endanger a patient's life.

**SAYERS, STEPHEN CHARLES, M.D., BRIGHTON, IL, Lic. #G5574**

On December 9, 2005, the Board and Dr. Sayers entered into an Agreed Order suspending his medical license for a minimum of 24 months and until he demonstrates that he is physically, mentally, and otherwise competent to safely practice medicine. During the period of Dr. Sayers' active suspension he is required to abstain from the consumption of alcohol and drugs and undergo alcohol and drug screening. The action was based on Dr. Sayers' arrest for possession of cocaine, his plea of guilty for possession of a controlled substance and subsequent receipt of deferred adjudication.

**SCOTT, TEDDY CHARLES, M.D., EL CAMPO, TX, Lic. #E1481**

On December 9, 2005, the Board and Dr. Scott entered into an Agreed Order restricting Dr. Scott's license for three years by requiring that he be supervised by another physician when performing any bariatric procedures; that he obtain 10 hours of continuing medical education in post-surgical complications each year of the order; that he complete a course in record keeping of at least 10 hours; and that he pay an administrative penalty of $5,000. Dr. Scott is not permitted to supervise or delegate prescriptive authority to a physician assistant or advanced nurse practitioner or supervise a surgical assistant during the term of the order. The action was based on allegations that Dr. Scott did not meet the standard of care in his postoperative treatment of a patient on whom he performed an open vertical banded gastroplasty, because the patient showed signs of deterioration.
and organ failure in the immediate postoperative period and should have been re-explored in spite of non-revealing CT results and drain output.

SEIDEL, CLIFFORD CHARLES, M.D., DALLAS, TX, Lic. #C1355
On December 9, 2005, the Board and Dr. Seidel entered into an Agreed Order whereby Dr. Seidel, who is 82 years of age, voluntarily surrendered his medical license.

SHIPLEL, ALLAN HENDLEY, M.D., ROSWELL, GA, Lic. #G6613
On December 9, 2005, the Board and Dr. Shippel entered into an Agreed Order requiring Dr. Shippel to notify the Board if he intends to return to practice in Texas and, if he does so, requiring him, for a period of seven years following his return, to abstain from the consumption of alcohol and other substances as described in the order; submit to screening for these substances as requested by the Board; to participate in the programs of Alcoholics Anonymous at least three times per week; to limit his practice to 40 hours per week; and not treat his immediate family. Additionally, Dr. Shippel must obtain a forensic psychiatric evaluation from a board-appointed psychiatrist upon his return to Texas. The action was based on the action of the Georgia Board of Medical Examiners in placing Dr. Shippel on indefinite probation under various terms and conditions following his completion of an alcohol rehabilitation program.

STINNETT, JAMES TAYLOR III, M.D., COMMERCE, TX, Lic. #D3411
On December 9, 2005, the Board and Dr. Stinnett entered into an Agreed Order suspending Dr. Stinnett’s license, staying the suspension and placing him on probation for five years under the following terms and conditions: he must have a chaperone present anytime he sees a female patient; he must complete a course in physician-patient boundaries of at least 10 hours; he may not perform massage therapy on any of his psychiatric patients; and he must undergo psychiatric evaluation. If recommended by the evaluating psychiatrist, he must undergo continued psychiatric care and treatment. He was also assessed an administrative penalty of $2,500. The action was based on allegations that Dr. Stinnett touched a patient in an intimate manner while demonstrating massage techniques in the massage room in his home.

TALLAPUREDDY, SREEDHAR REDDY, M.D., WICHITA FALLS, TX, Lic. #BP30020971
On December 9, 2005, the Board and Dr. Tallapureddy entered into an Agreed Order publicly reprimanding him. The action was based on allegations that Dr. Tallapureddy failed to disclose on his application for a physician in training permit that he had been placed on academic probation and subsequently dismissed from a residency program at the University of Oklahoma Health Sciences Center.

THARAKAN, DAVID K., M.D., SAN ANTONIO, TX, Lic. #L0646
On December 9, 2005, the Board and Dr. Tharakan entered into a three-year Agreed Order requiring his practice to be monitored by another physician; that he obtain 20 hours of continuing medical education in each of the areas of pain management and record keeping/risk management in the first year of the order and 10 hours in each of these areas in each of the next two years of the order. The action was based on allegations that Dr. Tharakan failed to meet the standard of care in treating five patients and that he prescribed controlled substances in a nontherapeutic manner for these five patients.

TRIPLETT, RICHARD DANIEL, M.D., SPRING, TX, Lic. #J3251
On December 9, 2005, the Board and Dr. Triplett entered into an Agreed Order accepting the voluntary surrender of his medical license. Dr. Triplett’s license was suspended by an Agreed Order with the Board in 2001 and he has not practiced since that time. He now wishes to surrender his license because he is physically unable to satisfactorily practice medicine.

WALLACE, BRENT HOLMES, M.D., CLEBURNE, TX, Lic. #F2093
On December 9, 2005, the Board and Dr. Wallace entered into an Agreed Order requiring Dr. Wallace to complete 20 hours of continuing medical education in the area of medical record keeping and risk management. The action was based on allegations that Dr. Wallace, through an oversight, failed to ensure that
a follow-up X-ray was ordered for a patient for whom an X-ray some nine months later revealed adenocarcinoma.

**WALLIS, HAROLD F., M.D., LANCASTER, TX, Lic. #F7957**

On December 9, 2005, the Board and Dr. Wallis entered into an Agreed Order whereby Dr. Wallis voluntarily surrendered his medical license.

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

On December 7, 2005, a panel of the Texas Medical Board temporarily suspended Dr. Warr’s license after determining that his continuation in the practice of medicine constitutes a continuing threat to the public welfare. The action was based on the finding that Dr. Warr has a mental and/or physical condition that impairs his ability to safely practice medicine, as evidenced by his erratic behavior while employed as a radiologist, self-prescribing of multiple medications, refusal to submit to a physical or psychiatric evaluation, testimony that he was making errors in his work, failure to report to the Board in his renewals of his license his treatment for depression; and his dismissal by his employer.

**WIKOFF, RICHARD PAUL, M.D., FORT WORTH, TX, Lic. #L4807**

On December 9, 2005, the Board and Dr. Wikoff entered into an Agreed Order suspending Dr. Wikoff’s license until he demonstrates he is physically, mentally, and otherwise competent to safely practice medicine; publicly reprimanding Dr. Wikoff; and requiring him to pay an administrative penalty of $1,000. The action was based on allegations that Dr. Wikoff abused drugs and alcohol in an intemperate manner that could endanger a patient’s life.

**ZEPEDA, LUIS ERNESTO, M.D., HOUSTON, TX, Lic. #K1739**

On December 9, 2005, the Board and Dr. Zepeda entered into an Agreed Order assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Zepeda failed to keep adequate medical records for a number of patients from 2002 through February of 2003.

**Physician Assistants**

**COOK, GARY STEVEN, PORT LAVACA, TX, Lic. #PA00886**

On November 4, 2005, the Texas Physician Assistant Board and Mr. Cook entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Mr. Cook failed to timely provide properly requested medical records.

**KINGDON, DANA COKER, PLANO, TX, Lic. #PA01448**

On November 4, 2005, the Texas Physician Assistant Board and Ms. Kingdon entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Ms. Kingdon violated Board rules by failing to report, on a license renewal application, an arrest and conviction for the offense of evading arrest.

The Texas Medical Board, the state agency that regulates physicians, physician assistants, surgical assistants and acupuncturists, provides consumer protection through licensure, investigation and disciplinary action. The Board, under President Roberta M. Kalafut, D.O., and Executive Director Donald W. Patrick, M.D., J.D., and mandated by Senate Bill 104 of the 78th Legislature and S.B. 419 of the 79th Legislature, is strengthening and accelerating the disciplinary process for licensees who fail to meet the required standards of professional proficiency and behavior. Information on filing a complaint is on the agency web site at [www.tmb.state.tx.us](http://www.tmb.state.tx.us) or by calling (800) 201-9353.
Media contact Public Information Officer Jill Wiggins at jill.wiggins@tmb.state.tx.us or (512) 305-7018

Non-media contact: (512) 305-7030 or (800) 248-4062

Open records requests for orders may be made to

or write to:

Texas Medical Board
MC 251
P.O. Box 2018
Austin, TX 78768-2018

To receive press releases by e-mail: jill.wiggins@tmb.state.tx.us