Medical Board Disciplines 70 Doctors and Issues 700 Physician Licenses

At its August 27-29 meeting, the Texas Medical Board took disciplinary action against 70 licensed physicians.

The actions included 12 violations based on quality of care; six actions based on unprofessional conduct; three actions based on violation of probation or prior board order; nine actions based on inadequate medical records violations; five actions based on impairment due to alcohol or drugs or mental/physical condition; one action based on non-therapeutic prescribing; one action based on failure to properly supervise or delegate; five voluntary surrenders; one order modification; two temporary suspensions and 25 administrative orders based on minimal statutory violations. In addition, the board issued two cease and desist orders against unlicensed physicians. At its meeting July 25, the Texas Physician Assistant Board took action against two physician assistants.

At its August 27-29 meeting, the Texas Medical Board issued 700 physician licenses, for a total of 3,621 physician licenses issued in Fiscal Year 2008. (See previous release at http://www.tmb.state.tx.us/news/press/2008/090808a.php)

Proposed Rule Changes

Rule Review and proposed changes to the following chapters in Title 22 of the Texas Administrative Code will be published in the Texas Register for comment:

Chapter 165 Medical Records: Rule Review; 165.1(b)(7) adds that destruction of records is to be done to ensure confidentiality of records; 165.5(b)(1) requires physicians to allow for the transfer of records to another
physician if they are no longer going to able to see patients; 165.5(d) amends language such that any surrender of a license, regardless of whether it is for disciplinary reasons or not requires that the physician obtain a custodian for the records.

Chapter 169 Authority of Physicians to Supply Drugs: Rule Review; 169.2 update of name of Medical Board; 169.7 update of citation for DPS rules.

Chapter 178 Complaints: Rule Review; 178.1 gives statutory authority for chapter.

Chapter 179 Investigations: Rule Review; 179.1 gives statutory authority for chapter; 179.4(c)(2)(H) adds that probable cause for requesting an evaluation may be based on statements or actions by a person at a hearing; 179.6 clarifies that an investigation may not be completed within 180 days if DPRC or the Board’s internal QA committee determines further investigation is required.
Chapter 180  • Rehabilitation Orders: Rule review; grammatical edits.

Chapter 182  • Use of Experts: Rule review; 182.1  • gives statutory authority for chapter; 182.8  • clarifies that expert physician reviewers are to be in same specialty as that declared by licensee.

Chapter 187  • Procedural Rules: Rule review; 187.3  • allows for rules on extensions; 187.4  • grammatical change; 187.14  • deletion of provisions on admin penalties since inconsistent with newly adopted rules; 187.18  • clarifies that it’s not only witnesses who can testify outside the presence of the Respondent but also the complainant, which is consistent with what we already do; 187.24  • name update of Medical Board; 187.29  • grammatical correction; 187.59  • adds language to mirror 2001.081 of the APA; 187.70-.73  • allows for the automatic suspension of licenses after a hearing based on
convictions of certain offenses and not just based on incarceration and how the suspension may be lifted.

Chapter 190 Disciplinary Guidelines: Rule review; 190.1 provides for statutory authority for chapter; 190.8(1)(J) clarifies that reasonable notice of termination of physician-patient relationship is 30 days; (J) termination of patient care without providing reasonable notice to the patient of at least 30 days or otherwise obtaining the patient's consent to termination of care. 190.14 amends sanction guidelines for violations that are grounds for admin penalty orders, such that other sanctions other than the admin penalties are removed. This covers:

- failure to timely provide medical records, or overcharging for medical records
- failure to comply with board subpoena
- conviction of a misdemeanor
- failure to obtain/document CME
- failure to report healthcare liability claim
- failure to notify of address change
- failure to display notice concerning complaints
- use of misleading information in advertising relating to board certification
- submission of false or misleading statement in initial application or renewal of license

Chapter 192 Office-Based Anesthesia: Rule review; 192.2(c)(1)(B)(iv) deletion of
requirement for premeasured doses of epinephrine, etc. with regard to Level 1 services.

DISCIPLINARY ACTIONS

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

QUALITY OF CARE VIOLATIONS

ATLAS, RUTH M., M.D., Lic. #G7616, Houston, TX

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

BROWN, JEFFREY JOHN, M.D., Lic. #L4267, McAllen, TX

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

DIMAZANA, EPIFANIO V., M.D., Lic. #E2188, Corpus Christi, TX

On August 29, 2008, the Board and Dr. Dimazana entered into an Agreed Order requiring that Dr. Dimazana obtain 10 hours CME in ethics within one year (in addition to annual requirements) and pay an administrative penalty of $2,000. The action was based on Dr. Dimazana resigning his hospital admitting privileges after disciplinary action there, and for his failure to meet the standard of care, negligent practice, and lack of diligence on two occasions when he was unavailable or did not respond to attempted contacts by hospital staff concerning the admission of patients who had presented at the ER.
GARCIA, JOSEPH EDWARD, M.D., Lic. #H0368, Austin, TX

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

HIRSCH, DAVID M., D.O., Lic. #J3119, San Antonio, TX

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

IBONI, ROLAND D., D.O., Lic. #L7424, Rowlett, TX

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

MYINT, DANIEL THET, M.D., Lic. #H8550, Richardson, TX

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

PECHERO, RUBEN DANIEL, M.D., Lic. #D4834, McAllen, TX

On August 29, 2008, the Board and Dr. Pechero entered into a Mediated Agreed Order requiring him to attend five hours CME in spinal pain management and five hours in risk management within one year and pay an administrative penalty of $1,000. The Order was based on Dr. Pechero’s failure to indicate reasons for orthopedic surgery performed on one patient; failure to indicate reasons for orthopedic surgery, or do an adequate trial of pain management, prior to performing surgery on a second patient; and failure to do an adequate pre-operative workup on a third patient who scheduled for orthopedic surgery.
SALINAS, HILDEBRANDO, M.D., Lic. #L1446, McAllen, TX

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

SKIE, GREGORY, M.D., Lic. #G5617, Mansfield, TX

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

SURAPANENI, VEENA, M.D., Lic. #K6938, Cedar Park, TX

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

WALLACE, BRENT HOLMES, M.D., Lic. #F2093, Cleburne, TX

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

UNPROFESSIONAL CONDUCT VIOLATIONS

HOGAN, MATTHEW JAMES, M.D., Lic. #H5777, Atlanta, TX

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

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

MIKULECKY, MICHAEL STEVEN, M.D., Lic. #L6527, Redding, CA

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

VALADEZ, JAVIER ARNOLDO, M.D., Lic. #G5719, Dallas, TX

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

WILLIAMS, MICHAEL DUANE, M.D., Lic. #E2943, Amarillo, TX

On August 29, 2008, the Board and Dr. Williams entered into an Agreed Order requiring that, for two years, Dr. Williams have and document that he has a female chaperone present for all examinations of female patients. In addition, the order requires that Dr. Williams attend the professional boundaries course offered by Vanderbilt Medical Center for Professional Health, or a similar Board-approved course. The action was based on Dr. Williams’s failure to follow appropriate practices when examining a female patient.
WOODWARD, JOHN REAGAN, M.D., Lic. #D4884, Dallas, TX

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

VIOLATION OF PROBATION OR PRIOR ORDER

CANTU, DENNIS DAVID, M.D., Lic. #F1430, Laredo, TX

On August 29, 2008, the Board and Dr. Candu entered into an Agreed Order requiring him to attend eight hours CME in office management or risk management within one year (in addition to annual requirements) and pay an administrative penalty of $500. The action was based on Dr. Cantu’s failure to adequately comply with the educational requirement ordered in a 2007 disciplinary order.

MILLS, VIRGINIA M., M.D., Lic. #J2210, Houston, TX

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

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

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

INADEQUATE MEDICAL RECORDS

ALONSO, RAMIRO, M.D., Lic. #D4598, McAllen, TX
On August 29, 2008, the Board and Dr. Alonso entered into an Agreed Order requiring that he attend 10 hours CME in medical record-keeping within one year in addition to regular annual requirements and pay an administrative penalty of $500. The action was based on Dr. Alonso’s failure to document who administered the injection, the site of the injection, and the actual dose of the injection that was provided to a patient.

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

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

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

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

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

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

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

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

McMEANS, PAT MASON, M.D., Lic. #G8916, Beaumont, TX
On August 29, 2008, the Board and Dr. McMeans entered into an Agreed Order requiring that he obtain 10 hours CME in medical record-keeping and 10 hours CME in risk management within one year (in addition to annual requirements) and pay an administrative penalty of $3,000. The action was based on Dr. McMeans’s failure to maintain adequate medical record documentation in the treatment of five weight loss patients.

McNALLY, LAWRENCE B., M.D., Lic. #G2780, Dallas, TX

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

RAJ, JHANSI M., M.D., Lic. #G8735, Fort Worth, TX

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

SRIVATHANAKUL, SURAPHANDHU, M.D., Lic. #E7288, Victoria, TX

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

IMPAIRMENT DUE TO ALCOHOL OR DRUGS OR MENTAL/PHYSICAL CONDITION

COLEMAN, BRENT J., D.O., Lic. #G3241, Uvalde, TX

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

GREEN, DEMETRIS ALLEN, M.D., Lic. #J4168, Spring, TX

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

MARTINEZ, JORGE A., M.D., Lic. #H1801, McAllen, TX

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

SHIPPEL, ALLAN HENDLEY, M.D., Lic. #G6613, Roswell, GA

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

WHITE, STEPHEN CURTIS, M.D., Lic. #L3183, Longview, TX
On August 29, 2008, the Board and Dr. White entered into an Agreed Order suspending Dr. White’s license for an indefinite period until such time as he petitions the Board and provides clear and convincing evidence to show that he is competent to safely return to medical practice. The action was based on Dr. White’s use of cocaine and his three arrests for possession of illegal drugs.

**NONTHERAPEUTIC PRESCRIBING**

**FINDLAY, DAVID JOHN, M.D, Lic. #L1847, Weatherford, TX**

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

**FAILURE TO PROPERLY SUPERVISE OR DELEGATE**

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

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

**VOLUNTARY SURRENDERS**

**BISHOP, ROBERT T., M.D., Lic. #C7545, Dallas, TX**

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

**BOHORQUEZ, JULIO CESAR, M.D., Lic. #F3414, Houston, TX**

On August 29, 2008, the Board and Dr. Bohorquez entered into an Agreed Voluntary Order of Suspension wherein Dr. Bohorquez voluntarily agreed to the suspension of his license and practice of medicine. The order is based on Dr. Bohorquez’s current inability to practice medicine due to a serious illness and his ongoing treatment for that illness.
On August 29, 2008, the Board and Dr. Moore entered into an Agreed Order of Voluntary Surrender wherein Dr. Moore voluntarily and permanently surrendered his license in lieu of Board disciplinary action related to a violation concerning failure to comply with the chart monitor requirement set forth in a 2005 Board order.

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

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

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

On August 29, 2008, the Board and Dora Busby Crandall, M.D., entered into a Temporary Suspension Order.

ORDER MODIFICATION

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

MASSEY, CHARLES R. JR., M.D., Lic. # G5341, Fredericksburg, TX

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

ADMINISTRATIVE ORDERS/MINIMAL STATUTORY VIOLATIONS

Twenty-five* licensees agreed to enter into administrative orders with the Board for minimal statutory violations.

CEASE AND DESIST ORDERS

GONZALEZ, JESSICA, M.D., McAllen, TX

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

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

On June 27, 2008, the Board and Mr. Carroll, 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 Mr. Carroll representing himself to be a physician and writing a prescription at a medical care facility in Porter, Texas. The order requires Mr. Carroll to immediately halt all such activity.

PHYSICIAN ASSISTANTS

At its meeting July 25, the Texas Physician Assistant Board took action against the following physician assistants:
BENTON, FLOYD H., P.A., Lic. No. PA00039, Sterling City, TX

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

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

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

* Amended and re-posted April 22, 2009, to reflect better data on the number of administrative orders and minor statutory violations.