TMB disciplines 39 physicians at November meeting, adopts rule changes

At its November 7, 2014 meeting, the Texas Medical Board disciplined 39 licensed physicians and issued two cease and desist orders. The disciplinary actions included seven orders related to quality of care violations, three orders related to unprofessional conduct, three revocations, five voluntary surrenders, two suspensions, one order related to criminal activity, three orders related to peer review actions, one order related to inappropriate prescribing, three orders related to violation of prior Board order, five orders related to violation of Board rules, one order related to Texas Physician Health Program violations, and five orders related to inadequate medical records.

The Board issued 200 physician licenses at the November meeting, bringing the total number of physician licenses issued in FY15 to 660.

RULE CHANGES ADOPTED

CHAPTER 163. LICENSURE

§163.7, Ten Year Rule
The Amendment to rule 163.7, relating to the Ten Year Rule, amends the rule to eliminate the requirement of current board certification and simply allows proof of passage of a written, monitored specialty certification examination from a member board of the American Board of Medical Specialties or Bureau of Osteopathic Specialists, or by the American Board of Oral and Maxillofacial Surgery by an applicant to satisfy the ten year rule without holding current board certification.

CHAPTER 183. ACUPUNCTURE

§183.4, Licensure
The Amendments to rule 183.4, relating to Licensure and the demonstrated ability of licensure applicants to communicate in English, amends 183.4(a)(8)(B) by adding an updated Test of English as Foreign language (TOEFL) test score requirement for Internet Based Testing (iBT®), reflecting TOEFL’s new test score scale, and deleting the outdated referenced to TOEFL’s former test score scale. The amendment is made so that the TOEFL test requirement correctly references TOEFL’s current test score scale.

§183.11, Complaint Procedure Notification
The Amendments to rule 183.11, relating to Complaint Procedure Notification, amends the rule to correct an incorrect citation to Section 187 to the correct citation to Section 178 of this title relating to Complaint Procedure Notification. The amendment is made so that the citation in the rule is accurate and correct and consistent with Texas statutes.

CHAPTER 190. DISCIPLINARY GUIDELINES

§190.8, Violation Guidelines
The Amendment to rule 190.8, relating to Violations Guidelines, corrects the spelling of the term “meningococcal” in subsection (1)(L)(iii)(II)(d).
DISCIPLINARY ACTIONS

QUALITY OF CARE

Baumgartner, Teri Lynne, M.D., Lic. No. K6959, Athens
On November 7, 2014, the Board and Teri Lynne Baumgartner, M.D., entered into an Agreed Order requiring Dr. Baumgartner within one year complete at least 12 hours of CME, divided as follows: eight hours in medical recordkeeping and four hours in treating high risk pregnancy. The Board found Dr. Baumgartner failed to meet the standard of care in regards to one patient by failing to adequately assess and treat the patient’s symptoms and failing to adequately document the medical records as to the patient’s noncompliance with treatment.

Dave, Pramesh Chandrakant, M.D., Lic. No. K0014, Arlington
On November 7, 2014, the Board and Pramesh Chandrakant Dave, M.D., entered into an Agreed Order publicly reprimanding Dr. Dave and requiring Dr. Dave to within one year complete at least 8 hours of CME in liposuction procedures and complications, with at least four hours in risk management, and four hours in medical ethics; within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year and three attempts pass the Medical Jurisprudence Exam; and have his practice monitored by another physician for eight consecutive monitoring cycles. The Board found Dr. Dave’s medical recordkeeping was inadequate, primarily in regard to anesthesia monitoring as well as patients’ discharge criteria and post-discharge arrangements; and there was concern about the volume of aspirate removed from one patient, as well as the technical aspects of the procedure.

Mayo, Carlos O., M.D., Lic. No. K3329, Houston
On November 7, 2014, the Board and Carlos O. Mayo, M.D., entered into an Agreed Order requiring Dr. Mayo to have his practice monitored by another physician for four consecutive monitoring cycles; within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education Program (PACE); and within one year complete at least eight hours of CME in obstetrical care. The Board found Dr. Mayo failed to use further laboratory analysis to confirm or rule out early pregnancy. Dr. Mayo should have at least used quantitative beta HCG testing, but he did not do so. The Board also found Dr. Mayo’s medical records lacked sufficient documentation of the history and physicals he performed and his recommendation for treatment.

Medina, Marelyn, M.D., Lic. No. J9759, McAllen
On November 7, 2014, the Board entered a Final Order publicly reprimanding Marelyn Medina, M.D., and requiring Dr. Medina to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 24 hours of CME, divided as follows: eight hours in ethics, eight hours in risk management and eight hours in endocrinology and diseases of the thyroid; and have her practice monitored by another physician for eight consecutive monitoring cycles. The Board found Dr. Medina failed to meet the standard of care in her diagnosing and treatment of hypothyroidism and iodine deficiency in a patient. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Medina has 20 days from the service of the order to file a motion for rehearing.

Moore, Robert Alan, M.D., Lic. No. E6533, Bellaire
On November 7, 2014, the Board and Robert Alan Moore, M.D., entered into an Agreed Order requiring Dr. Moore to within one year complete at least 12 hours of CME in risk management; and pay an administrative penalty of $5,000 within 60 days. The Board found Dr. Moore admitted to wrong-site lumbar area radiofrequency ablation to a patient’s right lumbar region instead of the left region without the patient’s consent. Although the patient needed ablation on both sides, Dr. Moore and the patient had agreed to the ablation on the left side first.

Rozenboom, Morgen Melinda, M.D., Lic. No. K2115, Texarkana
On November 7, 2014, the Board and Morgen Melinda Rozenboom, M.D., entered into an Agreed Order prohibiting Dr. Rozenboom from engaging in the practice of obstetrics, labor and delivery, or home births, and prohibiting her from
supervising, delegating to, or associating with any midlevel providers including midwives in such practices until successfully completing the following requirements: within one year complete at least 24 hours of CME, divided as follows: eight hours in managing obstetrical emergencies, eight hours in risk management, including physician-patient communications and eight hours in medical recordkeeping; within one year obtain certification in neonatal resuscitation from the Neonatal Resuscitation Program offered by the American Medical Association of Pediatrics; and upon lifting the restriction, have her practice monitored by another physician for four consecutive monitoring cycles. The Board found Dr. Rozenboom failed to document her management of a patient’s post-partum complications, including her assessment of the patient or what actions she took to stabilize the patient. The medical records demonstrate that the patient’s vital signs were not monitored with appropriate frequency or regularity during the post-partum period, including when the patient exhibited signs of respiratory distress. The documentation that does exist contains errors and inaccuracies. Furthermore, Dr. Rozenboom did not honor the patient’s request to be transferred to the hospital sooner.

Schrapps, Jerome Francis, M.D., Lic. No. J2907, Beaumont
On November 7, 2014, the Board and Jerome Francis Schrapps, M.D., entered into a Mediated Agreed Order requiring Dr. Schrapps to have his practice monitored for eight consecutive monitoring cycles by another physician; and within one year complete at least 16 hours of CME, divided as follows: 16 hours in identifying and treating post-operative complications and eight hours in ethics, with at least two of those hours in obtaining informed consent from patients. The Board found Dr. Schrapps failed to document any discussion with a patient regarding plans to conduct a sleeve gastrectomy, and failed to document written informed consent. Dr. Schrapps appropriately recognized that the patient's medical issues were possibly secondary to a gastric leak, but did not take the patient back to surgery to address the leak on a timely basis. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

UNPROFESSIONAL CONDUCT
Jolivet, David Anthony, M.D., Lic. No. G2160, Carlsbad
On November 7, 2014, the Board and David Anthony Jolivet, M.D., entered into an Agreed Order requiring Dr. Jolivet to submit to an evaluation by the Physician Health Program (PHP); and within one year complete at least 16 hours of CME, divided as follows: eight hours of risk management, four hours in ethics and four hours in medical recordkeeping. The Board found Dr. Jolivet admitted to prescribing controlled substances to his family members beyond the 72-hour period of immediate need and without maintaining adequate medical records, admitted to striking a family member in a dispute, and admitted to struggles with depression and alcohol consumption.

Miller, George Givens, M.D., Lic. No. G8286, Houston
On November 7, 2014, the Board and George Givens Miller, M.D., entered into a Mediated Agreed Order requiring Dr. Miller to within one year complete at least eight hours in CME, divided as follows: four hours in medical ethics and four hours in risk management. The Board found Dr. Miller failed to report a pending investigation by a health care entity to the Board when he filed his online renewal applications in 2006 and 2008. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Smith, Raleigh Arnold, M.D., Lic. No. F4547, Aransas Pass
On November 7, 2014, the Board and Raleigh Arnold Smith, M.D., entered into a Mediated Agreed Order requiring Dr. Smith to submit to and obtain an independent medical evaluation and follow all recommendations for care and treatment; within one year successfully complete the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and within one year complete at least eight hours of CME, divided as follows: four hours in ethics and four hours in risk management. The Board found Dr. Smith engaged in inappropriate conduct and made unprofessional comments towards a co-worker in the presence of a patient and hospital staff and failed to notify the Board of actions by hospitals during the appropriate license renewal periods on his applications for renewal. This order resolves a formal complaint filed at the State Office of Administrative Hearings.
REVOCATION

Gonzalez-Angulo, Ana Maria, M.D., Lic. No. L6917, Houston
On November 7, 2014, the Board and Ana Maria Gonzalez-Angulo, M.D., entered into an Agreed Order of Revocation, revoking Dr. Gonzalez-Angulo’s Texas medical license and requiring her to immediately cease practicing in Texas. Dr. Gonzalez-Angulo agreed to the revocation of her license in lieu of further disciplinary proceedings. The Board found that on September 29, 2014, in the 248th District Court of Harris County, Texas, a jury found Dr. Gonzalez-Angulo guilty of one count of the first degree felony offense of Aggravated Assault of a Family Member. Dr. Gonzalez-Angulo was sentenced to serve 10 years in prison.

Hawkins, Willie James, M.D., Lic. No. G2147, Missouri City
On November 7, 2014, the Board entered a Final Order revoking Willie James Hawkins, M.D.’s Texas medical license. The Board found that Dr. Hawkins on November 19, 2012, in the 337th District Court, Harris County, Texas, pled guilty to a violation of the Medical Practice Act, a Class A Misdemeanor. The presiding judge found that the evidence substantiated Dr. Hawkins’ guilt, but deferred making an adjudication of guilt and, instead, placed him on deferred adjudication community supervision for two years. The order of deferred adjudication issued against Dr. Hawkins stemmed from his September 2011 through February 2012 tenure as the operator, and supervising physician at the Wellness and Weightloss Clinic, located in Houston, Texas. Dr. Hawkins failed to exercise the proper diligence and oversight that those roles entail. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Hawkins has 20 days from the service of the order to file a motion for rehearing.

Johnson, Rahman C., M.D., Lic. No. BP10043418, Albuquerque, NM
On November 7, 2014, the Board entered a Default Order against Rahman C. Johnson, M.D., which revoked his Texas medical license. On March 28, 2014, the Board filed a Complaint with the State Office of Administrative Hearings (SOAH) in Docket No. 503-14-2947. The Complaint alleged Dr. Johnson was terminated from his residency program following an arrest for driving while intoxicated. Dr. Johnson was served notice of the Complaint but did not file an answer. All other deadlines passed without any response from Dr. Johnson, therefore the Board granted a Determination of Default and Dr. Johnson’s Texas medical license was revoked by Default Order.

VOLUNTARY SURRENDER

Dunegan, Gerald, M.D., Lic. No. D0856, Houston
On November 7, 2014, the Board and Gerald Dunegan, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Dunegan agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Dunegan was under investigation for allegations related to his practice and prescribing habits. Dr. Dunegan reported to the Board that he has a physical condition that prevents him from continuing to practice medicine.

Gutierrez, Jaime Alberto, M.D., Lic. No. D2109, Houston
On November 7, 2014, the Board and Jaime Alberto Gutierrez, M.D., entered into an Agreed Voluntary Surrender Order on Formal Filing in which Dr. Gutierrez agreed to voluntarily surrender his Texas medical license effective 120 days from the date of this order in lieu of further disciplinary proceedings. Dr. Gutierrez’s license is therefore permanently canceled on March 7, 2014. Dr. Gutierrez was the subject of a formal complaint at the State Office of Administrative Hearings related to the operation of unlicensed pain management clinics, improper supervision of midlevel providers, nontherapeutic prescribing and standard of care violations related to six patients. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Lewis, Billy Wayne, M.D., Lic. No. D7149, Bedford
On November 7, 2014, the Board and Billy Wayne Lewis, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Lewis agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Lewis reported to the Board that he has a medical condition which precludes him from practicing medicine with reasonable skill and safety to patients.
Raben, Cyril Anthony, M.D., Lic. No. H6922, Fayetteville, AR
On November 7, 2014, the Board and Cyril Anthony Raben, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Raben agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Raben surrendered his license to practice in Ohio, with consent to permanent revocation, after allegations of misconduct by the State Medical Board of Ohio. Dr. Raben was also denied application to renew his license by the state of Illinois based on the actions by the state of Ohio.

Salameh, Raja Nicolas, M.D., Lic. No. G9654, McAllen
On November 7, 2014, the Board and Raja Nicolas Salameh, M.D., entered into an Agreed Voluntary Surrender in which Dr. Salameh agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Salameh is unable to practice medicine because of illness.

SUSPENSION
Sanjar, Mansour R., M.D., Lic. No. G3069, Baytown
On October 7, 2014, the Board entered an Order of Suspension By Operation of Law, suspending Mansour R. Sanjar, M.D.‘s Texas medical license. The Board found that on March 12, 2014, in the U.S. District Court Southern District of Texas, Houston Division, a jury found Dr. Sanjar guilty of a felony, as follows: one count of Conspiracy to Commit Health Care Fraud, two counts of Health Care Fraud, one count of Conspiracy to Defraud the United States and to Pay Health Care Kickbacks, and two counts of Payment and Receipt of Healthcare Kickbacks. Dr. Sanjar’s sentencing is scheduled for January 12, 2015. The Order remains in effect until superseded by a subsequent Order of the Board.

Ware, John Roscoe, M.D., Lic. No. G0260, Dallas
On November 7, 2014, the Board and John Roscoe Ware, M.D., entered into an Agreed Order of Suspension, suspending Dr. Ware’s Texas medical license until such a time as he requests in writing to have the suspension stayed or lifted, and appears before the Board and provides clear and convincing evidence that he is physically, mentally, and otherwise competent to safely practice medicine. The Board found Dr. Ware underwent a neuropsychological examination in 2013 and was diagnosed with mild dementia and significant executive dysfunction. The weight of the clinical evidence indicates Dr. Ware is not currently safe to practice medicine.

CRIMINAL ACTIVITY
Khaznadar, Mohamedaouf A., M.D., Lic. No. K1504, Amarillo
On November 7, 2014, the Board and Mohamedaouf A. Khaznadar, M.D., entered into an Agreed Order publicly reprimanding Dr. Khaznadar and requiring Dr. Khaznadar to pay an administrative penalty of $2,000 within 60 days. The Board found Dr. Khaznadar entered a guilty plea and received deferred adjudication for a misdemeanor charge of offering to engage in sexual conduct on October 28, 2013.

PEER REVIEW ACTIONS
Davis, Jennifer Lee, M.D., Lic. No. J4070, Corpus Christi
On November 7, 2014, the Board and Jennifer Lee Davis, M.D., entered into an Agreed Order requiring Dr. Davis to within one year complete at least 16 hours of CME, divided as follows: four hours in risk management, four hours in medical recordkeeping and four hours in ethics; and comply with all terms and conditions imposed by the November 7, 2013, Medical Staff Performance Improvement Committee action requiring proctoring at Driscoll Children’s Hospital. The Board found Dr. Davis was subject to disciplinary action by Driscoll Children’s Hospital regarding her medical recordkeeping.

Sokhon, Kozhaya Chehade, M.D., Lic. No. M9668, Houston
On November 7, 2014, the Board and Kozhaya Chehade Sokhon, M.D., entered into an Agreed Order publicly reprimanding Dr. Sokhon and requiring Dr. Sokhon to have his practice monitored by another physician for eight
consecutive monitoring cycles; within one year complete at least 20 hours of CME, divided as follows: eight hours in cardiac catheterization, eight hours in risk management and four hours in ethics; within 180 days complete the competency course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and pay an administrative penalty of $5,000 within 120 days. The Board found Dr. Sokhon violated the standard of care regarding his care and treatment of the patient at issue. Dr. Sokhon was subject to discipline by peer review at Conroe Medical Center, and resigned from that facility while under investigation.

**Wolffe, Eduardo Antonio, M.D., Lic. No. M0313, El Segundo, CA**

On November 7, 2014, the Board and Eduardo Antonio Wolffe, M.D., entered into an Agreed Order publicly reprimanding Dr. Wolffe and requiring Dr. Wolffe to within one year and three attempts pass the Medical Jurisprudence Exam. The Board found Dr. Wolffe voluntarily resigned from a practice position with a hospital while under investigation, or to avoid, an investigation based on his delivery of care and treatment for two patients.

**INAPPROPRIATE PRESCRIBING**

**Cary, Adam Brian, D.O., Lic. No. M2581, Frisco**

On November 7, 2014, the Board and Adam Brian Cary, D.O., entered into an Agreed Order requiring Dr. Cary to within one year complete at least 16 hours of CME, divided as follows: eight hours in risk management and eight hours in ethics; and within one year and three attempts pass the Medical Jurisprudence Exam. The Board found Dr. Cary prescribed to one patient with whom he had a close personal relationship without adequate documentation of a clinical diagnosis and for time periods exceeding the patient’s immediate needs.

**VIOLATION OF PRIOR ORDER**

**Brown, Forrest Carroll, M.D., Lic. No. D3169, Dallas**

On November 7, 2014, the Board and Forrest Carroll Brown, M.D., entered into a Modified Agreed Order requiring Dr. Brown to within one month complete an independent medical evaluation and follow all recommendations for care and treatment. The Board found Dr. Brown has not complied with terms of his June 2013 Order. All other provisions of the Order, as modified, remain in full force.

**Matthews, Jonathan Richard, D.O., Lic. No. L9803, Trophy Club**

On November 7, 2014, the Board and Jonathan Richard Matthews, D.O., entered into an Agreed Order requiring Dr. Matthews to within 90 days complete all outstanding CME requirements as required by his June 2013 Orders. The Board found Dr. Matthews failed to complete all CME requirements of his June 2013 Orders by the deadlines set forth in the Orders.


On November 7, 2014, the Board and Daniel Eric Rousch, D.O., entered into an Agreed Order requiring Dr. Rousch to within one year and three attempts pass the Medical Jurisprudence Exam; and within 90 days complete all deficient CME hours ordered by the 2013 Order. The Board found Dr. Rousch violated his February 2013 order by failing to implement recommendations of his practice monitor and failing to complete any pre-approved CME hours at the time of his Informal Settlement Conference.

**VIOLATION OF BOARD RULES**

**McWherter, Joseph Francis, M.D., Lic. No. E8713, Fort Worth**

On November 7, 2014, the Board and Joseph Francis McWherter, M.D., entered into a Mediated Agreed Order requiring Dr. McWherter to remove the “while avoiding breast cancer” language from his website and provide proof to the Board of such removal within 30 days; within one year complete at least four hours of CME in risk management; and pay an administrative penalty of $1,000 within 60 days. The Board found the following statement on Dr. McWherter’s website had the potential to be false, deceptive, and/or misleading if taken out of context, “[h]is program allows women to
experience the life-enhancing benefits of hormonal replacement safely while avoiding breast cancer.” This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Mercer, Lloyd Faust, Jr., M.D., Lic. No. G3610, Tyler
On November 7, 2014, the Board and Lloyd Faust Mercer, Jr., M.D., entered into an Agreed Order prohibiting Dr. Mercer from treating patients for chronic pain or engaging in the practice of pain management; shall not seek to reinstate DEA/DPS controlled substance registration certificates for Schedules II, III, IIIN, and IV; shall not treat or otherwise serve as a physician for immediate family, and shall not prescribe, dispense, administer or authorize controlled substances or dangerous drugs with addictive potential or potential for abuse to himself or his immediate family; and within one year and three attempts pass the Medical Jurisprudence Exam. The Board found Dr. Mercer failed to adhere to treatment, monitoring, and documentation requirements regarding six chronic pain patients, four of which were his family members. Dr. Mercer’s treatment was not within the standard of care.

Shaw-Rice, Judi Ann, M.D., Lic. No. J1134, Houston
On November 7, 2014, the Board and Judi Ann Shaw-Rice, M.D., entered into a Mediated Agreed Order publicly reprimanding Dr. Shaw-Rice and requiring Dr. Shaw-Rice to not reregister or obtain DEA/DPS controlled substances certificates until authorized by the Board; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 10 hours of CME, divided as follows: five hours in medical ethics and five hours in medical recordkeeping; within one year complete the prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; not be permitted to delegate prescriptive authority for controlled drugs, but shall otherwise be authorized to supervise midlevel providers; and pay an administrative penalty of $5,000 within one year. The Board found Dr. Shaw-Rice submitted an application for a pain management clinic in which she inaccurately stated that she owned the clinic, which was actually owned by a non-physician; midlevels supervised by Dr. Shaw-Rice failed to follow the Board’s guidelines for the treatment of chronic pain; and Dr. Shaw-Rice’s midlevels failed to fully and properly follow protocols to monitor the patients for effectiveness of treatments, side effects, or abuse or diversion of medications.

On November 7, 2014, the Board and William F. Sorrels, D.O., entered into an Agreed Order requiring Dr. Sorrels to within one year complete at least 21 hours of CME, divided as follows: eight hours in risk management, eight hours in medical recordkeeping, and five hours in doctor-patient communications; and pay an administrative penalty of $1,000 within 60 days. The Board found Dr. Sorrels prescribed naltrexone to a patient without obtaining a complete history and physical exam, and failed to maintain a medical record for the treatment of the patient.

Trevino, Jose De Jesus, M.D., Lic. No. F2074, Corpus Christi
On November 7, 2014, the Board and Jose De Jesus Trevino, M.D., entered into an Agreed Order requiring Dr. Trevino to have his practice monitored by another physician for eight consecutive monitoring cycles; and within one year complete at least eight hours of CME in the treatment of chronic pain. The Board found Dr. Trevino’s record of clinical evaluation and documentation supporting prescribing were inadequate.

TEXAS PHYSICIANS HEALTH PROGRAM (PHP) VIOLATION
Illich, Melanie Bivona, M.D., Lic. No. J2104, Waco
On November 7, 2014, the Board and Melanie Bivona Illich, M.D., entered into an Agreed Order requiring Dr. Illich to limit her practice to no more than 40 hours per week; prohibiting her from taking night or weekend call and shall arrange for call coverage; shall not treat or otherwise serve as a physician for her immediate family and shall not prescribe, dispense, administer or authorize controlled substances or dangerous drugs to herself or immediate family; undergo a 96-hour inpatient evaluation for substances abuse; continue to participate in Alcoholics Anonymous no less than five times a week; obtain a Board-approved treating psychiatrist and follow all recommendations for care and treatment; participate in activities of a county or state medical society committee on physician health and rehabilitation; abstain from the consumption of prohibited substances as defined in the Order; and participate in the Board’s drug
INADEQUATE MEDICAL RECORDS

**Brimmer, Robert Alvah, II, M.D., Lic. No. K3110, Fort Worth**
On November 7, 2014, the Board and Robert Alvah Brimmer, II, M.D., entered into a Mediated Agreed Order requiring Dr. Brimmer to pay an administrative penalty of $2,000 within 60 days. The Board found that the evidence was sufficient to support the entry of this Order due to the failure to document the rationale regarding the care of one inmate patient. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Gross, Robert Hadley, M.D., Lic. No. G5125, San Angelo**
On November 7, 2014, the Board and Robert Hadley Gross, M.D., entered into an Agreed Order on Formal Filing requiring Dr. Gross to within 90 days submit an adequate written protocol to the Compliance Department of the Board; within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and within one year complete at least eight hours of CME in risk management. The Board found Dr. Gross did not adequately maintain adequate medical records with regard to seven patients. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**James, Kevin Bernard, M.D., Lic. No. M4201, Southlake**
On November 7, 2014, the Board and Kevin Bernard James, M.D., entered into a Mediated Agreed Order requiring Dr. James to within one year complete the K-STAR risk management course; and pay an administrative penalty of $2,000 within 60 days. The Board found Dr. James inadequately documented his conversations with a patient as to the rationale for surgery. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Saqer, Rezik A., M.D., Lic. No. K2282, Houston**
On November 7, 2014, the Board and Rezik A. Saqer, M.D., entered into a Mediated Agreed Order requiring Dr. Saqer to within one year 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 $500 within 60 days. The Board found Dr. Saqer’s medical records did not fully comply with the Board’s medical recordkeeping rules. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Ward, Gregory A., M.D., Lic. No. K1126, Fort Worth**
On November 7, 2014, the Board and Gregory A. Ward, M.D., entered into an Agreed Order requiring Dr. Ward to within one year complete at least 8 hours of CME in medical recordkeeping. The Board found Dr. Ward incorrectly dictated and described a procedure that was different than the procedure he actually performed on the patient. Dr. Ward dictated the operative note several days after surgery and did not review the note before electronically signing it.

**CEASE AND DESIST**

**Gogia, Prem P., No License, Sugar Land**
On November 7, 2014, the Board and Prem P. Gogia entered into an Agreed Cease and Desist Order prohibiting Mr. Gogia from acting as, or holding himself out to be, a licensed physician in the state of Texas. Mr. Gogia shall not refer to himself as doctor; Dr. Gogia; or Prem P. Gogia, M.D., without clearly designating that he is not licensed to practice medicine in the state of Texas. The Board found Mr. Gogia improperly held himself out to the public using titles of “Dr.” and “Doctor” and the suffix “M.D.” in his business cards and within his advertisements.

**Paletta, Antonio Giovanni, No License, Round Rock**
On October 27, 2014, a Board panel directed the Executive Director to enter a Cease and Desist Order against Antonio Giovanni Paletta requiring him to immediately cease from engaging in the practice of medicine without a license and from referring to himself as a doctor or physician in any manner, including by referring to himself as “doctor,” “Dr.,” or
“M.D.,” unless he also designates the authority under which the title is used or the college or honorary degree that gives rise to the use of the title. The Board panel found that Mr. Paletta engaged in the unlicensed practice of medicine and held himself out as a doctor during the airing of a local radio show.

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

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