Pain clinic certification may help in ‘pill mill’ fight

Texas’ many legitimate pain management clinics offer an important service to patients. On the other hand, so-called pill mills bill themselves as “pain management clinics” but operate outside controlled substance laws and with little concern for patient safety.

Law enforcement officers find pill mill customers lined up seeking prescriptions for opioids, benzodiazepines, barbiturates or carisoprodol. These medicines play an important role in controlling legitimate pain; for abusers, the drugs produce an addictive high. Taken in excess, they can suppress breathing to a fatal degree.

To help curtail pill mill activity, lawmakers adopted Senate Bill 911 this past legislative session. The law directs the Texas Medical Board to adopt rules that promote patient safety at pain management clinics. Under the new requirements, the physician owner/operator of a pain management clinic must register with the TMB by September 1, 2010. In addition, a pain management clinic may not operate in Texas unless the clinic is owned and operated by a medical director who is a physician who practices in Texas, has an unrestricted medical license and holds a certificate of registration for that pain management clinic.

Certificates, once issued, are not transferable or assignable. Only the primary physician owner is required to register with the board if there is more than one physician owner of the clinic. Each clinic requires a separate certificate.

The bill also stipulates that:
1) The owner/operator of a pain management clinic, an employee of the clinic, or a person with whom a clinic contracts for services may not:
   • have been denied, by any jurisdiction, a license issued by the Drug Enforcement

Vitally Important
Doctors must register for electronic death records

Death certificates are posing problems for families of the deceased as well as physicians.

House Bill 1739 mandated electronic death registration for funeral homes and medical certifiers, and took effect September 1, 2007. Doctors had until 2008 to sign on.

The law requires death reports to be filled out and filed electronically with the Texas Department of State Health Services, which maintains the state’s vital statistics. The electronic system allows funeral homes to fill out their
Death records, continued from page 1

portion and a doctor (or justice of the peace) to fill out his or her portion of the required certificate.

To avoid being penalized, all doctors who sign death certificates need to register with Texas’ electronic death record system by following this link: www.requestTER.texasvsu.org. Doctors have five days to fill out their portion of a death certificate, and they may delegate most of it to office staff, although the physician must still enter a personal identification number to complete the actual electronic certification. So far roughly 9,700 doctors out of an expected 15,000 have registered.

The Texas Medical Board currently has more than 150 complaints against doctors for not signing death certificates in a timely fashion. Doctors face a $500 fine from the TMB per violation.

Death certificate delays prevent families from following through with cremation plans. Without a death certificate, survivors can do nothing about a decedent’s will, insurance policy, bank accounts or other paperwork. Funeral homes are subject to inquiries from the Texas Funeral Service Commission for late certificates.

Some doctors have no problem in complying with the new law. “It could not be any simpler. Put in a couple of diagnoses, cause of death, confirm the demographics, and it’s over with,” says family practitioner Dr. Leonides Cigarros, MD, of Laredo Medical Center in a video for DSHS.

Other physicians have encountered some difficulty with the system for a variety of reasons.

Victor Farinelli, who works for DSHS’s Vital Statistics Unit, says the state still accepts paper from doctors who haven’t gone digital. “We have to think of the public’s interest, too,” he said.

For assistance with registering, send an email to: help-ter@dshs.state.tx.us

When should you use a chaperone?

The following guidelines are from the American Medical Association:

For the sake of ethics and prudence, doctors should establish a policy that patients can request a chaperone, and make them available on a consistent basis for patient exams.

This policy should be communicated to patients, preferably through a conversation initiated by the intake nurse or the physician.

The request by a patient to have a chaperone should be honored.

An authorized health professional should serve as a chaperone whenever possible. Physicians should establish clear rules about respecting patient privacy and confidentiality to which all chaperones must adhere.

If a chaperone is provided, a separate opportunity for private conversation between the patient and the physician should be arranged. The physician should keep inquiries and history-taking, especially those of a sensitive nature, to a minimum during the course of the chaperoned examination.
‘Clerkships’: Are you at risk for improper supervision or delegation?

By Suzanne Mitchell, J.D.
Assistant General Counsel
Texas Medical Board

Are you a physician involved with graduate medical education and trainee supervision? If so, you may have heard about organizations claiming that they can improve patient safety by matching “pre-qualified” international medical graduates (IMGs) with “willing and qualified attending physicians, hospitals, residency programs, and hospitalist groups to facilitate and supervise pre-residency clinical experience in various primary care specialties.”

If this sounds too good to be true, it may well be. You may be inadvertently subjecting yourself to Board scrutiny regarding how you supervise and delegate to these IMGs.

These organizations describe their “clerkships” as a “win-win” for both IMGs and the “discerning medical residency programs” to which they will be introduced. The IMGs will be given “insured practical hands-on clinical experiences” that will ostensibly give them a “leg up” when it comes time for them to apply for a residency; and the supervising clinicians and healthcare organizations will have an easier time filling primary care residency positions with individuals they know and trust. These organizations also advertise that “all costs” are paid by the participating IMGs, and that “for a limited time, these services are offered to qualified medical residency programs for FREE.”

You may be wondering why any of this should matter to you. Remember, first, that although these positions are often called “clerkships”, these “clerks” are not “students”, since they have already graduated from international medical schools. This means that the regulations in Board Rule 162.1(b) that govern how you supervise medical students do NOT apply in this situation.

Accordingly, the only way that these IMGs can provide the patient care services advertised by these clerkship programs is via delegation from a supervising physician (that would be YOU) pursuant to the Medical Practice Act and Board Rules. A physician may delegate medical acts to another person only when:

- The physician determines that the person is qualified and properly trained; AND
- The physician reasonably believes that sound medical judgment would support the delegation; AND
- The delegated act can be properly and safely performed by the person to whom it is delegated; AND
- the person to whom the act is delegated does not represent to the public that he is authorized to practice medicine; AND
- the person acts under the physician’s supervision.

Keep in mind as well that Board rules pertaining to delegated prescriptive authority would not authorize you to delegate to an IMG the ability to carry out or sign a prescription drug order. You may only delegate prescriptive authority at certain sites, and then only to a physician assistant (PA) or an advanced practice nurse acting under adequate physician supervision.

So, to avoid possible Board discipline for improper supervision or delegation, you would have to make sure you followed these rules, and be sure (regardless of what the organization tells you about the IMGs’ backgrounds and competence) that you have made an independent assessment about their ability to handle delegated medical acts. After all, you remain ultimately responsible for any actions taken by those to whom you delegate.

Please also note that if you supervise IMGs from these programs, you may be subject to Board discipline for “aiding and abetting” the IMG’s unlicensed practice of medicine.

The Texas Medical Board has the authority to, and frequently does, investigate individuals who are believed to be practicing medicine without a license. Practicing medicine is a third degree felony and each day a violation occurs constitutes a separate offense. A person who is finally convicted of practicing medicine without a license in Texas may ultimately be ineligible for Texas medical licensure.

General delegation guidelines are included in Section 157.001 of the Medical Practice Act. Additional information can be found in:

continued on page 4
Agency or a state public safety agency under which the person may prescribe, dispense, administer, supply, or sell a controlled substance; 
• have held a license issued by the Drug Enforcement Agency or a state public safety agency in any jurisdiction, under which the person may prescribe, dispense, administer, supply, or sell a controlled substance, that has been restricted; or 
• have been subject to disciplinary action by any licensing entity for conduct that was a result of inappropriately prescribing, dispensing, administering, supplying, or selling a controlled substance.

2) A pain management clinic may not be owned wholly or partly by a person who has been convicted of, pled nolo contendere to, or received deferred adjudication for:
• an offense that constitutes a felony; or
• an offense that constitutes a misdemeanor, the facts of which relate to the distribution of illegal prescription drugs or a controlled substance as defined by Texas Occupations Code Annotated §551.003(11).

3) The medical director of a pain management clinic must, on an annual basis, ensure that all personnel:
• are properly licensed, if applicable,
• are trained including 10 hours of continuing medical education related to pain management, and
• are qualified for employment.

4) Regulations regarding the registration and operation of pain management clinics do not apply to the following settings:
• a medical or dental school or an outpatient clinics associated with a medical or dental school;
• a hospital, including any outpatient facility or clinic of a hospital;
• a hospice established under 40 TAC §97.403 (relating to Standards Specific to Agencies Licensed to Provide Hospice Services) or defined by 42 CFR §418.3;
• a facility maintained or operated by this state;
• a clinic maintained or operated by the United States;
• a nonprofit health organization certified by the board under Chapter 177 of this title (relating to Certification of Non-Profit Health Organizations);
• a clinic owned or operated by a physician who treats patients within the physician’s area of specialty who uses other forms or treatment, including surgery, with the issuance of a prescription for a majority of the patients; or
• a clinic owned or operated by an advanced practice nurse licensed in this state who treats patients in the nurse’s area of specialty and uses other forms of treatment with the issuance of a prescription for a majority of the patients.

Contact Pre-Licensure, Registration and Consumer Services at (512) 305-7030 if you have any additional questions. Visit this link for more information: http://www.tmb.state.tx.us.

Have a question? Call the Texas Medical Board at 512-305-7030

'Clerkships', continued from page 3

• Texas Medical Board Rules Chapters 162, 163, 171, 172, 193
The board has adopted the following rules and rule changes since the last issue of the Bulletin. The rules can be found on the TMB web site at http://www.tmb.state.tx.us/rules/changes/2010/2010changes.php

Chapter 175, Fees, Penalties and Forms: proposed amendments to §175.5, relating to Payment of Fees or Penalties, regarding fee refunds for applicants who withdraw their applications within 45 days of initial application.

Chapter 180, Operation of Program: proposed new amendment §180.4, relating to Operation of Program, which establishes the requirements for eligibility, referrals, drug-testing, and fees for the Physician Health Program.

Chapter 183, Acupuncture: new amendments to §183.4, Licensure, which increases number of attempts on Acupuncture JP exam upon showing of good cause; §183.9, Impaired Acupuncturists, regarding procedures for probable cause hearings for mental and physical examinations, implementation of Physician Health Program for Impaired Acupuncturists.

Chapter 187, Procedural Rules: new amendments to §187.43, Proceedings for the Modification/Termination of Agreed Orders and Disciplinary Orders, will prohibit probationers from requesting modification/termination of an order if the probationer is under investigation for alleged noncompliance with the order, and clarifies that modification/termination requests may be made yearly since the effective date of an order; proposed new Subchapter I Proceedings for Cease and Desist Orders, subchapter based on passage of HB2256 passed during the 81st Legislative session; §187.83, Proceedings for Cease and Desist Orders, establishes the procedures for cease and desist orders to be issued by the executive director after the opportunity for participation in an informal settlement conference; §187.84, Violation of Cease and Desist Orders, establishes the penalties for violation of cease and desist orders; proposed new Subchapter J, Procedures Related to Out of Network Health Benefit Claim Dispute Resolution, subchapter based on passage of HB2256 passed during the 81st Legislative session; §187.85, Purpose and Constructions; §187.86, Scope; §187.87, Definitions; §187.88, Complaint Process and Resolution; and §187.89, Notice of Availability of Mandatory Mediation.

Chapter 189, Compliance Program: new amendments to §189.2, Definitions amends the title "chief of compliance" to "compliance manager"; §189.3, Responsibilities of Probationers, sets out the requirements for third party reports submitted to the Board in relation to a probationer's order with the Board; §189.8, Procedures Relating to Non-compliance, amends the title "chief of compliance" to "compliance manager."

Chapter 190, Disciplinary Guidelines: new amendments to §190.14, Disciplinary Sanction Guidelines, provides that if a physician is determined to have negotiated in bad faith in relation to an out-of-network health benefit claim, the licensee may be fined up to $2,000 by the Board.

Chapter 192, Office-Based Anesthesia Services and Pain Management Clinics: new amendments delete references to Pain Management Clinics; §192.1, Definitions; §192.2, Provision of Anesthesia Services in Outpatient Settings, require that anesthesia services and equipment provided in an outpatient setting remain available until the patient is discharged; §192.4, Registration, excludes Level I services from registration requirements and deletes languages relating to pain management clinics; §192.5, Inspections; repeal §192.7, Operation of Pain Management Clinics.

Chapter 195, Pain Management Clinics: new chapter with language from Chapter 192 moved into this chapter; §195.1, Definitions; §195.2, Certification of Pain Management Clinics; §195.3, Inspections; §195.4, Operation of Pain Management Clinics, adds language about minimum requirements for quality assurance procedures.

Chapter 198, Unlicensed Practice: new amendments delete language regarding cease and desist orders which is moved to Chapter 187; amends §198.3, Investigation of Complaints; repeals §198.4, Cease and Desist Order; repeals §198.5, Contested Cease and Desist Proceeding; and repeals §198.6, Violation of Cease and Desist Order.
Formal Complaints have been filed with the State Office of Administrative Hearings regarding the licensees listed below. Formal Complaints are public documents and are posted on physician profiles on the TMB web site. The Texas Occupations Code, Medical Practice Act, defines a Formal Complaint as follows: Sec. 164.005. INITIATION OF CHARGES; FORMAL COMPLAINT.

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

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

These cases were unresolved at the time of publication.

<table>
<thead>
<tr>
<th>Name</th>
<th>Licence No.</th>
<th>Date filed</th>
<th>Allegations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Davill Armstrong, M.D.</td>
<td>F3025</td>
<td>11/24/09</td>
<td>Failure to comply with a Board order; unprofessional conduct; aiding the practice of medicine by a person or entity not licensed to practice medicine.</td>
</tr>
<tr>
<td>Ruth Atlas, M.D.</td>
<td>G7616</td>
<td>3/5/10</td>
<td>Failure to meet the standard of care; failure to maintain adequate medical records; prescribing dangerous drugs without establishing a proper physician-patient relationship.</td>
</tr>
<tr>
<td>Howard Bernstein, M.D.</td>
<td>E9536</td>
<td>1/26/10</td>
<td>Failure to meet the standard of care; violation of Board pain treatment guidelines; unprofessional conduct; prescribing to a known drug abuser; non-therapeutic prescribing.</td>
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<tr>
<td>Jesus A. Caquias, M.D.</td>
<td>F8432</td>
<td>3/31/10</td>
<td>Nontherapeutic prescribing; failure to meet the standard of care; failure to follow guidelines for the practice of alternative medicine.</td>
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<tr>
<td>Bruce E. Cox, M.D.</td>
<td>E4272</td>
<td>12/15/09</td>
<td>Unprofessional conduct.</td>
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<tr>
<td>Silvia E. Flores, M.D.</td>
<td>K9060</td>
<td>11/3/09</td>
<td>Failure to meet the standard of care; negligence in performing medical services; action taken by peers.</td>
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<tr>
<td>William C. Harris, III, P.A.</td>
<td>PA01401</td>
<td>1/26/10</td>
<td>Failure to renew license; revocation of privileges by another entity.</td>
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<tr>
<td>Thad W. Houseman, P.A.</td>
<td>PA01862</td>
<td>4/12/10</td>
<td>Failing to practice in a manner consistent with public health and welfare; violation of a Board order.</td>
</tr>
<tr>
<td>Reuben A. Isern, M.D.</td>
<td>E8585</td>
<td>2/3/10</td>
<td>Unprofessional conduct; failure to comply with a Board order.</td>
</tr>
<tr>
<td>Susan B. Kern, M.D.</td>
<td>G6785</td>
<td>3/8/10</td>
<td>Unprofessional conduct; failure to comply with a Board order.</td>
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<tr>
<td>Raul E. Loaisiga, M.D.</td>
<td>L0383</td>
<td>3/31/10</td>
<td>Engaging in sexually inappropriate behavior or comments directed towards a patient; failure to meet the standard of care.</td>
</tr>
</tbody>
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<thead>
<tr>
<th>Name</th>
<th>License No.</th>
<th>Date filed</th>
<th>Allegations</th>
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</thead>
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<tr>
<td>Shaffin Ali Mohamed, M.D.</td>
<td>J7589</td>
<td>11/3/09</td>
<td>Unprofessional conduct; failure to comply with a Board subpoena.</td>
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<tr>
<td>Paul James Parkey, M.D.</td>
<td>D3362</td>
<td>3/8/10</td>
<td>Failure to meet the standard of care; inadequate supervision; delegating professional medical responsibility to unqualified person.</td>
</tr>
<tr>
<td>James Andrew Paskow, M.D.</td>
<td>H8790...</td>
<td>5/6/10...</td>
<td>Failure to prescribe consistent with public health and welfare; unprofessional conduct; violation of Board rules on treatment of pain; failure to use professional diligence.</td>
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<tr>
<td>Joseph J. Patrick, M.D.</td>
<td>G7864</td>
<td>5/20/10</td>
<td>Failure to meet the standard of care; disciplinary action taken by a peer review committee.</td>
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<tr>
<td>Gerald Ratinov, M.D.</td>
<td>D2823</td>
<td>4/17/10</td>
<td>Failure to meet the standard of care; violation of pain medication guidelines; failure to supervise adequately; permitting another person to use his license to practice medicine.</td>
</tr>
<tr>
<td>Charles I. Sitomer, M.D.</td>
<td>G7341</td>
<td>5/12/10</td>
<td>Failure to practice medicine in an acceptable, professional manner; failure to obtain informed consent; failure to use diligence in one’s professional practice.</td>
</tr>
<tr>
<td>James H. Thomas, Jr., M.D.</td>
<td>G0199</td>
<td>5/6/10</td>
<td>Failure to comply with a Board subpoena; failure to report change of address within 30 days; unprofessional conduct.</td>
</tr>
</tbody>
</table>

Workplace clinics considered ‘alternate practice sites’ for docs

Workplace medical clinics are on the increase. A 2008 study by the National Business Group on Health and Watson Wyatt reported that more than 23% of self-insured companies have on-site health programs for their employees. Firms that have already adopted this model include Toyota, Pepsi, and Pitney Bowes.

Often such clinics are staffed only by a nurse practitioner or physician assistant. A question arises regarding doctors who oversee and delegate prescriptive authority, as well as general duties, to the mid-level practitioners. Specifically, are doctors complying with the Medical Practice Act and Board rules?

Workplace clinics – as well as clinics based at grocery stores or other retailers – are generally considered “alternate practice sites” for physicians. Under Texas Medical Board rules, an alternate practice site may be located up to 75 miles from either the delegating physician’s residence or primary practice site. The delegating physician must be on-site 10% of the hours of operation of the site each month and must be available while on-site to care for patients usually seen by the physician assistant or nurse practitioner. The PA or APN must be onsite too at this time so the physician can evaluate how the midlevel is doing.

Doctors may seek waivers from the Board for the:

1) mileage limitation between a supervising physician’s primary practice site and alternate practice site: and

2) on-site supervision requirements, though the physician must be available onsite at regular intervals.

3) And, when on-site, the physician must be available to treat patients.

Before granting a waiver, the Board must determine that the types of health care services provided by the PAs and APNs are limited in nature and duration, within the scope of delegated authority, and that patient health care will not be adversely affected.

Before you accept directorship for such an on-site clinic, please check the Board’s rules to ensure that your actions will not place you in violation of the Medical Practice Act and subject to disciplinary sanctions. For more information, visit this page on the TMB website: http://www.tmb.state.tx.us/professionals/physicians/delegatingPrescriptiveAuthority.php
The Texas Medical Board issued or reissued licenses to 2,690 physicians between November 2009 and June 2010. The board congratulates the following new Texas licensed physicians:

Ahmad, Ammar, MD
Ahmed, Faheem, MD
Ahmed, Faraqui, MD
Ahmed, Sameer Zia, MD
Ahmed, Sana Mahmood, MD
Aidinian, Gilbert, MD
Aina, Oluwemimo, MD
Akay, Mehmet Hakan, MD
Akbart, Imran, MD
Akhlachi, Mohsen, MD
Akinyemi, Adeola Bolanle, MD
Akinyemi, Emmanuel Olusesan, MD
Ahmadi, Georges Elle, MD
Alapati, Shilpala, MD
Alavi, Amir, DO
Albo, Zimbali, MD
Albritton, Karen Halaburt, MD
Adaper, Arora, DO
Alexander, Bryan Scott, MD
Ali, Abbas Khider, MD
Ali, Bhaktiar, MD
Ali, Syed Sameer, MD
Ali, Uzma, MD
Ali, Zarah Karam, MD
Alilhan, Mujahed Mohammad, MD
Alishahi, Yasmine, MD
Allison, Andrew Ebbelin, MD
Allison, Nanette, DO
Allison, Nathan D, MD
Alonso, Carol Ann, MD
Alosie, Ogechika Karl, MD
Altobelli, James Brian, MD
Alvarez, Maria, MD
Aly, Salman Siraj, MD
Aly, Saarif, MD
Aman, Ayesha Aslam, MD
Amaya, Zeda, MD
Amaya, Hellman, Diana Stella, MD
Ambreen, Farhana, MD
Amiel, Gilad Eliyahu, MD
Amin, Sabina, MD
Amin, Farhana, MD
Amjad, Ramak Raymond, MD
Amor, Karrie Tomiska, MD
Anderson, April Lauren, MD
Anderson, Brian Benjamin, DO
Anderson, Christine Marcelita, MD
Anderson, Aneur, MD
Anderson, Jiah Kashiya, MD
Andrade-Fegali, Yohanna, MD
Andrews, Carol Lynn, MD
Andrews, Genevieve Ann, MD
Angel, Richard, DO
Angelos, Erin Leigh, MD
Angier, Gregory Nabil, MD
Anguay, John C, MD
Ansari, Maria, MD
Ansari, Saadaf Abbas, MD
Anthony, Kerri, MD
Antoine, Christine, MD
Arwar, Asif, MD
Aoun, Rita, MD
Apte, Darshana Mandal, MD
Apuya, Jesus Serra, MD
Ara, Mary Margaret, MD
Arain, Faisal Akhter, MD
Archibong, Emma Virginia, MD
Archie, Ryan Neal, MD
Arentz, Suellen Candice, MD
Arjo, Sarah H, MD
Armstead, Sumiko, MD
Armstrong, Felicia Ann, MD
Arnold, Benjamin Allen, MD
Arnold Iii, Hays L, MD
Arnouk, Johnny Issam, MD
Arson, Joshua Paul, MD
Arora, Anisha, MD
Arora, Gaurav, MD
Arouse, Ayman Molhem, MD
Arrieta, Omar Steven, MD
Arroyo, Estrella, DO
Ashley Jr, William Wallace, MD
Ash, Lorraine Marjorie, MD
Ashbrooks, Darrin, MD
Ashley, Jennifer Philocete, MD
Ashley Jr, William Wallace, MD
Asis, Antonio, MD
Asis, Martin Jose, MD
Aston, Jason David, MD
Atai, Faith Data, MD
Atar, Mohammed Abdul Ahad, MD
Attur, Sumitha, MD
Attaya, Eman Nabil, MD
Austin, Ned Alvin, MD
Avila, Fred Antonio, MD
Awobudey, Marc Taibo, MD
Ayala, Natalie, MD
Ayala, Omar, MD
Ayala Garcia, Liliam Enid, MD
Ayaram, Shabnam, MD
Ayub, Asma, MD
Azam, Ghazala Ahmed, MD
Aziz, Shamida, MD
Aziz, Khadja, MD
Babaria, Darshesh, MD
Babic, Aleksandar Milan, MD
Bach, Harold Gregory, MD
Backmann, Justin Matthew, MD
Backardjiev, George, MD
Badawy, Mohamed Karim, MD
Bader, Bradford Allen, MD
Bagnell, Kristi Bengtson, MD
Bak, Elizabeth Leigh, DO
Bahadorani, John Nader, MD
Baig, Harris Rehan, MD
Baig, Nazia, MD
Bailey, Amanda Michelle, MD
Bailey, Yvette, MD
Bains, Kristin Carroll, MD
Baird, Christopher Wallace, MD
Baisden, Beth Ann, MD
Bakdaleh, Yahya, MD
Baker, Jqwiana Samia, MD
Baker, Macarthuir L, MD
Balch, Glen Charles, MD
Balder, Shemus Detamo, MD
Ball, Timothy Ryan, MD
Ballard, Luke Justin, MD
Ballas, Leslie, MD
Balkh, Robert Alejandro, MD
Balmakund, Tony Michele, MD
Baluch, Amir, MD
Balun, Melissa Evelyn, DO
Band, Michelle Lynnette, MD
Bandyopadhyay, Subhankar, MD
Banerjee, Kakoli, MD
Banerjee, Suman Kumar, MD
Banks, Kamakji J, MD
Banks, Kristine Elizabeth, MD
Bao, Jianxiong Richard, MD
Baptiste, Nadine, MD
Barak, Orly, MD
Barcenas, Carlos Hernando, MD
Barak, Henry Zvi, MD
Barker, Gregory Mark, MD
Barker, Holly Ann, MD
Barr, Sarah Nicole, MD
Bartolome, Sonja, MD
Bartz, Roger Anthony, MD
Basrao, Jaswant Singh, DO
Bass, Nancy Elizabeth, MD
Bastow, Catherine Flickinger, MD
Bastow, Robert Kirk, MD
Batchelor, Krystl Renae, DO
Bathala, Elizabeth, MD
Battista, John Turbeville, MD
Batiste, James Douglas, MD
Battles, Kristen Ann, DO
Chases, Noah Nathan, MD
Chaudhari, Akok Mohan, MD
Chaudhari, Swetanshu, MD
Chaudhary, Prateek, DO
Chavali, Sneha, MD
Chavda, Shailendra Natvar, MD
Chavez, Alma Isela, MD
Chavez-Gelo, Edna Melina, MD
Chlebiewski, Jack, MD
Chelliah, Aruna, MD
Chen, David Ping, MD
Chen, Julia Han, MD
Chen, Li Ern, MD
Chen, Nancy, MD
Chen, Sharon Wen-Wen, MD
Cheng, Jonathan Chi-Hong, MD
Cheng, Sophia, HS, MD
Cheppyala, Sree, MD
Cherian, Veneetha, MD
Chern, Eric Lee-An, MD
Chesley, Rachel Margaret, MD
Cheung, Esther Margaret, MD
Cheung, Winnie, DO
Chew, Andrew Moon, MD
Chiu, Albert Joseph, MD
Chiang, Andrew, DO
Choo, Andrew Moon, MD
Choudhri, Moebeen Naeem, MD
Chow, Joseph Lin Yun, MD
Chow, Yvonne, C, MD
Christie, Pearl, MD
Chui, Vincent, MD
Chua, Albert Joseph, MD
Chuang, Hubert, MD
Chuang, John, MD
Chughtai-Harvey, Isabelle Claire, MD
Chukwunyere, Emmanuel Amad, MD
Chung, Christopher Pei-Chia, MD
Chung, Joyeon, MD
Cilento, Benjamin West, MD
Cipriani, Maria Yolanda, MD
Cisneros, Laura E, MD
Cizdziel, Kara Marie, MD
Clayton, David Byron, MD
Clark, Samuel David, DO
Clarke, Clarence George, DO
Clarke, Dave Fitzgerald, DO
Clarke, Erin Elizabeth, MD
Clarkson, Wesley Allen, DO
Clemens, Mark Warren, MD
Cloonan, Timothy G, MD
Coan, Micheal Casey, DO
Coburn, Mark Winfred, MD
Coffie, Lincoln G, MD
Cohan, Sandra Rochelle, MD
Cobath, Melissa Sue, MD
Coleman-Henderson, Kimberlee Annette, MD
Colen, Jessica Suarez, MD
Collister Jr, John Tom, MD
Commons, Bradford Stager, MD
Condron, Michael Robert, MD
Conlon, Julia Teresa, MD
Connally, Michael James, MD
Connaughton, James Christopher, MD
Connors, Christopher James, MD
Conoley, Jack Autrey, MD
Conroy, Melinda Dawn, DO
Contreras, Alejandor, MD
Contreras, Michael Gary, MD
Conway, Benjamin J, MD
Coombs-Skiles, Caroline Hellen, MD
Coonfield, Kimberly Vogel, MD
Cooper, Ashley Marie, MD
Cornforth, Katherine Elizabeth, MD
Cosgrove, Edward Joseph, MD
Costin, Moises R, MD
Cost, Nicholas Glenn, MD
Coster, Heath Earl, MD
Coulson, Colby James, MD
Coullier, Tuere Sarah, MD
Cox, Lyndsey Alison, MD
Crabtree, Shana Alexander, MD
Cragun, William Chad, MD
Crawford, Jennifer Lauren, MD
Crawford, Natalie Minns, MD
Creech, Kristin Nicole, MD
Cree, Christopher, MD
Crim, Chad David, MD
Crisan, Luminita Sanda, MD
Cron, Michael Ross, MD
Crooks, Ian Martin, MD
Crum, Charles, MD
Cunningham, Shani, DO
Curlee, Laura Denise, DO
Currie, Oscar Jovan, MD
Curry, Alana Davis, MD
Cusick, Matthew Garrett, MD
Cutrell, James Bradford, MD
Curran, Curtis Olives, MD
Da Silva, Leonard Dimitri, MD
Dallas, John David, MD
Dandaia, Kalyan, MD
Dandamudi, Saroja, MD
Dang, Linh Mai, MD
Danielessson-Sandén, Ingela Liz Helen, MD
Danish, Robert K, MD
Dannenbaum, Mark Joseph, MD
Dao, Lori Michele, MD
Daramola, John, MD
Dare, Paul Frederic, MD
Das, Rituparna, MD
Das, Subhash Chandra, MD
Daumerie, Geraldine Jacqueline, MD
Dave, Amish S, MD
Dave, Viral Arvindbhai, MD
Davenport, Crystal Michelle, MD
Davenport, Dominique Constantza, DO
David, Emilia, MD
Davila Arroyo, Himara, MD
Davis, Arlene N, MD
Davis, Bradley James, MD
Davis, Justin Mark, MD
Davis, Keisha Yvonne, MD
Davis, Kurtis William, MD
Davis, Lance Edwin, MD
Day, Warren Brent, MD
De La Torre, Javier Eduardo, MD
De La Torre, Miguel Alberto, MD
Dearing, Paul David, MD
Debacker, Christopher Macdonald, MD
Decamp, Byron Seth, MD
Dees, Charles Donald, MD
Defrancis, Jason Gregory, MD
Degreaffenreidtz, Deanne Lotta, MD
Dekorse, Tyson Benjamin, MD
Del Rosario, Sannee Blake, MD
Delaughter, Jonathan Paul, DO
Delgado, Antonio Jose, MD
Delgado, Ruby, MD
Demico, Elizabeth G, MD
Denard, Christo, MD
Denduluri, Sandeep, MD
Desai, Kumar Subodh, MD
Desai, Snehil Subodh, MD
Desena, Allen Douglas, MD
Desena, Holly Capitano, MD
Desikian, Kamalamann, MD
Desouza, Cypriano Victor, MD
Devine, Allison Marie, MD
Dewitt, Nathan William, MD
Diallo, Rakiya Engo, MD
Diaz, Elena Susan, MD
Diaz, Jessica D, MD
Diaz, Rebecca Wald, MD
Dick, Michael, MD
Dickson, Wesley Allan, MD
Dickstein, Rian Jason, MD
Diederich, Andrew David, MD
Dierks, Marie Elizabeth, DO
Dillon, Benjamin Ethan, MD
Dimas, Vassiliki, MD
Dimmitt, Dean Bradshaw, MD
Ding, Bryan Char-Hoa, MD
Dittel, Walter, MD
Dixon, Brian James, MD
Dixon, Jared, MD
DO, Daan Thuy, MD
DO, Jennifer Stratton, MD
Doddapaneni, Ajay Kumar, MD
Dogan, David Alan, MD
Doherty, Sean David, MD
Doma, Siva, MD
Domignuez, Manuel, MD
Dondapati, Chandra Malini, DO
Donepudi, Sreechandra Karth, MD
Dong, Mei, MD
Doniparthi, Venkatakalakshmi, MD
Donnelly, Jennifer Lauren, MD
Doroftei, Olga, MD
Dorsett, Allen Ray, DO
Doshi, Nehal Dilip, MD
Dotzler, Susan Ann, MD
Dowell, Gene Lee, MD
Downie, Benjamin Joel, MD
Drennan, Emily Lorraine, MD
Dronaval, Goutham, MD
Du, Kholi Huy, MD
Du, Lin, DO
Du Cret, Rene Pierre, MD
Du Toit, Francois Johannes, MD
Dubin, Ruth Farnham, MD
Dubois, Holly Colleen, MD
Ducharme, Erin Elizabeth, MD
Duhon, Bradley Stuart, MD
Duke, Sharon Nelson, DO
Dulgheru, Ovidiu Adrian, MD
Dumais, Jules Arthur, MD
Dumas, Alain, MD
Dunn, Robert North, MD
Duong, Chuong, DO
Duret-Uzodinma, Jenny Jean-Julien, MD
Durham, Megan Rae, MD
Dvorak, Anna Kej, MD
Dwyer, Matthew Michael, MD
Eager, Robert Michael, MD
Since the Fall 2009 issue of the Medical Board Bulletin, the Board has taken disciplinary action on 265 physicians, five physician assistants, two acupuncturists and two surgical assistants. The Board issued three cease and desist orders for unlicensed practice. The following is a summary of those actions.

**TEMPORARY RESTRICTION/SUSPENSION**

**Cavender, Lundy Eldridge, M.D., Lic. No. H7711, Burleson TX**

On June 2, 2010, a Disciplinary Panel of the Board, including at least one physician, entered an Order of Temporary Suspension (With Notice of Hearing) against the medical license of Lundy Eldridge Cavender, Jr., M.D., after concluding that Dr. Cavender's continuation in the practice of medicine presents a continuing threat to the public welfare. The temporary suspension remains in effect pending further Board action. This immediate temporary suspension with notice was initiated after the Board found evidence that included the following: unprofessional or dishonorable conduct by exposing himself and masturbating in view of female employees on numerous occasions in public areas of his office clinic; and being unable to practice medicine with reasonable skill and safety to patients as the result of a mental or physical condition, as indicated by two suicide attempts and a self-admission into a psychiatric treatment program in 2009 to seek treatment for unresolved psychiatric conditions.

**O’Neal, Don Martin, M.D., Lic. No. E2769, Sulphur Springs TX**

On May 24, 2010, a Disciplinary Panel of the Board entered an Order of Temporary Suspension (Without Notice of Hearing) against the medical license of Don Martin O’Neal, M.D., after concluding that Dr. O’Neal’s continuation in the practice of medicine presents a continuing threat to the public welfare. The temporary suspension remains in effect pending further Board action. This immediate temporary
suspension without notice was initiated after the Board found evidence that included the following: In November 2008, the Drug Enforcement Administration (DEA) investigated Dr. O’Neal for prescribing various narcotics in significant quantities to numerous patients; in August 2009, Dr. O’Neal surrendered his DEA authorization to prescribe controlled substances to avoid further DEA investigation and potential criminal charges; in January 2010, a physician colleague of Dr. O’Neal discovered that he had been using the colleague’s signature stamp to authorize his continued prescribing of controlled substances to numerous patients; and in April 2010, based on Dr. O’Neal’s continuation of narcotics prescribing without a valid DEA authorization of his own, and by using the DEA authorization of another physician, he was charged with a total of 55 felony counts related to the allegations of fraudulent and/or unauthorized prescribing of controlled substances.

**Patrick, Joseph J., M.D., Lic. No. G7864, Houston TX**

On June 2, 2010, a Disciplinary Panel of the Board, including at least one physician, entered an Order of Temporary Restriction (With Notice of Hearing) against the medical license of Joseph J. Patrick, M.D., after concluding that Dr. Patrick’s continuation in the practice of medicine would constitute a continuing threat to the public welfare. The temporary restriction remains in effect pending further Board action. This immediate temporary restriction with notice was initiated after the Board found evidence that Dr. Patrick: non-therapeutically prescribed controlled substances, and prescribed in a manner inconsistent with the public health and welfare, as evidenced by his having written over 21,000 prescriptions for controlled substances in a 19-month period, including 900 controlled substance prescriptions through an emergency medical ambulance service; failed to adequately supervise persons to whom he delegated prescriptive authority; and pre-signed prescriptions that were issued while he was out of the country. In addition, the Board also found that Dr. Patrick did not timely respond to the Board’s requests to provide information and medical records. Dr. Patrick admitted he had not acted diligently in his role as Medical Director at the several clinics where the prescriptions were issued. The 2010 Order temporarily restricts Dr. Patrick’s practice by prohibiting: any practice other than as an emergency room (ER) physician in a hospital ER; prescription of any Schedule II drugs for any purpose; prescription of controlled substances or other pain medications other than for acute pain and in an amount in excess of what is needed by a patient for 72 hours; authorization of refills for any controlled substances or other pain medications, and prescription of controlled substances or other pain medications for any patient he has previously seen in the ER and prescribed such drugs.

**Shiller, Alan Dale, M.D., Lic. No. H8398, Palestine TX**

On March 17, 2010, a disciplinary panel of the Texas Medical Board entered an order of temporary suspension without notice of hearing against Alan Dale Shiller, M.D., effective immediately. The length of a temporary suspension is indefinite and it remains in effect until the Board takes further action. The panel determined that Dr. Shiller’s continuation in practice would constitute a continuing threat to the public welfare. The action was based on the following findings: On December 4, 2009, Dr. Shiller, while on-call for ophthalmological emergencies at Palestine Regional Medical Center, was observed driving his vehicle into a utility pole. He left the scene and drove off the highway, through several mailboxes and into a tree. He was taken to the emergency room where staff found an empty 100 mg vial of demerol in his pants pocket. A toxicology screen performed at the hospital was positive for barbiturates, benzodiazepines, opiates and PCP.

**QUALITY OF CARE VIOLATIONS**

**Angel, Robert Tate, M.D., Lic. No. C8881, Waco TX**

On February 5, 2010, the Board and Dr. Angel entered into a mediated agreed order requiring Dr. Angel to pass, within one year of the order entry date, the SPEX exam given by the Federation of State Medical Boards. Dr. Angel has three attempts to pass the SPEX within this time period. Until Dr. Angel passes the SPEX within the designated time period, he must abstain from the practice of medicine involving direct patient contact and limit his medical practice to administrative, non-clinical medicine. Dr. Angel must also complete eight hours of CME in medical record-keeping within one year of the order entry date. The Board’s action was based on Dr. Angel’s failure to meet the standard of care, failure to maintain adequate medical records and his delivery of non-therapeutic medical care to three patients, one of whom died.

**Atun, Victor J., M.D., Lic. No. K6986, Sugar Land TX**

On June 4, 2010, the Board and Victor J. Atun, M.D., entered into an Agreed Order requiring Dr. Atun to complete within one year eight hours of CME in hand surgery and pay an administrative penalty of $1,000...
within 60 days. The Board’s basis for action was Dr. Arun's failure to practice medicine in an acceptable, professional manner and safeguard against potential complications when he did not recognize a patient's potential for self-injury and decided not to cast-immobilize the hand of a patient with a thumb injury, resulting in the need for a third surgery.

Bacon, Robert J., Jr., M.D., Lic. No. F0861, Houston TX
On February 5, 2010, the Board and Dr. Bacon entered into an agreed order requiring Dr. Bacon to pay an administrative penalty of $2,500 within 90 days. The Board’s action was based on Dr. Bacon’s failure to meet the standard of care and maintain adequate medical records. The Board found that Dr. Bacon did not prescribe methadone to a transferred patient with opioid dependence in a therapeutic manner.

Bessonett, Paula Alinda, M.D., Lic. No. H4166, Grand Saline TX
On May 3, 2010, the Board and Paula Alinda Bessonett, M.D., entered into an Agreed Order requiring Dr. Bessonett to complete an Advanced Cardiac Life Support Course and obtain ACLS certification within one year; complete within one year 16 hours of CME, including eight hours in reading EKG results and eight hours in treatment of acute coronary syndrome. The action was based on the Board’s finding that Dr. Bessonett failed to meet the standard of care by not recognizing a patient’s myocardial infarction.

Burbano De Lara, Jose Luis, M.D., Lic. No. F9254, Carrollton TX
On February 5, 2010, the Board and Dr. Burbano De Lara entered into an agreed order requiring Dr. Burbano De Lara to complete 30 hours of CME in risk management, physician-patient communications, and in anticoagulation therapy or pulmonary medicine or management of pulmonary emboli. The Board’s action was based on Dr. Burbano De Lara’s failure to meet the standard of care with a patient on Coumadin treatment. The Board found that Dr. Burbano De Lara did not appropriately monitor the patient’s care and communicate laboratory results and medication adjustments to her or warn her of potential risks associated with the drug.

Carlin, Brian T., M.D., Lic. No. E5354, Pollok TX
On February 5, 2010, the Board and Dr. Carlin entered into an agreed order publicly reprimanding Dr. Carlin, and requiring him to successfully complete the assessment portion of the Knowledge, Skills, Training, Assessment and Research (KSTAR) program at Texas A&M within one year; and complete 18 hours of CME in endocrinology for adults and children, and in medical record-keeping, within one year. The action was based on the Board’s finding that Dr. Carlin failed to practice medicine in an acceptable, professional manner and failed to safeguard against potential complications when he incorrectly treated a 10-year-old boy’s diabetes.

Clark, Robert Dwight, D.O., Lic. No. K7696, Fort Worth TX
On April 9, 2010, the Board and Robert Dwight Clark, D.O., entered into an Agreed Order publicly reprimanding Dr. Clark and requiring him to complete 15 hours of CME, including 10 hours in the topic of anesthesia for the high-risk patient and five hours in medical record-keeping. The Board’s action was based on Dr. Clark’s failure to meet the standard of care by failing to adequately evaluate a patient pre-operatively, which resulted in an unsafe anesthesia plan, which may have caused or contributed to his death.

Clarke, Lawrence Ross, M.D., Lic. No. G5839, Pasadena TX
On June 4, 2010, the Board and Lawrence Ross Clarke, M.D., entered into an Agreed Order requiring Dr. Clarke to complete within one year 20 hours of CME in pain management and 10 hours in medical record-keeping; and pay an administrative penalty of $1,000 within 60 days. The Board’s action was based on Dr. Clarke’s violation of rules regarding the treatment of chronic pain and inadequate medical records for one patient.

Contreras, Freddie Lee, M.D., Lic. No. G3244, Texarkana TX
On June 4, 2010, the Board and Freddie Lee Contreras, M.D., entered into an Agreed Order requiring Dr. Contreras to: complete within one year 16 hours of CME including eight hours in medical record-keeping and eight hours in risk management; and pay an administrative penalty of $1,000 within 60 days. The basis for action was the Board’s finding that Dr. Contreras prescribed to a family member of a clinic employee without documentation and in the absence of immediate need.

Dawson, Mark Clifton, M.D., Lic. No. G3276, Austin TX
On June 4, 2010, the Board and Mark Clifton Dawson, M.D., entered into an Agreed Order requiring Dr. Dawson to complete within one year eight hours of CME in psychopharmacology. The basis for action was the Board’s finding that Dr. Dawson violated the standard of care in prescribing benzodiazepines, which were not indicated, to a patient with substance
abuse issues.

Dean, Odell Joseph, Jr., M.D., Lic. No. J9656, Lufkin TX

On June 4, 2010, the Board and Odell Joseph Dean, Jr., M.D., entered into an Agreed Order requiring Dr. Dean to complete within one year 20 hours of CME, including a minimum of 15 hours in the treatment of prostate cancer and five hours in medical record-keeping; and pay an administrative penalty of $3,000 within 90 days. The basis for action was the Board’s finding that Dr. Dean failed to meet the standard of care for one patient when Dr. Dean did not appropriately perform a prostatectomy to treat prostate cancer.

De Freitas, Junior, M.D., Lic. No. J9655, Denton TX

On June 4, 2010, the Board and Junior De Freitas, M.D., entered into an Agreed Order requiring Dr. De Freitas to complete within one year 15 hours of CME in each of the following topics: preoperative assessment, patient communications and documentation. The Board’s basis for action was Dr. De Freitas’ unprofessional conduct and failure to practice medicine in an acceptable manner in his treatment of a patient with non-Hodgkin’s lymphoma.

Fagan, Wayne Anthony, Lic. No. J4105, Corpus Christi TX

On March 5, 2010, the Board and Wayne Anthony Fagan, M.D., entered into an agreed order requiring Dr. Fagan to have his practice monitored by a physician for two years; complete eight hours of CME in risk management, eight hours of CME in medical record-keeping, and 15 hours of CME in the topic of reading pathology slides within one year; and pay an administrative penalty of $3,000 within 90 days. The action was based on the Board’s finding that Dr. Fagan failed to maintain adequate medical records or meet the standard of care when he misdiagnosed basal cell carcinoma in a patient who subsequently developed metastatic melanoma.

Floyd, Hilliard Derek, M.D., Lic. No. F3959, Dumas TX

On June 16, 2010, the Board and Hilliard Derek Floyd, M.D., entered into an Agreed Order requiring Dr. Floyd to have a physician monitor his practice for an eight-cycle term and implement recommendations as directed by the Board; complete within one year 14 hours of CME including eight hours in safety and preventing patient error and six hours in surgery risk management; pay an administrative penalty of $2,500 within 60 days. The action was based on Dr. Floyd’s failure to meet the standard of care and failure to use diligence in his professional practice when he failed to recognize internal bleeding in a patient and failed to transfer her to a Tier One hospital in a timely manner.

Foreman, Bruce Phillip, M.D., Lic. No. G0707, El Paso TX

On June 4, 2010, the Board and Bruce Phillip Foreman, M.D., entered into a Mediated Agreed Order requiring Dr. Foreman to pay an administrative penalty of $1,500 within 90 days. The Board’s action was based on Dr. Foreman’s failure to correctly interpret ultrasound images which showed a questionable breast lesion indicating a need for an ultrasound-guided core-needle biopsy.

Garvin, Clifford David, M.D., Lic. No. F9469, Denison TX

On June 4, 2010, the Board and Clifford David Garvin, M.D., entered into an Agreed Order requiring Dr. Garvin to complete within one year eight hours of CME in risk management and eight hours of CME in ethics; and pay an administrative penalty of $2,500 within 180 days. The basis for action was Dr. Garvin’s failure to meet the standard of care and failure to adequately supervise delegates treating a patient with rapid and difficult breathing.

Gibson, Donald, II, M.D., Lic. No. H5209, Houston TX

On April 9, 2010, the Board and Donald Gibson, II, M.D., entered into an Agreed Order requiring Dr. Gibson to complete within one year eight hours of CME in risk management and eight hours of CME in ethics; and pay an administrative penalty of $2,500 within 180 days. The basis for action was Dr. Gibson’s failure to meet the standard of care, non-therapeutic prescribing, inadequate supervision and failing to maintain adequate medical records for four weight management patients.

Gripion, Edward Brown, M.D., Lic. No. D5020, Beaumont TX

On February 1, 2010, the Board and Dr. Gripion entered into a three-year agreed order requiring Dr. Gripion to have a practice monitor and within one year complete 20 hours of CME in medical record-keeping and chronic pain management. The action was based on the Board’s finding that Dr. Gripion failed to meet the standard of care, maintain adequate medical records and prescribe controlled substances in a manner consistent with public health and welfare for a patient with a psychiatric disorder as well as chronic pain.

Hamoudi, Walid Hamad, M.D., Lic. No. K7027, Woodville TX

On June 4, 2010, the Board and Walid Hamad Hamoudi, M.D., entered into a Mediated Agreed Order subjecting Dr. Hamoudi to the following terms and
conditions for three years: Dr. Hamoudi may not practice or prescribe outside his current employment with the Texas Department of Criminal Justice (“TDCJ”) at the University of Texas Medical Branch in Galveston until he requests and is granted permission from the Board to do so and provides sufficient evidence that his practice is consistent with the Medical Practice Act. In addition, Dr. Hamoudi must provide to the Board a copy of his peer review records on a quarterly basis; maintain a copy of his monthly controlled substances prescribing and activity report from the Texas Department of Public Safety; maintain a logbook of all prescriptions written by Dr. Hamoudi or any physician extenders; refrain from prescribing any drug for any patient unless the drug is medically indicated and is prescribed in therapeutic doses; maintain adequate medical records on all patient services performed; within six months pass the Medical Jurisprudence Exam; within six months complete 10 hours of CME in risk management and 10 hours in evaluating and prescribing for pain management patients; and pay an administrative penalty of $5,000. The Board's action was based on Dr. Hamoudi's failure to practice medicine in an acceptable, professional manner consistent with public health and welfare.

Healing, Robert Dyson, M.D., Lic. No. G2986, Jasper TX
On June 4, 2010, the Board and Robert Dyson Healing, M.D., entered into a Mediated Agreed Order requiring Dr. Healing to complete within one year a course called “Annual High Risk Emergency Medicine” offered by the Center for Emergency Medicine Education; and complete within one year eight hours of CME in risk management and eight hours in medical-record-keeping. The Board’s action was based on Dr. Healing's failure to meet the standard of care when he failed, while on-call, to immediately report to the bedside of a patient in respiratory distress.

Hendricks, Joel R., M.D., Lic. No. G9596, Kaufman TX
On February 5, 2010, the Board and Dr. Hendricks entered into a mediated agreed order requiring Dr. Hendricks to take a patient with a gangrenous appendix to surgery in an expeditious manner. The Board found Dr. Hendricks's failure to meet the standard of care and maintain adequate medical records in the case of an infant. The Board's action was based on Dr. Hendricks's failure to meet the standard of care and maintain adequate medical records in the case of an infant. The Board found that Dr. Hendricks didn't independently review the patient's CT scans, and thus failed to notify her of a kidney lesion, delaying her treatment for renal cell carcinoma.

Huang, Wentian, M.D., Lic. No. M1153, Garland TX
On February 5, 2010, the Board and Dr. Huang entered into an agreed order requiring Dr. Huang to complete 10 hours of CME in risk management within one year and pay an administrative penalty of $1,000 within 60 days. The Board’s action was based on Dr. Huang’s failure to meet the standard of care and exercise diligence in his treatment of a hospital patient. The Board found Dr. Huang didn't independently review the patient’s CT scans, and thus failed to notify her of a kidney lesion, delaying her treatment for renal cell carcinoma.

Johnson, Terry Lee, M.D., Lic. No. J5795, Wichita Falls TX
On February 5, 2010, the Board and Dr. Johnson entered into an agreed order requiring Dr. Johnson to complete 20 hours of CME in medical record-keeping and physician-patient communication within one year, and pay an administrative penalty of $1,000 within 90 days. The Board's action was based on Dr. Johnson's failure to meet the standard of care and maintain adequate medical records in the case of an infant. The Board found that Dr. Johnson remarked that the child had a “funny” facial appearance and did not adequately evaluate the infant's fever.

Khan, Nameem Ullah, M.D., Lic. No. L6235, Amarillo TX
On February 5, 2010, the Board and Dr. Khan entered into a mediated agreed order of public reprimand barring Dr. Khan from performing conscious sedation and requiring Dr. Khan to complete a formal education program in conscious sedation within two years; and complete 20 hours of CME in orthopedic emergencies and pain management. The Board’s action was based on Dr. Khan's failure to meet the standard of care by use of inappropriate anesthesia agents and procedures for sedation for a patient with a dislocated shoulder. As a result of Dr. Khan’s action the patient died.

Khan, Wasim Mohammad, M.D., Lic. No. J9729, Lufkin TX
On June 4, 2010, the Board and Wasim Mohammad Khan, M.D., entered into an Agreed Order requiring Dr. Khan to have a physician monitor his practice; complete within one year eight hours of CME in medical record-keeping; and pay an administrative penalty of $2,000 within 90 days. The Board’s action was based on Dr. Khan’s failure to comply with Board guidelines for the treatment of pain and failure to use diligence in his professional practice in his treatment of a patient who died from an overdose.

Iyer, Sridhar Krishnamurthy, M.D., Lic. No. N5739, Denton TX
On February 19, 2010, the Board and Sridhar Krishnamurthy Iyer, M.D., entered into an agreed order...
granting Dr. Iyer a Texas medical license with the following terms and conditions: Dr. Iyer’s practice must be monitored by a physician for four sequential three-month periods; and within one year Dr. Iyer must complete 12 hours of CME in the subject of antimicrobial therapy for tuberculosis and 12 hours in the subject of medical record-keeping. The action was based on Dr. Iyer’s failure to meet the standard of care resulting in a patient’s permanent loss of eyesight, and failure to maintain adequate medical records.

**Johnson, Alfred Raymond, D.O., Lic. No. F8525, Richardson TX**

On April 9, 2010, the Board and Alfred Raymond Johnson, D.O., entered into a Mediated Agreed Order requiring Dr. Johnson to use a revised informed consent form and special medical chart tracking system with patients undergoing a non-commercial, non-FDA approved desensitization therapy for chemical sensitivity. In addition, Dr. Johnson is required to complete 10 hours of CME in allergy/immunology and 8 hours of CME in medical record-keeping within one year; complete a 14-hour certification board review course in allergy/immunology within two years; submit within 60 days a list of therapies and extracts used in his practice; and pay an administrative penalty of $4,500 within 90 days. The action was based on the board’s finding that Dr. Johnson failed to obtain informed consent regarding intradermal injection of extract from diesel exhaust or maintain adequate medical records.

**Joo, Sang Bai, M.D., Lic. No. E9252, Houston TX**

On February 22, 2010, the Board and Sang Bai Joo, M.D., entered into a two-year mediated agreed order that requires Dr. Joo to have a chart monitor; pass the Texas Medical Jurisprudence Examination within three attempts within one year; complete 10 hours of CME in risk management and eight hours of CME in medical record-keeping; and pay an administrative penalty of $1,000 within 90 days. The action was based on the Board’s finding that Dr. Joo failed to meet the standard of care and prescribed drugs in a nontherapeutic manner for a patient with substance abuse problems.

**Laurora, Kenneth Joseph, M.D., Lic. No. L6237, Livingston TX**

On April 9, 2010, the Board and Kenneth Joseph Laurora, M.D., entered into an Agreed Order that requires Dr. Laurora to be monitored by a physician for two years; complete within one year eight hours of CME in medical record-keeping and eight hours in nephrology; and pay an administrative penalty of $3,000 within 180 days. The basis for action was Dr. Laurora’s failure to meet the standard of care and safeguard against potential complications when he transfused a large amount of blood within a short timeframe to a patient who subsequently died. Dr. Laurora failed to document a cardiologist’s recommendation, a crucial factor in Dr. Laurora’s treatment decision.

**Martinez, Ruben D., M.D., Lic. No. F1783, Harlingen TX**

On December 14, 2009, the Board and Dr. Martinez entered into an agreed order requiring that Dr. Martinez have a practice monitor for three years; that within one year he obtain 10 hours of CME in high-risk obstetrics and 10 hours of CME in gynecological malignancies; and that within 120 days he pay an administrative penalty of $5,000. The action was based on Dr. Martinez’s failure to admit a patient with signs and symptoms of pregnancy-induced hypertension to the hospital for fetal surveillance and his treating a patient with hormones in whom such treatment was contraindicated.

**Moheb, Ramin, M.D., Lic. No. L0430, Orange TX**

On February 5, 2010, the Board and Dr. Moheb entered into a four-year agreed order placing Dr. Moheb under the following terms and conditions: Dr. Moheb must limit his medical practice to a group, institutional setting or locum tenens position and continue to receive treatment from a Board-approved psychiatrist and psychotherapist once every four weeks. The Board based its action on Dr. Moheb’s diagnosis of depression that resulted in standard of care issues.

**Moradi, Mahoor Charles, M.D., PIT Permit No. BP10034004, Coppell TX**

On June 4, 2010, the Board and Mahoor Charles Moradi, M.D., entered into an Agreed Order publicly reprimanding Dr. Moradi and referring him to the Texas Physician Health Program to address impairment due to intemperate use of controlled substances, along with a recommendation that the program require Dr. Moradi to undergo an independent forensic psychiatric evaluation. The Board’s basis for action was Dr. Moradi’s inability to practice medicine with reasonable safety because of excessive use of drugs, inappropriate prescription of dangerous drugs to himself, writing false prescriptions for dangerous drugs and termination from his residency program.


On April 9, 2010, the Board and George Alan Nasser, M.D., entered into an Agreed Order publicly reprimanding Dr. Nasser and requiring him to have another...
physician monitor his practice for one year; complete within one year 10 hours of CME in risk management, 10 hours in medical record-keeping and 10 hours in anti-coagulation issues in cardiology; and pay an administrative penalty of $5,000 within 180 days. The action was based on the Board’s finding that Dr. Nasser failed to meet the standard of care when he performed a non-emergent pacemaker placement procedure on a patient who had an increased risk of bleeding, who later died.

On April 9, 2010, the Board and Leonard Gaylon Nepper, D.O., entered into an Agreed Order requiring Dr. Nepper to have another physician monitor his practice for one year and provide to the Board’s Compliance Division selected patient medical and billing records. The action was based on the Board’s finding that Dr. Nepper failed to meet the standard of care for two patients because he was not diligent in obtaining the patients’ previous medical records or tests to confirm a diagnosis prior to treating and prescribing pain medication.

On February 5, 2010, the Board and Dr. Nguyen entered into an agreed order which placed Dr. Nguyen under certain terms and conditions for three years. The terms and conditions include: a practice monitor; 30 hours of CME including 10 hours in medical record-keeping within one year, 10 hours in adult prescribing and 10 hours in pediatric prescribing within two years. The disciplinary action was based on the Board’s finding that for 15 patients Dr. Nguyen did not do appropriate work-ups for chronic cough conditions and prescribed excessive doses extended over long periods of time.

Nielson, David Hugh, M.D., Lic. No. K0962, San Antonio TX
On February 5, 2010, the Board and Dr. Nielson entered into an agreed order requiring Dr. Nielson to complete 15 hours of CME in medical record-keeping, risk management and ethics within one year; and pay an administrative penalty of $4,000 within 60 days. The action was based on the Board’s finding that Dr. Nielson failed to keep adequate medical records, failed to use proper diligence in his professional practice, and failed to adequately supervise the activities of those acting under his supervision. The Board found that digital photos that were part of patient records were inadvertently deleted and that Dr. Nielson authorized a person to represent his clinic and that person misrepresented risks and procedures for Dr. Nielson’s treatment of rosacea.

O’Neal, Don Martin, M.D., Lic. No. E2769, Sulphur Springs TX
On June 4, 2010, the Board and Don Martin O’Neal, M.D., entered into an Agreed Order placing Dr. O’Neal under the following terms and conditions for two years. Dr. O’Neal is required to: have a physician monitor his practice; complete within one year 20 hours of CME in pain management and 10 hours in medical record-keeping; and pay an administrative penalty of $3,000 within 180 days. The action was based on Dr. O’Neal’s failure to meet the standard of care; failure to comply with pain treatment guidelines and nontherapeutic prescribing.

Ortiz, Dennis Lawrence, D.O., Lic. No. H0705, Colleyville TX
On June 4, 2010, the Board and Dennis Lawrence Ortiz, D.O., entered into an Agreed Order that requires Dr. Ortiz to complete within one year eight hours of CME in the subject of patient-physician relationships and pay an administrative penalty of $1,000 within 90 days. The basis for action was Dr. Ortiz’ failure to use proper diligence when he did not personally evaluate a urology patient during the post-operative period.

Pacheco-Serrant, Helson, M.D., Lic. No. K6208, El Paso TX
On June 4, 2010, the Board and Helson Pacheco-Serrant, M.D., entered into an Agreed Order requiring Dr. Pacheco-Serrant to complete within one year 30 hours of CME including 10 hours in medical record-keeping, 10 hours in risk management and 10 hours in indications and diagnosis for spinal surgery; and pay an administrative penalty of $12,000 within 60 days. The Board’s basis for action was the finding that Dr. Pacheco-Serrant failed to meet the standard of care, failed to maintain adequate medical records and failed to obtain informed consent in his treatment of a spinal surgery patient.

Parr, Deborah K., M.D., Lic. No. K5699, Durango CO
On June 4, 2010, the Board and Deborah K. Parr, M.D., entered into an Agreed Order publicly reprimanding Dr. Parr and requiring Dr. Parr to complete within on year 15 hours of CME in opioid dependence and chronic pain, and 15 hours in care and treatment of depressive disorders; and pay an administrative penalty of $10,000 within 90 days. The Board’s
action was based on Dr. Parr’s failure to meet the standard of care in her treatment of two patients with substance abuse issues; and failure to prescribe dangerous drugs in a manner consistent with public health and welfare.

Paulis, Cynthia Barbara, D.O., Lic. No. J7622, Massapequa, NY

On June 4, 2010, the Board and Cynthia Barbara Paulis, D.O., entered into a Mediated Agreed Settlement Order requiring Dr. Paulis to complete within one year 10 hours of CME in medical record-keeping and 15 hours in emergencies in pediatrics; and pay an administrative penalty of $1,000 within 90 days. The Board’s action was based on Dr. Paulis’ failure to practice medicine in an acceptable professional manner consistent with public health and welfare and failure to maintain adequate medical records in the case of one pediatric patient. The Board found Dr. Paulis did not confirm that the patient could tolerate fluids without vomiting and failed to adequately document the presence or absence of bowel sounds.

Perry, John Edward, III, M.D., Lic. No. L1430, Houston, TX

On April 9, 2010, the Board and John Edward Perry, III, M.D., entered into a Mediated Agreed Order publicly reprimanding Dr. Perry and placing him under certain terms and conditions that remain in effect until modified by a subsequent order of the Board. The order prohibits Dr. Perry from possessing, administering or prescribing any schedule II or III controlled substances except as medically necessary in approved settings; prohibits Dr. Perry from the practice of chronic pain management and limits his medical practice to a group or institutional setting; and requires that Dr. Perry’s practice be monitored by another physician. In addition, Dr. Perry must pay an administrative penalty of $15,000 within 18 months; complete 16 hours of CME, including eight in ethics and eight in pain management; and may not delegate prescriptive authority to physician extenders. The basis for action was Dr. Perry’s failure to meet the standard of care in his treatment of a patient, failure to safeguard against potential complications, non-therapeutic prescribing and providing medically unnecessary services to a patient.

Pham, Roger C., M.D., Lic. No. H4614, Arlington, TX

On April 9, 2010, the Board and Roger C. Pham, M.D., entered into an Agreed Order requiring Dr. Pham to have a physician monitor his practice for three years; complete within one year the medical record-keeping and controlled substance management courses offered by Case Western Reserve University School of Medicine; and pay an administrative penalty of $1,000 within 60 days. The basis for action was Dr. Pham’s failure to adequately document or treat a patient’s chronic pain and anxiety.

Rajala, Teresa Dewlett, M.D., Lic. No. G8079, McKinney, TX

On February 5, 2010, the Board and Dr. Rajala entered into a required order requiring Dr. Rajala to complete the physician prescribing course at University of California San Diego Physician Assessment and Clinical Education (PACE) or complete 24 hours of CME in ethics, medical record-keeping and prescribing controlled substances within one year. The action was based on the Board’s finding that Dr. Rajala prescribed dangerous drugs without maintaining adequate medical records when she wrote 14 prescriptions for hydrocodone and Arthorotec over a 15-month period for a patient with a hip injury without establishing a proper physician-patient relationship.

Reyes, Ramon Gilberto Almodovar, M.D., Lic. No. J1367, Helotes, TX

On April 9, 2010, the Board and Ramon Gilberto Reyes Almodovar, M.D., entered into an Agreed Order requiring Dr. Almodovar to complete 24 hours of CME in risk management, medical record-keeping and pain management within one year; have a physician monitor his practice for eight consecutive reporting periods of three months each; and pay an administrative penalty of $5,000 within 60 days. The basis for action was Dr. Almodovar’s failure to meet the standard of care, non-therapeutic prescribing and violation of Board rules related to pain management.

Rice, Theresa Cachuela, M.D., Lic. No. G1174, Houston, TX

On March 1, 2010, the Board and Theresa Cachuela Rice, M.D., entered into an agreed order requiring Dr. Rice to pass the Texas Medical Jurisprudence Examination within one year, within three attempts; complete 24 hours of CME in medical record-keeping, risk management and ethics within one year; and pay an administrative penalty of $1,500 within 60 days. The action was based on the Board’s finding that Dr. Rice failed to meet the standard of care, aided and abetted the practice of medicine by a person not licensed by the Board and failed to supervise adequately the activities of those acting under her supervision. The Board considered as a mitigating circumstance that Dr. Rice was one of several doctors duped by a Nigerian businessman who had a history of fraudulent activity.

continued on next page
Richardson, Sidney Holt, M.D., Lic. No. C4516, Cameron TX

On April 9, 2010, the Board and Sidney Holt Richardson, M.D., entered into an Agreed Order requiring Dr. Richardson to limit his practice of medicine to non-clinical positions as Milam County Health Authority and as Medical Director of the Cameron Nursing Center and not engage in direct patient care. In addition, the order requires that Dr. Richardson not re-register when his DEA and DPS controlled substances certificates expire on April 30, 2010. The basis for the Board’s action was Dr. Richardson’s non-therapeutic prescribing and his failure to adequately document and justify the quantity and use of controlled substances prescribed to five patients he treated for pain management.

Sabbagh, Mouin Fayez, M.D., Lic. No. J6229, Lake Jackson, TX

On February 5, 2010, the Board and Dr. Sabbagh entered into a mediated agreed order requiring Dr. Sabbagh to: complete four hours of CME in risk management within one year; complete the courses in physician prescribing and medical record keeping offered by University of California San Diego Physician Assessment and Clinical Education (PACE); comply with the Board’s prescribing rules; and maintain a logbook of all prescriptions written for scheduled drugs. The Board’s action was based on Dr. Sabbagh’s failure to meet the standard of care by prescribing dangerous drugs to family members without maintaining adequate medical records.

Sanchez-Zambrano, Sergio, M.C., Lic. No. E7263, Cleburne TX

On February 5, 2010, the Board and Dr. Sanchez-Zambrano entered into an agreed order requiring Dr. Sanchez-Zambrano to complete 20 hours of CME in medical record-keeping, physician-patient communication and neurological emergencies/common problems. The Board’s basis for action was Dr. Sanchez-Zambrano’s failure to treat a patient according to the generally accepted standard of care and failure to maintain adequate medical records for one patient.

Shaw, Grady Carlton, M.D., Lic. No. F7158, Corsicana TX

On June 4, 2010, the Board and Grady Carlton Shaw, M.D., entered into an Agreed Order restricting Dr. Shaw’s license and placing him under the following terms and conditions for three years: Dr. Shaw may not treat chronic pain for patients needing pain treatment beyond three months; and Dr. Shaw must have his practice monitored by another physician. In addition, the Agreed Order requires Dr. Shaw to complete within one year 10 hours of CME in pain management and complete an additional 10 hours in years two and three of the Order for a total of 30 hours of CME in pain management; and complete within one year 10 hours of CME in medical record-keeping. The Board’s action was based on Dr. Shaw’s failure to meet the standard of care in the treatment of a chronic pain patient who became dependent on Methadone.

Siddiqi, Shah Naweed, M.D., Lic. No. J4515, Houston TX

On June 4, 2010, the Board and Shah Naweed Siddiqi, M.D., entered into an Agreed Order of public reprimand requiring Dr. Siddiqi to complete within one year the Knowledge, Skills, Training, Assessment, and Research program’s clinical competency assessment offered by the Texas A&M Health Science Center Rural and Community Health Institute; complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; complete within one year eight hours of CME in physician-patient communication; and pay an administrative penalty of $10,000 within 90 days. The action was based on the Board’s finding that Dr. Siddiqi failed to meet the standard of care, safeguard against complications and maintain adequate medical records in his treatment of two patients.

Sorokolit, Walter Theodore, M.D., Lic. No. F2456, Fort Worth TX

On April 9, 2010, the Board and Walter Theodore Sorokolit, M.D., entered into an Agreed Order requiring Dr. Sorokolit to complete eight hours of CME in medical record-keeping and eight hours in hand surgery; and pay an administrative penalty of $3,000 within 180 days. The Board’s action was based on Dr. Sorokolit’s failure to meet the standard of care with one hand surgery patient when he did not appropriately examine the patient, causing him to make a questionable diagnosis, resulting in the patient’s need for further surgery.

Stroud, Robert Lee, M.D., Lic. No. E2888, Austin TX

On June 4, 2010, the Board and Robert Lee Stroud, M.D., entered into an Agreed Order requiring Dr. Stroud to complete within one year courses in physician prescribing and physician-patient communication offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board’s action was based on Dr. Stroud’s failure to meet the standard of care and his nontherapeutic prescribing for a liver-transplant patient.
Sudhivoraseth, Niphon, M.D., Lic. No. F2468, Marshall TX

On February 5, 2010, the Board and Dr. Sudhivoraseth entered into a three-year agreed order, requiring that Dr. Sudhivoraseth have a practice monitor; submit new accounting and billing protocols to the Board; complete 20 hours of CME in diagnosis and treatment of pediatric allergies within one year; pay a $5,000 administration penalty within 60 days. In addition Dr. Sudhivoraseth shall prohibit his wife from signing office documents or treating patients under the auspices of the “R.N.” designation she received in another state. The basis for action was the Board’s finding that Dr. Sudhivoraseth violated the standard of care in his treatment of 10 pediatric patients by performing skin testing without proper controls; using expired extracts; and by performing intradermal airborne allergy testing without previous prick puncture testing.

Suvunrungsi, Precha, M.D., Lic. No. E0159, Killeen TX

On June 4, 2010, the Board and Precha Suvunrungsi, M.D., entered into an Agreed Order publicly reprimanding Dr. Suvunrungsi and requiring him to contact within 30 days the Texas A&M Health Science Center Rural and Community Health Institute (“K-STAR”) for the purpose of scheduling an assessment of Dr. Suvunrungsi and his practice of medicine and to determine whether he should undergo an education plan; and complete within one year eight hours of CME in the subject of pharmacology/drug interactions for elderly populations. The Board’s action was based on Dr. Suvunrungsi’s failure to meet the standard of care, failure to safeguard against potential complications and nontherapeutic prescribing of Digoxin for a nursing home patient who subsequently died.

Tadlock, Hugh M., M.D., Lic. No. G3835, Fort Hood TX

On February 5, 2010, the Board and Dr. Tadlock entered into an agreed order requiring Dr. Tadlock to use a chaperone anytime he performs a physical exam on a female patient, making a note of the chaperone’s presence on the patient’s chart; to complete 16 hours of CME in physician-patient communication within one year; and to pay an administrative penalty of $5,000 within 60 days. The basis for disciplinary action was Dr. Tadlock’s failure to meet the standard of care when he performed an exam on a female patient without explanation or informed consent.

Tijimes, Jorge E., M.D., Lic. No. E3784, McAllen TX

On June 4, 2010, the Board and Jorge E. Tijimes, M.D., entered into a Mediated Agreed Order requiring Dr. Tijimes to have a physician monitor his practice; complete within one year eight hours of CME in spine surgery and eight hours of CME in radiographic study interpretation. The Board’s action was based on Dr. Tijimes’ failure to use proper diligence in his treatment of five patients.

Tuinstra, Theodore John, D.O., Lic. No. D4576, Dallas TX

On February 24, 2010, the Board and Theodore John Tuinstra, D.O., entered into an agreed order requiring Dr. Tuinstra to surrender his DEA and DPS Controlled Substances Registration Certificates and refrain from reregistering for 10 years; have a physician monitor for three years; and complete within one year 25 hours of CME in risk management, medical record-keeping and ethics. In addition, Dr. Tuinstra is not allowed to supervise or delegate prescriptive authority to physician extenders. The action was based on the Board’s finding that Dr. Tuinstra failed to maintain adequate medical records and failed to meet the standard of care by prescribing dangerous drugs without establishing a proper physician-patient relationship.

Vertkin, Gene, M.D., Lic. No. M2854, Fort Worth TX

On June 4, 2010, the Board and Gene Vertkin, M.D., entered into an Agreed Order requiring Dr. Vertkin to complete within one year 10 hours of CME in risk management. The Board’s action was based on Dr. Vertkin’s failure to meet the standard of care when he performed an interscalene nerve block on the wrong side during a patient’s surgery.

Villanueva, Rita L., M.D., Lic. No. M0597, San Benito TX

On February 5, 2010, the Board and Dr. Villanueva entered into an agreed order requiring Dr. Villanueva to pay an administrative penalty of $2,000 within 60 days. The Board’s action was based on Dr. Villanueva’s failure to obtain proper informed consent for laser hair removal on a 16-year-old patient.

Weldon, Lloyd Kent, D.O., Lic. No. E6947, Fort Worth TX

On February 5, 2010, the Board and Dr. Weldon entered into a three-year agreed order requiring Dr. Weldon to have a practice monitor; pay an administrative penalty of $3,000 within 90 days; and complete 20 hours of CME in pain management and medical record-keeping within one year. The action was based on the Board’s finding that Dr. Weldon failed to meet the standard of care in his treatment of six patients, treated for pain management issues. The Board further found that Dr. Weldon failed to maintain
adequate medical records and follow guidelines for the treatment of intractable pain.

Zamora, Jose L., M.D., Lic. No. G6427, Houston TX
On February 5, 2010, the Board and Dr. Zamora entered into an agreed order requiring Dr. Zamora to complete at least eight hours of CME in risk management within one year and pay an administrative penalty of $1,000 within 90 days. The Board’s action was based on Dr. Zamora’s failure to meet the standard of care in performing medical services for two patients. The Board found that Dr. Zamora improperly attempted an initial catheterization and arteriogram through a patient’s right groin, rather than his left groin, despite severe ischemia in the patient’s right leg. Additionally, the Board found that Dr. Zamora failed to visualize under fluoroscopy the advancement of the balloon before inflation during another patient’s angioplasty.

UNPROFESSIONAL CONDUCT VIOLATIONS

Anabtawi, Isam Nazmi, M.D., Lic. No. D5588, Port Arthur TX
On February 5, 2010, the Board and Dr. Anabtawi entered into an agreed order of public reprimand requiring Dr. Anabtawi to complete five hours of CME in ethics within one year and pay an administrative penalty of $8,000. The Board’s action was based on Dr. Anabtawi’s indictment on 150 felonious counts of health care fraud and, in lieu of trial, entrance into a federal 18-month pretrial diversion program.

Apostolakis, Louis William, M.D., Lic. No. L2104, West Lake Hills TX
On April 9, 2010, the Board and Louis William Apostolakis, M.D., entered into an Agreed Order requiring Dr. Apostolakis to pay an administrative penalty of $1,000 within 30 days. The basis for action was Dr. Apostolakis’ violation of a Board rule prohibiting physicians from providing, dispensing or distributing a drug for a fee.

Armstrong, Kenneth Lee, M.D., Lic. No. F6396, Round Rock TX
On April 9, 2010, the Board and Kenneth Lee Armstrong, M.D., entered into an Agreed Order requiring Dr. Armstrong to complete within one year 30 hours of CME, including 20 hours in physician-patient boundaries and 10 hours in treatment of psychiatric disorders in family practice. The action was based on Dr. Armstrong’s unprofessional or dishonorable conduct toward a patient whom he telephoned repeatedly to suggest and arrange meetings outside of the professional practice site.

On December 14, 2009, the Board and Dr. Dipprey entered into a five-year agreed order of public reprimand requiring that she undergo an independent psychiatric evaluation and continue care under a treating psychiatrist; that within one year she complete a professional boundaries course and obtain eight hours of continuing medical education in medical record-keeping and that within 90 days she pay an administrative penalty of $5,000. The action was based on Dr. Dipprey’s assault and battery conviction on an individual with whom she lived and was romantically involved and on her prescription of controlled substances to the same individual, even though Dr. Dipprey knew or should have known this individual had a drug addiction, and on Dr. Dipprey’s failure to maintain adequate medical records for these transactions.

Koenigsberg, Alan David, M.D., Lic. No. G7837, Plano TX
On June 4, 2010, the Board and Alan David Koenigsberg, M.D., entered into a Mediated Agreed Order requiring Dr. Koenigsberg to pay an administrative penalty of $500 within 90 days. The basis for action was Dr. Koenigsberg’s unprofessional conduct and failure to promptly respond to Board requests for records.

Martinez, Jorge, M.D., Lic. No. H1801, McAllen TX
On April 9, 2010, the Board and Jorge Martinez, M.D., entered into an Agreed Order requiring Dr. Martinez to submit within six months a new report from La Hacienda regarding his compliance with his substance abuse rehabilitation program; maintain a log of all “energy” drinks he consumes along with any alcohol content for six months; and pay an administrative penalty of $2,000 within 60 days. The basis for the Board’s action was Dr. Martinez’s unprofessional or dishonorable conduct that is likely to deceive, defraud or injure the public through his intemperate use of alcohol or drugs.

McLaughlin, Jerry Dewayne, II, M.D., Lic. No. J2961, Hobbs NM
On June 4, 2010, the Board and Jerry Dewayne McLaughlin, M.D., entered into an Agreed Order requiring Dr. McLaughlin to pay an administrative penalty of $3,000 within 30 days. The Board’s action was based on Dr. McLaughlin’s unprofessional conduct, failure to comply with a Board subpoena requesting medical records and failure to respond to multiple follow-up contacts by Board staff attempts to gather
the requested records.

**Milam, Mary, M.D., Lic. No. E4529, Fort Worth TX**

On April 9, 2010, the Board and Mary Milam, M.D., entered into an Agreed Order requiring Dr. Milam to complete eight hours of CME in patient-physician communication and eight hours in risk management within one year; and pay an administrative penalty of $1,000 within 60 days. The Board’s action was based on Dr. Milam’s unprofessional conduct when she made insensitive remarks to a patient diagnosed with metastatic cancer.

**Miller, Jerry Winkler, M.D. Lic. No. H1626, El Paso TX**

On February 5, 2010, the Board and Dr. Miller entered into an agreed order requiring Dr. Miller to complete eight hours of CME in medical ethics and eight hours of CME in risk management within one year; pay an administrative penalty of $4,000 within 60 days; correct his physician profile on the Texas Medical Board website within 30 days; and submit to the Board a written plan for ensuring prompt response to on-call pages from hospital ER personnel. The Board’s action was based on Dr. Miller’s failure to practice medicine in an acceptable, professional manner; failure to use professional diligence; and failure to timely respond in person when on-call or when requested by emergency room or hospital staff.

**Silver, Steven L., M.D., Lic. No. L7184, Tyler TX**

On June 4, 2010, the Board and Steven L. Silver, M.D., entered into a Mediated Agreed Order requiring Dr. Silver to complete within one year 16 hours of CME in medical record-keeping; complete within one year the PACE clinician-patient communication course; and within one year provide to the Director of Compliance a written report outlining what he learned at the courses described. The Board’s action was based on Dr. Silver’s inadequate medical records and unprofessional conduct toward a patient.

**Smith-Blair, Gayle La Treece, M.D., Lic. No. H4710, Dallas TX**

On February 5, 2010, the Board and Dr. Smith-Blair entered into a mediated agreed order requiring Dr. Smith-Blair to complete 10 hours CME in ethics and risk management within one year; pass the Texas Jurisprudence Examination within three attempts within one year; pay an administrative penalty of $1,000 within 60 days. The Board’s action was based on Dr. Smith-Blair’s using misleading and deceptive advertising and failure to supervise adequately the activities of those acting under her supervision, namely an ordained minister from Dr. Smith-Blair’s church, identified by Dr. Smith-Blair as a “clinician” on her website, who was alleged to have given an unwanted kiss to an individual during a counseling session.

**Woodward, John Reagan, M.D., Lic. No. D4884, Dallas TX**

On April 9, 2010, the Board and John Reagan Woodward, M.D., entered into an Agreed Order that requires Dr. Woodward to complete within one year 10 hours of CME in the area of prescribing controlled substances and/or risk management. The basis for action was Dr. Woodward’s violation of a Board rule that prohibits the use of pre-signed prescriptions for controlled substances.

**Worrell, Paul Stephen, D.O., Lic. No. F7329, Dallas TX**

On February 5, 2010, the Board and Dr. Worrell entered into an agreed order requiring that Dr. Worrell pass the Texas Medical Jurisprudence Examination within one year and within three attempts; and pay an administrative penalty of $1,000 within 60 days. The basis for action was the Board’s finding that Dr. Worrell provided false information to the Board, including his failure to report an April 2005 arrest when he renewed his license in 2008.

**NONTHERAPEUTIC PRESCRIBING VIOLATIONS**

**Atkinson, William Hudson, M.D., Lic. No. E2448, Wills Point TX**

On April 9, 2010, the Board and William Hudson Atkinson, M.D., entered into a Mediated Agreed Order subjecting Dr. Atkinson to the following terms and conditions for two years. Within one year from the date of mediation, February 18, 2010, Dr. Atkinson must complete the University of California San Diego PACE course in physician-prescribing and medical record-keeping for a minimum of 39.5 hours, complete 16 hours of CME in chronic pain management and complete eight hours of CME in addiction. In addition, for one year Dr. Atkinson must submit to the Board’s Compliance Department a log book documenting all prescribed controlled substances each month. The basis for disciplinary action was Dr. Atkinson’s non-therapeutic prescribing for four patients.

**Dyke, Marshall James, M.D., Lic. No. D1619, Houston TX**

On February 5, 2010, the Board and Dr. Dyke entered into a mediated agreed order requiring Dr. Dyke to have his practice monitored monthly by another physician and to pay an administrative penalty of $1,000 within 180 days. The Board’s action was based on Dr.?
Dyke’s nontherapeutic prescribing and unprofessional conduct. This order shall terminate in 120 days, provided that Dr. Dyke meets all of the requirements.

**Packard, Stanton Clark, M.D., Lic. No. J6641, Pasadena TX**

On February 5, 2010, the Board and Dr. Packard entered into an agreed order placing Dr. Packard under the following terms and conditions: take and pass the Texas Medical Jurisprudence Examination within three attempts within one year; complete 20 hours of CME in medical record-keeping and pain management within two years. The basis for action was the Board’s finding that Dr. Packard: inappropriately prescribed dangerous drugs or controlled substances to family members; violated Board rules regarding maintenance of adequate medical records and the treatment of pain; and failed to practice medicine in an acceptable, professional manner.

**Ritchey, Elizabeth E., M.D., Lic. No. G6604, New Braunfels TX**

On February 5, 2010, the Board and Dr. Ritchey entered into a two-year agreed order requiring Dr. Ritchey to have a practice monitor; pass the Texas Medical Jurisprudence Exam within three attempts within one year; complete 20 hours of CME in medical record-keeping and chronic pain management within one year; and maintain a logbook of all prescriptions written for drugs with addictive potential or potential for abuse. The Board’s action was based on Dr. Ritchey’s failure to appropriately diagnose, treat or document care provided to several patients.

**Robinson, Eldon Stevens, M.D., Lic. No. J9545, Lubbock TX**

On February 5, 2010, the Board and Dr. Robinson entered into a mediated agreed order requiring Dr. Robinson to pass the Texas Medical Jurisprudence Examination within one year; complete 10 hours of CME in medical record-keeping; and pay an administrative penalty of $1,000 within 60 days. The Board’s action was based on Dr. Robinson’s failure to maintain adequate medical records in relation to a facelift procedure he performed on a patient.

**Xiques, Pablo L., M.D., Lic. No. E3823, Grand Prairie TX**

On April 9, 2010, the Board and Dr. Xiques, M.D., entered into a Mediated Agreed Order requiring Dr. Xiques to limit the hours of his medical practice; refrain from prescribing or authorizing refills of any Schedule I or Schedule II drugs; and surrender his license by December 15, 2010 to avoid further legal action. The action was based on the Board’s finding that Dr. Xiques failed to meet the standard of care in his prescription of narcotics, benzodiazepines and muscle relaxants without adequate documentation and treatment plans for two patients.

**INADEQUATE MEDICAL RECORDS**

**Allen, Mark Lee, M.D., Lic. No. J1610, Plano TX**

On April 9, 2010, the Board and Mark Lee Allen, M.D., entered into an Agreed Order that requires Dr. Allen to complete 10 hours of CME in medical record-keeping within one year and pay an administrative penalty of $1,000 within 60 days. The Board’s action was based on Dr. Allen’s inadequate medical records for a patient which were “disorganized and difficult to decipher.”

**Barlow, Lloyd Hammon, M.D., Lic. No. M0988, Eldorado TX**

On April 9, 2010, the Board and Lloyd Hammon Barlow, M.D., entered into an Agreed Order that requires Dr. Barlow to pass the Texas Medical Jurisprudence Examination within three attempts within one year; complete within one year eight hours of CME in medical record-keeping and eight in ethics; and pay an administrative penalty of $3,000. The Board based its action on Dr. Barlow’s failure to use diligence and maintain adequate medical records.

**Bartlett, Sylvan, M.D., Lic. No. E7810, Odessa TX**

On February 22, 2010, the Board and Sylvan Bartlett, M.D., entered into an Agreed Order requiring Dr. Bartlett to pass the Texas Medical Jurisprudence Examination within one year and within three attempts; complete five hours of CME in medical record-keeping; and pay an administrative penalty of $500 within 90 days. The Board’s action was based on Dr. Bartlett’s failure to maintain an adequate medical record in relation to a facelift procedure he performed on a patient.

**Bennack, Laura J., M.D., Lic. No. K0261, San Antonio TX**

On February 5, 2010, the Board and Laura J. Bennack, M.D., entered into an Agreed Order requiring Dr. Bennack to complete eight hours of CME in medical record-keeping and five hours of CME in risk management. The action was based on the Board’s finding that Dr. Bennack’s medical records were inadequate for one patient.

**Brashear, Doyle Hubbard, M.D., Lic. No. C4954, Lufkin TX**

On April 9, 2010, the Board and Doyle Hubbard Brashear, M.D., entered into an Agreed Order that requires Dr. Brashear, a psychiatrist, to cease treatment
of chronic pain patients and complete eight hours of CME in medical record-keeping. The basis for action was Dr. Brashear’s failure to maintain adequate medical records, and his failure to follow Board rules on the treatment of pain management.

**Campbell, Andrew Foil, M.D., Lic. No. G1284, Dallas TX**

On June 4, 2010, the Board and Andrew Foil Campbell, M.D., entered into an Agreed Order requiring Dr. Campbell to complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (“PACE”) program or an equivalent course. The action was based on the Board’s finding that Dr. Campbell failed to adequately document patient evaluations, diagnoses and justifications for treatment choices. Dr. Campbell was previously the subject of Board disciplinary action in 2008 for failing to properly dispose of patient records.

**Dar, Vaqar A., M.D., Lic. No. K4878, Flower Mound TX**

On February 5, 2010, the Board and Dr. Dar entered into an agreed order requiring Dr. Dar to complete within one year eight hours of CME in medical record-keeping and pay an administrative penalty of $1,000 within 60 days. The Board action was based on Dr. Dar’s failure to meet the standard of care and keep adequate medical records when he wrote a prescription for a family friend on two occasions without documenting an examination or creating a medical record.

**Faulkner, Marvin Lynn, D.O., Lic. No. K4423, Fort Worth TX**

On April 9, 2010, the Board and Marvin Lynn Faulkner, D.O., entered into an Agreed Order requiring Dr. Faulkner to pay an administrative penalty of $3,000, and complete eight hours of CME in both medical record-keeping and risk management. The basis for action was Dr. Faulkner’s failure to maintain adequate medical records for eight chronic pain patients.


On June 4, 2010, the Board and Olie Ray Garrison, D.O., entered into a Mediated Agreed Order requiring Dr. Garrison to have a physician monitor his practice for two consecutive monitoring cycles; complete within one year eight hours of CME in the area of gastrointestinal and liver-related issues. The Board’s action was based on Dr. Garrison’s failure to maintain adequate medical records or document his medical decision-making including reasons for not doing a plan for management of abnormal lab results.

**Gulbas, Paul Stephen, M.D., Lic. No. E1326, El Paso TX**

On June 4, 2010, the Board and Paul Stephen Gulbas, M.D., entered into an Agreed Order requiring Dr. Gulbas to complete within one year 10 hours of CME, including five hours in risk management and five hours in medical record-keeping. The Board’s action was based on Dr. Gulbas’ failure to adequately document his discussion of LASIK surgery complications with a patient.

**Henderson, James Michael, M.D., Lic. No. E4398, Childress TX**

On February 5, 2010, the Board and Dr. Henderson entered into a three-year mediated agreed order that requires Dr. Henderson to retain a practice management consultant approved by the Board who will recommend revised protocols for Dr. Henderson’s supervision and delegation of prescriptive authority to physician extenders. Dr. Henderson must submit to the Board the names of up to three potential consultants within 30 days. Once approved by the Board, the consultant must provide a list of recommended revised protocols within 60 days. In addition, Dr. Henderson is required to have a physician monitor, designated by the compliance division of the Board, to review compliance with these revised protocols quarterly within 12 months. The action was based on the Board’s finding that Dr. Henderson failed to maintain adequate medical records for a single hospice patient with a recurrent complaint of shoulder pain. The patient was seen almost exclusively by a nurse practitioner between June 2004 and August 2007 when the patient was diagnosed with an inoperable tumor.

**Hughes, Larry Charles, D.O., Lic. No. J1692, Groesbeck TX**

On February 5, 2010, the Board and Dr. Hughes entered into an agreed order requiring Dr. Hughes to have a physician monitor his practice for two years; pass the Texas Medical Jurisprudence Exam within one year; and complete 30 hours of CME in pain management and medical record-keeping within one year. The Board’s action was based on Dr. Hughes’ failure to maintain adequate medical records for 15 chronic pain patients, and specifically his failure to meet record-keeping standards for the treatment of intractable pain. The Board found Dr. Hughes did not adequately document: his rationale for prescribing large doses of controlled substances; treatment goals; a discussion of risks and benefits with the patients;
assessment of the patients’ potential for substance abuse; and results of additional diagnostic testing and lab results.

**Khan, Ahmed I., M.D., Lic. No. H0073, Dallas TX**

On February 5, 2010, the Board and Dr. Khan entered into an agreed order requiring Dr. Khan to complete five hours of CME in medical record-keeping within one year. The basis for action was Khan's failure to maintain adequate medical records for one patient.

**Kukreja, Suresh, M.D., Lic. No. F5991, Garland TX**

On June 4, 2010, the Board and Suresh Kukreja, M.D., entered into an Agreed Order requiring Dr. Kukreja complete within one year 10 hours of CME in medical record-keeping and five hours of CME in risk management. The Board's action was based on Dr. Kukreja's failure to document his diagnosis of an infant’s plagiocephaly, and his discussion of the diagnosis with the child’s parents.

**Lichorad, Anna, M.D., Lic. No. L4532, Bryan TX**

On February 5, 2010, the Board and Dr. Lichorad entered into an agreed order requiring Dr. Lichorad to complete 20 hours of CME in pain management within one year; teach a two-hour course to two groups of residents at Brazos Valley Family Medicine Program in medical record-keeping and appropriate documentation for chronic pain patients within one year. The Board’s action was based on Dr. Lichorad’s failure to maintain adequate medical records in the case of four patients with chronic pain conditions.

**Lipsen, Bryan Charles, M.D., Lic. No. J8034, Houston TX**

On February 9, 2010, the Board and Dr. Lipsen entered into an agreed order requiring Dr. Lipsen to complete 10 hours of CME in medical record-keeping. The Board's action was based on Dr. Lipsen's failure to maintain adequate medical records for one patient.

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

On June 4, 2010, the Board and Joseph Francis McWherter, M.D., entered into a Mediated Agreed Order requiring Dr. McWherter to have his practice monitored by a physician for a term of eight reporting periods; and complete within one year 10 hours of CME in medical record-keeping. The Board's action was based on Dr. McWherter's inadequate medical records for a patient with endometriosis.

**Mathias, John Robert, M.D., Lic. No. H5378, Houston TX**

On June 4, 2010, the Board and John Robert Mathias, M.D., entered into an Agreed Order requiring Dr. Mathias to complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and have his medical record-keeping monitored by a physician for two years. The Board’s actions were based on Dr. Mathias’ general failure to maintain adequate medical records and his specific failure to maintain adequate records in accordance with Board rules regarding the treatment of pain and regarding the practice of alternative and complementary medicine.

**Merszei, Justin D., M.D., Lic. No. L3016, Houston TX**

On June 4, 2010, the Board and Justin D. Merszei, M.D., entered into an Agreed Order requiring Dr. Merszei to pay an administrative penalty of $1,000 within 60 days. The basis for action was Dr. Merszei’s failure to maintain adequate medical records for three patients.

**Michaels, Carla, D.O., Lic. No. K0934, Murphy TX**

On February 5, 2010, the Board and Dr. Michaels entered into an agreed order requiring Dr. Michaels to complete 20 hours of CME in pain management and endocrinology with a focus on diabetes within one year; and pay an administrative penalty of $500 within one year. The Board’s action was based on Dr. Michaels’ failure to use proper diligence in her professional practice and adequately document her diagnostic approach when she misdiagnosed a patient with pre-diabetes and metabolic syndrome.

**Plummer, Paula C., M.D., Lic. No. F4381, Houston TX**

On June 4, 2010, the Board and Paula C. Plummer, M.D., entered into an Agreed Order requiring Dr. Plummer to complete within one year eight hours of CME in medical record-keeping. The basis for action was Dr. Plummer’s failure to maintain adequate medical records for a patient.

**Prabhakar, Meenakshi Sundaram, M.D. Lic. No. K3401, Dallas TX**

On February 5, 2010, the Board and Dr. Prabhakar entered into an agreed order requiring Dr. Prabhakar to complete 10 hours of CME in medical record-keeping within one year and pay an administrative penalty of $1,000 within 60 days. The Board’s action was based on Dr. Prabhakar’s failure to maintain adequate medical records and comply with a Board subpoena.

**Rainey, William Cecil, M.D., Lic. No. H9139, Abilene TX**

On February 5, 2010, the Board and Dr. Rainey entered into a mediated agreed order requiring Dr. Rainey to complete two CME courses, “Risk Management Essentials for Physicians” and “Risk Management
Consult: Documentation” presented by MedRisk, within one year. The action was based on the Board’s finding that Dr. Rainey did not maintain adequate medical records for three patients at the Abilene State School.

**Reyes, Jose, M.D., Lic. No. H6540, San Antonio TX**

On February 5, 2010, the Board and Dr. Reyes entered into a two-year agreed order requiring Dr. Reyes to have a practice monitor; complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education program (PACE), or an equivalent course approved in advance; and complete 10 hours of CME in risk management within one year. The Board’s action was based on the Board’s finding that Dr. Rainey did not maintain adequate medical records for three patients at the Abilene State School.

**Reyes, Jose, M.D., Lic. No. H6540, San Antonio TX**

On February 5, 2010, the Board and Dr. Reyes entered into a two-year agreed order requiring Dr. Reyes to have a practice monitor; complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education program (PACE), or an equivalent course approved in advance; and complete 10 hours of CME in risk management within one year. The Board’s action was based on the Board’s finding that Dr. Rainey did not maintain adequate medical records for three patients at the Abilene State School.

**Routh, Lisa Carole, M.D., Lic. No. H2742, Houston TX**

On February 5, 2010, the Board and Dr. Routh entered into a mediated agreed order requiring Dr. Routh to have a practice monitor for three years; complete 15 hours of CME in psychopharmacology and medical record-keeping and risk management within one year; and agree that a 30-day notice of a probationer show compliance proceeding to address any allegation of non-compliance is adequate notice for formal disciplinary action. After one year under these conditions, Dr. Routh may seek amendment or termination of these conditions. The Board action was based on Dr. Routh’s failure to maintain adequate medical records for one patient who suffered a harmful drug interaction.

**Safarimaryaki, Shahrokh, M.D., Lic. No. K7092, Longview TX**

On June 4, 2010, the Board and Shahrokh Safarimaryaki, M.D., entered into a Mediated Agreed Order requiring Dr. Safarimaryaki to have a physician monitor his records and practice; and complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (“PACE”) program. The action was based on Dr. Safarimaryaki’s failure to maintain adequate medical records for one patient with psychiatric problems.

**Scharold, Mary Louise, M.D., Lic. No. D5101, Houston TX**

On February 5, 2010, the Board and Dr. Scharold entered into an agreed order requiring Dr. Scharold to complete 16 hours of CME in medical record-keeping and risk management within one year; and pay an administrative penalty of $2,000 within 60 days. The action was based on the Board’s finding that Dr. Scharold’s medical record documentation for one patient was “severely lacking”.

**Shivshanker, Krishnamurthy, M.D., Lic. No. F3611, Houston TX**

On April 9, 2010, the Board and Krishnamurthy Shivshanker, M.D., entered into an Agreed Order requiring Dr. Shivshanker to complete within one year eight hours of CME in medical record-keeping and eight hours in risk management. The basis for action was the Board’s finding that Dr. Shivshanker failed to maintain adequate medical records documenting gastrointestinal consultations provided to one patient.

**Sioco, Geraldo Manaloto, M.D., Lic. No. J2337, San Antonio TX**

On February 5, 2010, the Board and Dr. Sioco entered into an agreed order requiring Dr. Sioco to complete 10 hours of CME in medical record-keeping. The basis for disciplinary action was the Board’s finding that Dr. Sioco failed to maintain adequate medical records that adequately explained his decision to perform a heart catheterization on one patient.

**Thota, Archana, M.D., Lic. No. L0950, Wylie TX**

On June 4, 2010, the Board and Archana Thota, M.D., entered into an Agreed Order requiring Dr. Thota to complete within one year 10 hours of CME in medical record-keeping and 10 hours of CME in gastro-intestinal diseases. The Board’s action was based on Dr. Thota’s failure to maintain adequate medical records documenting her reason for deviating from the standard treatment for H. pylori bacterium for one patient.

**Wiseman, Richard John, M.D., Lic. No. F0084, Austin TX**

On February 5, 2010, the Board and Dr. Wiseman entered into an agreed order requiring Dr. Wiseman to complete the medical record-keeping course offered by the University of California Physician Assessment and Clinical Education (PACE) program within one year and pay an administrative penalty of $1,000 within 60 days. The action was based on the Board’s find-
ing that for one patient Dr. Wiseman kept inadequate medical records; provided, dispensed or distributed drugs without proper labeling or record-keeping; and dispensed drugs in violation of pharmacy laws.

**Zajac, Paul, M.D., Lic. No. M8449, Odessa TX**

On February 5, 2010, the Board and Dr. Zajac entered into an agreed order requiring Dr. Zajac to complete at least 10 hours of CME in medical record-keeping within one year. The action was based on the Board’s finding that Dr. Zajac’s medical record documentation of one emergency room patient was sparse and inadequate.

**Zamora, Santiago Armando, M.D., Lic. No. F4720, Austin TX**

On June 4, 2010, the Board and Santiago Armando Zamora, M.D., entered into an Agreed Order requiring Dr. Zamora to have his practice monitored by a physician for eight consecutive monitoring cycles; and complete within one year eight hours of CME in medical record-keeping. The Board’s action was based on Dr. Zamora’s failure to maintain adequate medical records for one pediatric patient.

**VOLUNTARY SURRENDERS/SUSPENSIONS**

**Aaron, Benjamin, M.D., Lic. No. C6847, Lakeside CA**

On June 4, 2010, the Board and Benjamin Aaron, M.D., entered into an Agreed Order requiring Dr. Aaron to voluntarily and permanently surrender his license in lieu of further proceedings relating to continuing medical education requirements.

**Anderson, Kevin Blake, M.D., Lic. No. M7826, Victoria TX**

On June 4, 2010, the Board and Kevin Blake Anderson, M.D., entered into an Agreed Voluntary Surrender Order, requiring Dr. Anderson to voluntarily and permanently surrender his license in lieu of further disciplinary hearings. The action was based on the Board’s finding that Dr. Anderson failed to use diligence in his professional practice.

**Brown, Thomas Joseph, M.D., Lic. No. J5712, San Antonio TX**

On February 5, 2010, the Board and Dr. Brown entered into an agreed voluntary surrender order whereby Dr. Brown voluntarily and permanently surrendered his Texas medical license due to illness and in lieu of further disciplinary proceedings.

**Burke, Gene, M.D., Lic. No. C5619, Houston TX**

On April 9, 2010, the Board and Gene Burke, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Burke agreed to permanently surrender his Texas medical license due to physical health problems.
DiBona, Daniel J., M.D., Lic. No. H0294, Austin TX
On February 5, 2010, the Board and Dr. DiBona entered into an agreed order of voluntary suspension in lieu of further disciplinary proceedings. The Board’s action was based on Dr. DiBona’s inability to practice medicine with reasonable skill and safety because of numerous medical problems.

Dickson, Teresa May, M.D., Lic. No. H4285, Tyler TX
On February 5, 2010, the Board and Dr. Dickson entered into an agreed voluntary surrender order, whereby Dr. Dickson voluntarily surrendered her license due to a medical condition.

Espiritu, Edgardo T., M.D., Lic. No. E4321, Sugar Land TX
On February 5, 2010, the Board and Edgardo T. Espiritu, M.D., entered into an Agreed Voluntary Surrender Order wherein Dr. Espiritu voluntarily surrendered his license in lieu of further disciplinary proceedings related to issues of overprescribing controlled substances to multiple patients.

Fougerousse, Charles Louis, M.D., Lic. No. F1548, Lufkin TX
On June 4, 2010, the Board and Charles Louis Fougerousse, M.D., entered into an Agreed Order of Voluntary Suspension, suspending Dr. Fougerousse’s medical license in lieu of further disciplinary proceedings. The Board’s action was based on Dr. Fougerousse’s inability to practice medicine with reasonable skill and safety to patients because of illness.

Grant, Howard, M.D., Lic. No. F2265, Houston TX
On June 4, 2010, the Board and Howard Grant, M.D., entered into an Agreed Voluntary Surrender Order in lieu of further disciplinary proceedings, requiring Dr. Grant to immediately cease practice in Texas. The action was based on Dr. Grant’s conviction of health care fraud, a felony, on June 2, 2010.

Harris, Darryl Clarence, M.D., Lic. No. L3676, Los Angeles CA
On June 4, 2010, the Board and Darryl Clarence Harris, M.D., entered into an Agreed Voluntary Surrender order, requiring Dr. Harris to immediately cease practice in Texas, in lieu of further disciplinary proceedings. The Board’s action was based on Dr. Harris’s failure to practice medicine in an acceptable professional manner consistent with public health and welfare.

Hinojosa, Jose Luis, M.D., Lic. No. H0450, Edinburg TX
On February 5, 2010, the Board and Dr. Hinojosa entered into an agreed order of voluntary surrender in which Dr. Hinojosa agreed to voluntarily and permanently surrender his Texas medical license in lieu of further disciplinary proceedings. The action was based on the Board’s finding that Dr. Hinojosa: failed to comply with requirements and guidelines for practicing telemedicine; wrote refill prescriptions for three patients whom he never saw and whose prior prescriptions he never reviewed; did not document any therapeutic evaluation that would establish the basic need for such medication. The patients were located in Florida and the prescriptions were written to be filled in Florida, where Dr. Hinojosa has never been licensed to practice medicine.

Horn, Joseph Jack, M.D., Lic. No. C4371, Plainview TX
On April 9, 2010, the Board and Joseph Jack Horn, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Horn permanently surrendered his Texas license in lieu of further legal proceedings.

Kornell, Bernard D., M.D., Lic. No. F2308, Dallas TX
On June 4, 2010, the Board and Bernard D. Kornell, M.D., entered into an Agreed Voluntary Surrender Order, in which Dr. Kornell voluntarily and permanently surrendered his medical license due to his physical condition, in lieu of further disciplinary proceedings.

Kutz, Susan, M.D., Lic. No. K6634, Midland TX
On February 5, 2010, the Board and Dr. Kutz entered into an agreed order of voluntary surrender in which the Board accepted Dr. Kutz’s voluntary and permanent surrender of her medical license in lieu of further disciplinary proceedings. The action was based on the Board’s finding that Dr. Kutz is unable to practice medicine due to a physical condition.

Lewis, Jeffrey Earl, M.D., Lic. No. F8555, Denton TX
On February 5, 2010, the Board and Dr. Lewis entered into an agreed voluntary surrender order in which Dr. Lewis voluntarily and permanently surrendered his Texas medical license in lieu of further disciplinary proceedings. The action was based on Dr. Lewis having written several prescriptions for controlled substances with expired Drug Enforcement Agency (DEA) and Department of Public Safety (DPS) registrations.

McNeel, Day Pattison, Jr., M.D., Lic. No. D0969, Canyon Lake TX
On June 4, 2010, the Board and Day Pattison McNeel, Jr., M.D., entered into an Agreed Voluntary Surrender Order, in lieu of further disciplinary proceedings, requiring Dr. McNeel to immediately cease practice in Texas. The voluntary surrender is permanent. The basis for action was the Board’s finding that Dr. McNeel prescribed controlled substances from Dec. 10,
2008, through July 6, 2009, even though his authority to prescribe such substances expired in 1998 and was subsequently cancelled by the Texas Department of Public Safety.


On June 4, 2010, the Board and Leonard Gaylon Nepper, D.O., entered into an Agreed Voluntary Surrender Order in which Dr. Nepper voluntarily and permanently surrendered his license due to his physical condition, in lieu of further disciplinary proceedings.

**Sargent, Michael Geoffrey, M.D., Lic. No. F7910, Katy TX**

On June 4, 2010, the Board and Michael Geoffrey Sargent, M.D., entered into an Agreed Order in which Dr. Sargent voluntarily and permanently surrendered his medical license due to his non-therapeutic prescribing of controlled substances. The Board's basis for action was Dr. Sargent's failure to practice medicine in an acceptable, professional manner and failure to use diligence in his practice.

**Sharma, Arun, M.D., Lic. No. J1390, Webster TX**

On June 4, 2010, the Board and Arun Sharma, M.D., entered into an Agreed Voluntary Surrender Order in lieu of further disciplinary proceedings, authorizing the Board to accept the voluntary surrender of Dr. Sharma's medical license and requiring Dr. Sharma to immediately cease practice in Texas. The Board's action was based on Dr. Sharma's conviction of conspiracy to commit health care fraud.

**Sharma, Kiran, M.D., Lic. No. J6240, Baytown TX**

On June 4, 2010, the Board and Kiran Sharma, M.D., entered into an Agreed Voluntary Surrender Order in lieu of further disciplinary proceedings, authorizing the Board to accept the voluntary surrender of Dr. Sharma's medical license and requiring Dr. Sharma to immediately cease practice in Texas. The Board's action was based on Dr. Sharma's conviction of conspiracy to commit health care fraud.

**Shear, Jeffrey M., M.D., Lic. No. G2224, Cupecoy, St. Maarten, N.A.**

On June 4, 2010, the Board and Jeffrey M. Shear, M.D., entered into an order in which Dr. Shear voluntarily and permanently surrendered his license due to a physical condition.

**Wofford, Gary Gene, M.D., Lic. No. G9014, Pueblo CO**

On June 4, 2010, the Board and Gary Gene Wofford, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Wofford permanently surrendered his medical license in lieu of further disciplinary proceedings before the Board. The Board's action was based on Dr. Wofford's voluntary relinquishment of his Colorado medical license for failure to comply with a Colorado State Board of Medical Examiners order.

**REVOCATIONS/SUSPENSIONS**

**Clardy, Christina, M.D., Lic. No. G2929, Houston TX**

On June 4, 2010, the Board and Christina Clardy, M.D., entered into an Agreed Order of Suspension, immediately suspending her medical license until Dr. Clardy requests in writing to have the suspension stayed or lifted and personally appears before the Board and provides convincing evidence that she is physically, mentally and otherwise competent to practice medicine. Such evidence must include complete and final resolution of any criminal charges and investigations that are currently pending. The basis for action was the Board's finding that Dr. Clardy engaged in unprofessional or dishonorable conduct following her arrest in Harris County on charges of engaging in organized crime. The charges arose out of Dr. Clardy's medical practice, identified as a “pill mill” due to non-therapeutic prescribing of controlled substances.

**Few, Jennifer Joanne, M.D., PIT No. BP10023537, Pearland TX**

On June 4, 2010, the Board entered a Default Order against Jennifer Joanne Few, M.D., which revoked her Physician-In-Training (PIT) No. BP10023537, that was effective until December 1, 2008. This follows an August 28, 2009, filing by the Board of a Complaint with the State Office of Administrative Hearings (SOAH) in case no. 503-09-6284, which alleged that Dr. Few provided false information to the Board, and failed to comply with Board directives. Further, it alleged that Dr. Few’s medical judgment and ability to practice under the PIT permit were impaired. Previously, she reported she suffered from Hodgkin’s lymphoma which was a false statement. Later, however, Dr. Few was diagnosed with major depressive disorder and Munchausen’s Syndrome. After making one response to the Board denying she had any condition-related practice impairment, Dr. Few failed to respond to any subsequent Board requests for information. The Board then filed the SOAH Complaint to seek revocation of her still-active PIT. After filing the SOAH Complaint, all notices were perfected and the Board issued a Determination of Default, and all other required deadlines passed without any response from Dr. Few and/or her attorney of record. As a result, all facts alleged in the Complaint were therefore deemed admitted, and Dr. Few’s PIT was revoked by Default Order.
Lengyel, Mircea Iaon, M.D., Lic. No. D2805, Houston TX

On February 5, 2010, the Board entered a final order against Dr. Lengyel, as issued by the State Office of Administrative Hearings in Docket No. 503-09-3769, revoking his medical license. The Order was based on Dr. Lengyel’s failure to maintain adequate medical records; failure to treat a patient according to the standard of care; prescribing dangerous drugs without establishing a proper physician-patient relationship; unprofessional and dishonorable conduct; prescribing dangerous drugs to a known abuser of narcotics; and nontherapeutic prescribing.

Luczkow, Daniel, M.D., Lic. No. K0911, West Barnstable, MA

On June 4, 2010, the Board and Daniel Luczkow, M.D., entered into an Agreed Revocation Order requiring Dr. Luczkow to immediately cease the practice of medicine in Texas. The Board’s action was based on Dr. Luczkow’s 2008 conviction for filing a false federal tax return.

Massey, Charles R. Jr., M.D., Lic. No. G5341, Fredericksburg TX

On November 6, 2009, the Board entered a final order revoking Dr. Massey’s Texas medical license. The Board adopted the findings of an administrative law judge of the State Office of Administrative Hearings in Docket No. 503-09-0554, regarding Dr. Massey’s failure to comply with board subpoenas and requests for records and his refusal to recognize the board’s authority to regulate his practice of medicine.


On April 9, 2010, the Board and William Robert Olmsted, M.D., entered into an Agreed Order of Revocation, terminating his Texas medical license. Dr. Olmsted is not licensed in any other state. The Order was based on Dr. Olmsted’s failure to comply with a 2009 Agreed Order.

AUTOMATIC REVOCATION AND SUSPENSION ORDERS

King, Clarence Gordon, Jr., M.D., Lic. No. E1883, San Antonio TX

On January 7, 2010, the Board entered an automatic revocation order for an indefinite period against Dr. King for a violation of a seven-year 2003 agreed order with terms and conditions related to substance abuse. The 2003 order required, among other things, that Dr. King abstain from the use of prohibited substances and undergo alcohol and drug screens. The 2003 order contained a provision allowing for an automatic revocation of Dr. King’s license for a positive alcohol or drug screen. Due to low-level positive screens in 2004 and 2006, the Board twice-modified Dr. King’s 2003 order by extending it each time by three years, resulting in a new termination date in 2015, but the Board did not exercise the auto-revocation provision due to mitigating circumstances. In May 2009, Dr. King again tested positive for a metabolite of ethanol consumption, and the Board exercised its authority under the 2003 order, as modified, to automatically revoke Dr. King’s license.

Marks, Timothy N., M.D., Lic. No. J3719, Dallas, TX

On January 8, 2010, the Board entered an automatic order of suspension for an indefinite period against Dr. Marks and it will remain in effect until superseded by a subsequent order of the Board. Authorized by a statutory mandate, the 2010 order was issued as the result of Dr. Marks’ incarceration in federal prison following his 2009 conviction in United States District Court for failing to file a tax return for three years.

McNeill, Scott Shaw, M.D., Lic. No. K7058, San Antonio TX

On January 15, 2010, the Board entered an automatic revocation order for an indefinite period against Dr. McNeill for violations of a 2004 10-year agreed order. The 2004 order required, among other terms and provisions, that Dr. McNeill submit to random alcohol and drug screenings to ensure abstinence from alcohol and/or other prohibited substances. The 2004 order also provided that any violation of that provision by having a positive drug screen could result in the automatic revocation of Dr. McNeill’s license. In addition to having other documented compliance violations, the immediate revocation of Dr. McNeill’s license was based on his violation of the 2004 order by testing positive for alcohol on a drug and alcohol screen performed in March 2009.

Waller, Stephen Frank, M.D., Lic. No. F8724, Conroe TX

On May 12, 2010, the Board entered an Automatic Suspension Order for an indefinite period against Stephen Frank Waller, M.D., and it will remain in effect until such time as Dr. Waller provides evidence that shows he is in compliance with the terms and conditions of his February 2009 Agreed Order. The 2009 Order required Dr. Waller to obtain 20 hours of CME, as well as successfully pass the Medical Jurisprudence Exam (JP Exam), all to be completed within one year.

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of the 2009 Order’s effective date. The 2009 Order also contained a provision that failure to complete the JP Exam could subject Dr. Waller to an automatic suspension of his medical practice license. Dr. Waller made no attempt to comply with either requirement of the 2009 Order, and at a hearing on the non-compliance, he offered no reasonable excuses for consideration. Accordingly, acting under the terms in 2009 Order, the Board automatically suspended Dr. Waller’s license.

FAILURE TO PROPERLY SUPERVISE OR DELEGATE

Kelly, Patrick F., DO, Lic. No. K5127, Woodward OK
On June 4, 2010, the Board and Patrick Kelly, DO, entered into an Agreed Order requiring Dr. Kelly to pay an administrative penalty of $2,000 within 60 days. The Board’s action was based on Dr. Kelly’s unprofessional conduct in his failure to respond in a timely manner to communications from a patient and failure to supervise adequately those acting under Dr. Kelly’s supervision.

Rivera, Rudolfo L., MD, Lic. No. E6894, Dallas TX
On November 6, 2009, the Board entered a final order requiring that within one year Dr. Rivera take and pass the Special Purpose Examination (SPEX); that within 180 days he complete 10 hours of CME in ethics/risk management, including at least two hours on the physician-patient relationship, and 10 hours in medical recordkeeping, and that he properly supervise those under his supervision and personally examine and/or treat patients. The Board adopted the findings of an administrative law judge of the State Office of Administrative Hearings regarding Dr. Rivera’s failure to properly delegate and supervise a pharmacist who provided drug therapy to a patient. Dr. Rivera filed a motion for rehearing within 20 days of the order. If 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.

Sheikh, Mansoora A., MD, Lic. No. M2097, Houston TX
On April 9, 2010, the Board and Mansoora A. Sheikh, MD, entered into an Agreed Order requiring Dr. Sheikh to complete the Knowledge, Skills, Training, Assessment, and Research (KSTAR) program at Texas A&M within one year; complete 10 hours of CME in medical record-keeping and 10 hours in managing medical emergencies within one year. The basis for action was Dr. Sheikh’s failure to adequately supervise an advanced practice nurse in the care of a patient with a ruptured appendix.

Watson, Stephen Wayne, MD, Lic. No. G6115, Plano TX
On April 9, 2010, the Board and Stephen Wayne Watson, MD, entered into an Agreed Order requiring Dr. Watson to complete within one year eight hours of CME in risk management; and pay an administrative penalty of $500 within 60 days. The basis for action was the Board’s finding that Dr. Watson violated the Board’s advertising rules, and failed to properly supervise nurses administering “Lipo Dissolve” treatments at his office.

VIOLATION OF PROBATION OR PRIOR ORDER

Armstrong, Davill, MD, Lic. No. F3025, Houston TX
On June 4, 2010, the Board and Davill Armstrong, MD, entered into a Mediated Agreed Order publicly reprimanding Dr. Armstrong, restricting him from supervising or delegating prescriptive authority to physician extenders, and requiring him to pay an administrative penalty of $4,000 within 30 days and pass the Medical Jurisprudence Examination within three attempts, within one year; schedule a professional assessment of his practice with the Texas A&M Health Science Center Rural and Community Health Institute; complete within one year complete 10 hours of CME in ethics and 10 hours in risk management. The Board’s action was based on Dr. Armstrong’s violation of a 2006 Order suspending his license, aiding and abetting the practice of medicine by a person not licensed to practice medicine and dishonorable conduct likely to defraud or injure the public. The Board found that Dr. Armstrong signed federal forms so two patients could receive Medicare, even though he was excluded from such activities due to his suspended license.

Fraser, Ronald Leo, MD, Lic. No. E7929, Houston TX
On February 22, 2010, the Board and Ronald Leo Fraser, MD, entered into an agreed order modifying a prior order that requires Dr. Fraser to pass within six months the Texas Medical Jurisprudence Examination, within two attempts. Failure to do so will result in the immediate suspension of Dr. Fraser’s medical license.

On June 4, 2010, the Board and Teresa Trumble Guerrero, MD, entered into an Agreed Order requiring her
to enter into an agreement within 60 days with First Advantage, a substance abuse monitoring program, to cover her costs associated with screenings for drugs and alcohol. The Board’s action was based on Dr. Guerrero’s violation of a 2008 Order requiring her to stay current on her balance.

**Kornell, Bernard D., M.D., Lic. No. F2308, Dallas TX**

On April 9, 2010, the Board and Bernard D. Kornell, M.D., entered into an Agreed Order Modifying a Prior Order, modifying a 2009 Order that was based upon Dr. Kornell’s unprofessional conduct. The new Order gives Dr. Kornell an additional year to complete the SPEX and JP exams and allows for no further time extensions. In addition, the Order institutes a practice restriction that restricts Dr. Kornell from having any physical contact with any patient in any venue, including any research area where he may practice.

**McCall, Norman Joel, M.D., Lic. No. E6137, Southlake TX**

On April 9, 2010, the Board and Norman Joel McCall, M.D., entered into an Agreed Order Modifying a Prior Order that extends Dr. McCall’s five-year probation set forth in a 2009 Order for an additional five years, and requires Dr. McCall to pay an administrative penalty of $2,000 within 90 days. The action was based on Dr. McCall’s failure to comply with the 2009 order: specifically, his arrest for calling in false prescriptions for controlled substances; failure to submit letters from psychiatrists proposing to treat him; and diverting prescriptions written for family members to himself.

**Sandbach, Emily Jane, M.D., Lic. No. M0555, Austin TX**

On February 5, 2010, the Board and Dr. Sandbach entered into an agreed order modifying a previous confidential rehabilitation order publicly reprimanding Dr. Sandbach, requiring her to pay an administrative penalty of $1,000 within 90 days, and requiring that she file missing psychiatric reports. The Board’s action was based on Dr. Sandbach’s noncompliance with a 2004 confidential order.

**Smith, Michael Dean, M.D., Lic. No. F4545, Houston TX**

On February 5, 2010, the Board and Dr. Smith entered into an agreed order modifying a prior order that states that any violation of Dr. Smith’s 15-year 2008 order will result in immediate suspension of his license without a formal hearing, and that requires Dr. Smith to pay an administrative penalty of $2,000 within 60 days. The Board’s action was based on Dr. Smith’s use of an alcohol-based hand sanitizer and failure to timely report to the Board taking Fioricet to treat a migraine, both violations of the 2008 order.

**Weldon, Bill E., D.O., Lic. No. F4669, Fort Worth TX**

On April 9, 2010, the Board and Bill E. Weldon, D.O., entered into a Mediated Agreed Order placing Dr. Weldon under the following terms and conditions for five years. Dr. Weldon must comply with all recommendations of his chart monitors and pay all outstanding chart monitor bills; have a physician monitor his practice related to chronic pain patients; contact within 30 days a practice evaluation program such as Texas A&M’s KSTAR program; and complete 10 hours of CME in medical record-keeping and 10 hours in prescribing for pain management. The basis for action was Dr. Weldon’s failure to pay chart monitoring fees and complete CME as required by a 2005 Board Order.

**ORDER MODIFYING A PRIOR ORDER**

**Anderson, Eli T., M.D., Lic. No. E6214, Houston TX**

On April 9, 2010, the Board and Eli T. Anderson, M.D., entered into an Agreed Order lifting Dr. Anderson’s Temporary Suspension and placing him on probation for 10 years. The order requires Dr. Anderson to limit his practice to an approved group or institutional setting; abstain from the consumption of prohibited substances; participate in the Board’s drug testing program; continue participating in Alcoholics Anonymous; submit to the Board the names of board-certified psychiatrists who agreed to treat Dr. Anderson; and refrain from treating his immediate family. The basis for action was Dr. Anderson’s compliance with a previous Board Order related to Dr. Anderson’s substance abuse.

**Lee, Sung, M.D., Lic. No. E6473, Sugar Land TX**

On April 9, 2010, the Board and Sung Lee, M.D., entered into an Agreed Order Modifying a Prior Order that requires Dr. Lee to complete 14.5 hours of CME in medical record-keeping, most of it completed by “in person” attendance, no later than July 1, 2010. All other terms and conditions of the 2007 Order remain in effect.

**Nakissa, Nasser, M.D., Lic. No. G6355, San Antonio TX**

On June 4, 2010, the Board and Nasser Nakissa, M.D., entered into an Agreed Order modifying his September 12, 2005 Agreed Order to require Dr. Nakissa to have a chart monitor for two additional monitoring cycles and that he fully implement all recommendations made in a chart monitor report in October 2009. In addition, Dr. Nakissa is prohibited from requesting a modification or termination of the 2005 Order as

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modified until both of the additional monitor cycles are completed and the Board has received the monitor reports for each cycle. The action was based on Dr. Nakissa’s compliance with all aspects of the 2005 Order except for implementing the chart monitor’s recommendations.

**Ward, Phillip Andrew, D.O., Lic. No. L6710, Anahuac TX**

On February 5, 2010, the Board and Dr. Ward entered into an agreed order modifying a prior order placing him under certain restrictions, including having his practice monitored for two years. In addition, Dr. Ward must complete 40 hours of CME in office-based procedures and medical record-keeping within two years. The order modifies a February 2009 order based on the Board’s finding that Dr. Ward failed to meet the standard of care in his improper treatment of an injury and failure to release medical records for a patient.

**IMPAIRMENT DUE TO ALCOHOL OR DRUGS**


On February 5, 2010, the Board and Dr. Havard entered into an agreed order of suspension until Dr. Havard is able to provide clear and convincing evidence that he is physically and mentally competent to safely practice medicine via the Board’s drug screening program and psychological and neuropsychiatric evaluations. During the suspension, Dr. Havard must abstain from the consumption of prohibited substances and be monitored by a psychiatrist. That Board’s action was based on Dr. Havard’s writing false prescriptions for dangerous drugs, and his inability to practice medicine with reasonable safety due to excessive use of drugs.

**FAILURE TO PROVIDE MEDICAL RECORDS**


On February 5, 2010, the Board and Dr. Kadri entered into an agreed order requiring Dr. Kadri to complete within one year eight hours of CME in office management, and pay an administrative penalty of $1,000 within 90 days. The Board’s action was based on Dr. Kadri’s interfering with a departing physician from posting notice and the sign required for patient notification, and withholding information from a departing physician that is necessary for notification of patients.

**PEER REVIEW ACTIONS**

**Patman, Ralph Donald, M.D., Lic. No. C7186, Dallas TX**

On June 4, 2010, the Board and Ralph Donald Patman, M.D., entered into an Agreed Order requiring Dr. Patman to complete within one year four hours of CME in ethics and pay an administrative penalty of $500 within 90 days. The basis for action was the formal censure of Dr. Patman by the American College of Surgeons for giving expert medical testimony that was judged by the ACS to have violated its bylaws.

**Trostel, Robert Rhoads, M.D., Lic. No. D0325, Garland TX**

On June 4, 2010, the Board and Robert Rhoads Trostel, M.D., entered into an Agreed Order restricting Dr. Trostel to a non-clinical setting and requiring him to pay an administrative penalty of $1,000 within 60 days. The Board’s action was based on disciplinary action taken by Dr. Trostel’s peers, mitigated by the fact Dr. Trostel is no longer practicing.

**ACTION BY ANOTHER STATE OR ENTITY**

**Carstens, George John, III, M.D., Lic. No. H0238, Tulsa OK**

On February 5, 2010, the Board and Dr. Carstens entered into an agreed order requiring Dr. Carstens to pay an administrative penalty of $2,000 within 90 days and comply with all requirements of a 2007 Oklahoma State Board of Medical Licensure and Supervision Order. The Texas Medical Board’s action was based on disciplinary action taken by Dr. Carstens’ peers. Dr. Carstens is currently in full compliance with the Oklahoma Order which requires that: he not treat or prescribe any medication to himself or his family members; any hospital where he works at to send monitoring reports to the Oklahoma Board; and that he undergo polygraph testing every six months.

**Edwards, Michael Charles, M.D., Lic. No. L2873, Thousand Oaks CA**

On February 5, 2010, the Board and Dr. Edwards entered into an agreed order subjecting Dr. Edwards to the following terms and conditions for 10 years: abstain from consumption of prohibited substances; submit to screenings for alcohol and drugs; submit to a psychological/psychiatric examination and comply with any treatment recommendations; limit his practice to a group or institutional setting; not supervise or delegate prescriptive authority to physician extenders for the first six months of this order; not treat or prescribe controlled substances for his immediate family; not dispense or prescribe any drugs with addictive potential except as is medically necessary for plastic surgery procedures; and attend Alcoholics Anonymous meetings five times a week. The Board’s action
was based on Dr. Edwards’ abuse of dangerous drugs, unprofessional conduct and disciplinary action taken by the Medical Board of California.

**Gapin, Tracy, M.D., Lic. No. N1323, Sarasota FL**

On February 5, 2010, the Board and Dr. Gapin entered into an agreed order requiring Dr. Gapin, who is also licensed in Florida, to submit all relevant information regarding disciplinary action against him by the Florida Board of Medicine within 10 days, and comply fully with the Florida Board’s Order. The Florida Order requires Dr. Gapin to pay a fine; perform 50 hours of community service; take five hours of CME in risk management; and provide a one-hour lecture on wrong-site surgeries.

**Greenwood, Denise R., M.D., Lic. No. J7977, Little Rock AR**

On November 6, 2009, the Board entered a Final Order revoking Dr. Greenwood’s Texas medical license, staying the revocation conditional on Dr. Greenwood’s compliance with 2006 and 2007 orders of the Arkansas Medical Board and requiring that Dr. Greenwood appear before the board and provide evidence to indicate she is competent to safely practice before returning to Texas to practice. The Board adopted the findings of an administrative law judge of the State Office of Administrative Hearings regarding Dr. Greenwood’s failure to comply with board subpoenas and requests for records and disciplinary action taken by the Arkansas and North Carolina medical boards.

**Murray, Conrad, M.D., Lic. No. M0502, Houston TX**

On April 9, 2010, the Board and Conrad Murray, M.D., entered into an Agreed Order of Restriction that prohibits Dr. Murray from using or administering any anesthetic agent that is normally administered by an anesthesiologist, including Propofol or any other heavy sedatives; or prescribing or administering any form of general sedation to a patient. Dr. Murray is prohibited from supervising or delegating prescriptive authority to physician assistants and other physician extenders. The agreed order does not prohibit Dr. Murray from prescribing or utilizing other medications, including pain medication, anti-anxiety medication or local or topical anesthetics. In addition, Dr. Murray is allowed to be part of a medical team providing Propofol or other heavy or general anesthetic as long as Dr. Murray does not personally administer or prescribe them. The action is based on the board’s finding that Dr. Murray is subject to criminal charges in California related to possible non-therapeutic prescribing that resulted in the death of a patient. Dr. Murray had his medical license temporarily restricted in California as a condition of bond. The license restrictions remain in effect until the criminal allegations in California are resolved and the board has adequate evidence to show that Dr. Murray is competent to safely practice medicine.

**Nguyen, Manh hai Hoang, M.D., Lic. No. M7474, Sugar Land TX**

On April 9, 2010, the Board and Manh hai Hoang Nguyen, M.D., entered into an Agreed Order publicly reprimanding Dr. Nguyen and requiring him to complete eight hours of CME in ethics and pay an administrative penalty of $1,000 within 60 days. The Board’s action was based on Dr. Nguyen’s termination from a residency program in Dallas, due to his attempted fraud with a co-worker to recover insurance proceeds from a lost cell phone.

**CRIMINAL CONVICTION**

**Bartschi, Carlin Grant, M.D., Lic. No. J0916, Gilbert AZ**

On June 4, 2010, the Board entered a Final Order regarding Carlin Grant Bartschi, M.D., revoking Dr. Bartschi’s medical practice license. The 2010 Order results from the State Office of Administrative Hearings (SOAH) docket no. 503-10-2510 findings of fact and conclusions of law wherein the SOAH court granted the Board’s Motion for Summary Disposition, finding that the Board was entitled to the decision as a matter of law. The Board’s action was based on evidence showing that Dr. Bartschi is incarcerated at a United States Penitentiary in Tuscon, Arizona, following his conviction in October 2008 on several felony counts that included: Evasion of Assessment; Evasion of Payment; Submission of Fictitious Obligations, and Mail Fraud. The Board asserted that it was required by statute to revoke a licensee’s license if the licensee was incarcerated in prison. The SOAH court considered the evidence submitted by the Board and agreed.

**Crain, Daniel A., D.O., Lic. No. J4063, Mexia TX**

On June 4, 2010, the Board and Daniel A. Crain, D.O., entered into an Agreed Order requiring Dr. Crain to pass within one year the Medical Jurisprudence Examination within three attempts; complete within one year five hours of CME in ethics and five hours in risk management; pay an administrative penalty of $1,500 within 90 days; obtain copies of medical records requested by two patients and write letters of apology to these patients within 45 days; place advertisements within 15 days in the highest circulation newspapers in Beaumont, Port Arthur and Orange to notify patients

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where they can contact him to obtain copies of their medical records. The action was based on Dr. Crain's being placed on deferred adjudication due to a Class A misdemeanor assault; failure to notify patients of termination of his practice; failure to release patient records; failure to comply with a Board subpoena or request for information; and failure to update his practice and/or mailing address to the Board within 30 days of the change.

**Mallou, Fernando, M.D., Lic. No. D1711, Rockwall TX**

On April 9, 2010, the Board entered a Voluntary Revocation Order to avoid further investigation, hearings and litigation. The action was based on Dr. Mallou's medical practice license for an indefinite period. The action was based on a Proposal for Decision (PFD) that issued following the Board's filing of a complaint, and subsequent motion for summary disposition, at the State Office of Administrative Hearings (SOAH) in docket no. 503-09-4217. The Board brought this action as the result of Dr. Mallou being convicted by a Dallas County jury in cause no. F-07-71821 for the second-degree felony offense of sexual assault, and his placement on 10 years probation. On the basis of the Board's showing that this initial felony conviction was a fact of record, the SOAH court granted the board's motion for summary disposition and issued the PFD, allowing for this final order. Dr. Mallou 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.

**CEASE AND DESIST**

**Mayer, Roxana Mercedes, (no license) Houston, TX**

On April 9, 2010, the Board and Roxana Mercedes Mayer, who does not hold a current license to practice medicine in the State of Texas, entered into an Agreed Cease and Desist Order. The Order was based on Ms. Mayer having engaged in the unlicensed practice of medicine, or having engaged in representing herself as a doctor or physician, in Houston, Harris County, Texas, by: holding herself out as a physician in a public place; introducing herself at a public forum on health care reform as a “general practitioner” who has practiced for “four years”; and in the guise of a physician, publicly presenting opinions on health care reform that were intended to be viewed as issuing from one segment of the profession, primary care physicians. Though Ms. Mayer specifically denied she engaged in the unlicensed practice of medicine, the Order requires her to immediately halt all such activity.

**Osborn, Charles Ray, M.D., D.C., (no license) Waxahachie TX**

On February 5, 2010, the Board and Dr. Osborn, who does not hold a current license to practice medicine in the State of Texas, entered into an Agreed Cease and Desist order. The order was based on Dr. Osborn's unlicensed practice of medicine in Ellis County, Texas, by: seeing and treating patients though the use of alternative medicine; offering alternative medicine consultations; and by using the “M.D.” designation after his name in association with the offer of alternative medicine consultations and treatment, all of which is denied by Dr. Osborn. The order requires Dr. Osborn to immediately halt all such activity.

**Webster, Bennie, Ph.D., (no license) Tyler, TX**

On April 9, 2010, the Board and Bennie Webster, Ph.D., who does not hold a current license to practice medicine in the State of Texas, entered into an Agreed Cease and Desist Order. The Order was based on Dr. Webster having engaged in the unlicensed practice of medicine, or having engaged in representing herself as a doctor or physician, in Tyler, Smith County, Texas, at the Community Health Clinic of Northeast Texas, by: representing that she was a doctor in a medical clinic; constructively practicing medicine by directing one or more physicians as to how and when to practice medicine; ordering the dispensation of narcotics from the clinic pharmacy to clinic patients; ordering clinic staff to write prescriptions for clinic patients; and referring to herself in the presence of one or more patients as “Dr. Bennie Webster,” resulting in one or more patients believing her to be a medical doctor, all of which has been denied by Dr. Webster. The order requires Dr. Webster to immediately halt all such activity.

**PHYSICIAN ASSISTANTS**

**Drees, James Dennis, P.A., Lic. No. PA00935, Marlin TX**

On December 4, 2009, the Texas Physician Assistant Board and James Dennis Drees entered into an agreed order requiring Mr. Drees to complete within one year a 20-hour professional boundaries course such as that offered by the University of California San Diego Phy-
sician Assessment and Clinical Education program and pay an administrative penalty of $1,000 within 90 days. The action was based on the board’s finding that Mr. Drees acted in an unprofessional manner, engaging in sexual contact with a patient, and was asked to resign his position at the hospital where he worked.

**Garza, Melissa, P.A.C., Lic. No. PA04048, Carrollton TX**

On December 4, 2009, the Texas Physician Assistant Board and Melissa Garza, P.A.C., entered into an agreed order requiring Ms. Garza to complete eight hours of CME in risk management and eight hours of CME in patient communication within one year. The board found that Ms. Garza failed to use proper diligence in her treatment of a patient on Coumadin therapy.

**Mazuca, Maricela Azeneth, P.A., Lic. No. PA03610, San Antonio TX**

On December 4, 2009, the Texas Physician Assistant Board and Maricela Azeneth Mazuca, P.A., entered into an agreed order requiring Ms. Mazuca to complete eight hours of CME in medical record-keeping and eight hours in endocrinology related to hypo/hyperthyroidism within one year; pass the Texas Jurisprudence Examination within one year. The action was based on the board’s finding that Ms. Mazuca’s treatment of five weight-management patients failed to meet the standard of care.

**Neill, John Andrew, P.A.-C, Lic. No. PA02472, Lytle TX**

On February 26, 2010, the Texas Physician Assistant Board and John Andrew Neill, P.A.-C, entered into an agreed order requiring Mr. Neill to pass within one year the Texas Physician Assistant Jurisprudence Examination, within three attempts; complete within one year 23 hours of CME in ethics, chronic pain management, risk management and medical record-keeping; and pay an administrative penalty of $1,000 within 60 days. The action was based on the board’s finding that Mr. Neill failed to practice in a manner consistent with public health and welfare, was subject to disciplinary action by his peers and maintained inadequate medical records.

**Stocks, Robert Dennis, P.A., Lic. No. PA01857, Houston TX**

On December 9, 2009, the Texas Physician Assistant Board and Robert Dennis Stocks, P.S., entered into an agreed order requiring Mr. Stocks to complete six hours of CME in medical record-keeping or risk management within one year; complete six hours of CME in endocrinology with an emphasis on hypo/hyperthyroidism within one year; and pass the Texas Physician Assistant Jurisprudence Exam within three attempts within one year. The action was based on the Board’s finding that Mr. Stocks failed to practice in a manner consistent with public health and welfare, prescribing non-therapeutically.

**SURGICAL ASSISTANTS**

**Coffey, Dorsey Shantel, S.A., Lic. No. SA0060, Austin TX**

On February 5, 2010, the Board and Dorsey Shantel Coffey, S.A., entered into a five-year agreed order of public reprimand requiring Ms. Coffey to abstain from the consumption of prohibited substances, except as prescribed by another physician for legitimate therapeutic purposes; participate in the Board’s drug testing program; attend Alcoholics Anonymous meetings three times a week; and submit to a psychiatric examination and comply with recommended treatment. The Board’s action was based on Ms. Coffey’s habitual use of drugs to the extent that she could not safely perform as a surgical assistant.

**Flores, David, S.A., Lic. No. SA-0069, Houston TX**

On April 1, 2010, the Board entered an Order of Automatic Suspension for an indefinite period against David Flores, S.A., and it will remain in effect until such time as Mr. Flores provides evidence and information that satisfies the Board that he is eligible to have his license reinstated. Authorized by a statutory mandate, the 2010 Order was issued as the result of Mr. Flores’ being convicted, and subsequently sentenced in September 2009 in Harris County, Texas, to 15 years in state prison for the felony offense of aggravated sexual assault of a child under 14 years of age. Mr. Flores is currently incarcerated and may not submit evidence to the Board until he has been released from prison.

**ACUPUNCTURISTS**

**Butler, Christopher Cook, L.Ac., Lic. No. AC00222, Austin TX**

On May 18, 2010, the Texas State Board of Acupuncture Examiners entered a Final Order against Christopher Cook Butler, requiring him to pay an administrative penalty of $250 within 30 days. The basis for action was the finding of the State Office of Administrative Hearings that in 2005 Mr. Butler failed to identify himself as an acupuncturist immediately after his name on a fax sent to the school nurse of a patient, and held himself out as a physician or surgeon.
by using the title of “Dr.” As a mitigating factor, the Board considered that the fax did include information that Mr. Butler was an acupuncturist, although the information was not in the proper form required.

**Liu, H.L. Helen, L.Ac., Lic. No. AC00259, Austin TX**

On May 14, 2010, the Texas State Board of Acupuncture Examiners and H.L. Helen Liu, L.Ac., entered into an Agreed Order of Voluntary Suspension suspending Ms. Liu’s license until such time as Ms. Liu requests to have the suspension lifted and provides clear evidence that she is able to safely practice acupuncture. The action was based on the Board’s finding that Ms. Liu cannot practice acupuncture with reasonable skill and safety due to illness.

**RULES VIOLATION**

**Schell, Michael Todd, M.D., PIT Permit No. BP10025584, Houston TX**

On June 4, 2010, the Board and Michael Todd Schell, M.D., entered into an Agreed Order requiring Dr. Schell to pass within one year the Medical Jurisprudence Examination given by the Texas Medical Board within three attempts; and pay an administrative penalty of $500 within 90 days. The Board’s action was based on Dr. Schell’s violation of Board rules requiring physicians to notify the Board in writing of changes in mailing and practice addresses.

**CORRECTIVE ORDERS**

Corrective orders are for violations that do not rise to the level of warranting a restriction on a physician’s license but may include requirements such as administrative penalties, continuing medical education or chart monitoring. Since the Fall 2009 issue of the Medical Board Bulletin, the Board has issued corrective orders to the 11 physicians listed below.

- Bhai, Aziz W., M.D., Lic. No. K8008
- Braden, Stephen Anthony, M.D., Lic. No. F3773
- Ha, Chen, M.D., Lic. No. M0099
- Haider, Munawar, M.D., Lic. No. L3325
- Hine, Peter William, M.D., Lic. No. H9995
- Kowalczyk, Teresa Danuta, M.D., Lic. No. K4932
- Lopez, Ramona Griffith, M.D., Lic. No. H4500
- Malik, Nadia, M.D., Lic. No. M9478
- Rodriguez, Raul Pedro, M.D., Lic. No. G5549
- Rosenthal, Jon Evan, M.D., Lic. No. M4489
- Thach, Thao Thanh, M.D., Lic. No. L6667

**ADMINISTRATIVE ORDERS**

Since the Fall 2009 issue of the Medical Board Bulletin, 71 licensees have agreed to enter into administrative “fast-track” orders with the Board for minimal statutory violations.