

Dr. Kirksey's Exemplary Tenure Ends

Dr. Oswalt Appointed to Board

Governor Rick Perry has appointed Charles E. Oswalt, M.D., F.A.C.S., to the Board.

Dr. Oswalt graduated from Texas Christian University *magna cum laude*. He received his medical degree from the University of Texas Medical Branch in Galveston, also *cum laude*. He was elected to Alpha Omega Alpha Honor Medical Society his senior year in medical school. After an internship at Denver General Hospital, he served two years in the U.S. Army, including a tour in Vietnam.



Dr. Oswalt

Dr. Oswalt received his surgical training at the U.T. Health Science Center in San Antonio. He practiced general surgery in Fort Worth and Graham, and is now a trauma and general surgeon at Hillcrest Baptist Hospital in Waco. He is certified by the American Board of Surgery and is a Fellow of the American College of Surgeons. He is a member of the Texas Medical Association, the Texas Surgical Society and the McLennan County Medical Society.

Dr. Oswalt has volunteered with the American Cancer Society for many years, serving as national delegate and president of the Texas division for two terms. He has been a reviewer for the Texas Medical Foundation for more than 20 years and has published 16 pieces in the medical literature.

Dr. Oswalt's appointment fills a vacancy left by the resignation of

Thomas D. Kirksey, M.D., who has served on the Board since 1995. During his tenure on the Board, Dr.

Kirksey served in many capacities, including Chairman of the Licensure Committee and Disciplinary Process Review Committee and as a member of the Finance, Telemedicine, Legislative, Executive, Surgical Assistants and Executive Search Committees. He also served as president of the Federation of State Medical Boards in 2003.



Drs. Kirksey and Kalafut

Executive Director Donald W. Patrick, M.D., J.D., said of Dr. Kirksey's departure: "Dr. Kirksey brought the whole package to this position at TMB: he is a global thinker but careful about details; he has charm but can be firm when indicated; he has a vast array of experience and tradition to draw upon, but is open to new ideas. In essence, his service on this board has been not just distinguished, but exceptional."

At the April 6-7 Board meeting, Board President Roberta Kalafut, D.O., presented Dr. Kirksey with a plaque and offered the Board's gratitude for Dr. Kirksey's long years of service. ♦

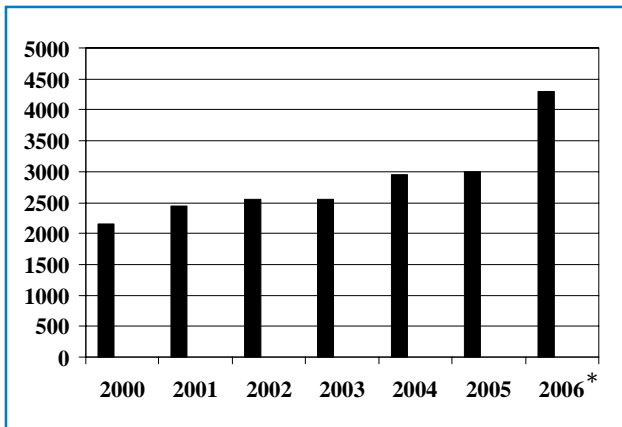
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FROM THE EXECUTIVE DIRECTOR

by Donald W. Patrick, M.D., J.D.

Texas is experiencing an unparalleled growth in licensure applications from physicians seeking to practice in Texas. During the first half of this fiscal year, there was an 88 per cent increase over the same period of fiscal year 2003. While there was mostly steady growth between 2000 and 2005, projections for 2006 are dramatically higher as evidenced by the chart.



* Projected

We have considered a variety of explanations for this influx of physicians seeking licensure in Texas.

Two which appear to have little or no correlation are the following:

- *Displacement of physicians caused by Hurricane Katrina.* Data shows only a small percentage of

applications received from applicants in states impacted by the hurricane.

- *More residents wanting a license in order to moonlight now that the 80 hour work week is being enforced.* Data shows the number of residents seeking licensure remains relatively stable.

Some have even suggested that the increase is driven by bad doctors fleeing medical malpractice actions in their home states. As Executive Director, I examine each applicant with a history of medical malpractice issues. Compared to the huge growth in the number of applicants, there is no significant increase in numbers of physicians with one or more documented malpractice action.

We are left with only one viable hypothesis : Tort reform as enacted appears to be working as envisioned by the Texas Legislature. Physicians with no malpractice history are flocking to Texas because it provides a more encouraging environment for the practice of medicine.

While Texas patients can celebrate the improved access to medical care, they can rest assured that consumer protection has also been strengthened. With the decreased accountability in the Texas tort system comes a patient complaint-driven system that understands its duty and responsibility to respond to those patients to redress their grievances against their erring physicians. TMB's strength in holding physicians

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MEDICAL BOARD BULLETIN

Newsletter of the Texas Medical Board



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Mission Statement

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

DISCIPLINARY ACTIONS



Since the Fall 2005 issue of the *Medical Board Bulletin*, the Board has taken disciplinary action on 152 physicians. The Texas Physician Assistant Board took action against two physician assistants. The following is a summary of those actions.

ACTIONS BASED ON QUALITY OF CARE VIOLATIONS:

AKKANTI, VENKAT REDDY, M.D., BASTROP, TX, Lic. #J8868

On April 7, 2006, the Board and Dr. Akkanti entered into an Agreed Order requiring Dr. Akkanti's practice to be monitored by another physician for one year and requiring him to obtain 20 hours of continuing medical education in record-keeping, dealing with difficult patients or risk management. The action was based on allegations that Dr. Akkanti failed to meet the standard of care in treating one patient in that he did not adequately manage her asthma, failed to maintain an adequate medical record and failed to reasonably evaluate her for diabetes risk.

ANDREWS, SARAH ELIZABETH, M.D., KATY, TX, Lic. #H9753

On April 7, 2006, the Board and Dr. Andrews entered into an Agreed Order requiring Dr. Andrews' practice to be monitored by another physician for one year; requiring her to obtain 15 hours of risk management courses; and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Andrews failed to meet the standard of care in her treatment of four patients in 1998 and 1999.

BARRETT, DAVID BENJAMIN, M.D., ATHENS, TX, Lic. #G7987

On December 9, 2005, the Board and Dr. Barrett entered into an Agreed Order revoking Dr. Barrett's medical license. The action was based

on allegations that Dr. Barrett failed to meet the standard of care in his treatment of 11 patients who were or may have been harmed by his actions.

BORRELL, LEO JAMES, M.D., HOUSTON, TX, Lic. #D8507

On February 3, 2006, the Board and Dr. Borrell entered into an Agreed Order requiring Dr. Borrell to complete 10 hours of continuing medical education in the area of boundary violations and 20 hours in ethics; to pass the Medical Jurisprudence Examination within one year; and to pay an administrative penalty of \$5,500. The action was based on allegations that Dr. Borrell created a medical record implying that he had examined a patient in person when he had not; that he had violated the physician-patient boundary by rendering a formal opinion to an employee regarding mental health and family relationships; and that as a "medical consultant" to a clinic that performed photofacial pulsed light treatments to the skin he had established a physician-patient relationship with a person who had an adverse reaction and whom he failed to examine before or after the treatments.

CAPLAN, BRIAN JEFFREY, M.D., MANSFIELD, TX, Lic. #F0142

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

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**CARTER, KAYWIN MAHONEY, M.D.,
LUFKIN, TX, Lic. #H3992**

On December 9, 2005, the Board and Dr. Carter entered into an Agreed Order requiring Dr. Carter to complete a course of at least 10 hours in the area of gynecological surgery and to pay an administrative penalty of \$1,000. The action was based on allegations that Dr. Carter was not diligent in a patient's care by misdiagnosing her ectopic pregnancy.

**CORLEY, RONALD G., M.D., LUFKIN, TX, Lic.
#D8519**

On April 7, 2006, the Board and Dr. Corley entered into an Agreed Order whereby Dr. Corley agreed to cease performing any procedures that require the use of implants without first obtaining permission from the Board. Additionally, Dr. Corley on his own initiative resigned all surgical privileges and, under the order, may not reapply for surgical privileges without first obtaining permission from the Board, and must complete a course in record-keeping of at least eight hours and an Internal Medicine Board Review Course of at least 30 hours. The action was based on allegations that Dr. Corley failed to meet the standard of care in his performance of orthopedic surgery on two patients.

**DELANEY, SUSAN DELPHINE, M.D.,
PLANO, TX, Lic. #G9447**

On April 7, 2006, the Board and Dr. Delaney entered into an Agreed Order requiring Dr. Delaney to complete 10 hours of continuing medical education in risk management; to take and pass the Medical Jurisprudence Examination; and to pay an administrative penalty of \$2,000. The action was based on allegations that Dr. Delaney prescribed a Schedule II drug to the son of a physician with whom she cross-covered, but from whom she had not taken a history or independently established a diagnosis to support the prescription. Additionally, Dr. Delaney also accepted from one of her patients a supply of the same drug and dispensed it to the patient's

mother without making a record or properly labeling the medication.

**DESHMUKH, AVI TRIMBAK, M.D.,
STEPHENVILLE, TX, Lic. #H1067**

On April 7, 2006, the Board and Dr. Deshmukh entered into an Agreed Order requiring Dr. Deshmukh to complete a course in risk management of at least 10 hours and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Deshmukh prescribed a sulfa drug to a patient with a known allergy to the drug.

**DUBBERLY, DANNY LEE, M.D.,
ROCKPORT, TX, Lic. #E8447**

On April 7, 2006, the Board and Dr. Dubberly entered into an Agreed Order requiring Dr. Dubberly to take and pass the Medical Jurisprudence Examination within one year and to attend at least 15 hours of continuing medical education in risk management and dealing with the difficult patient. The action was based on allegations that Dr. Dubberly failed to meet the standard of care by failing to prescribe testosterone therapy for one patient. As a mitigating factor, the circumstances surrounding the fact that the patient was a prison inmate impeded clear communication between Dr. Dubberly and the patient.

**FINLEY, KEVIN WAYNE, D.O., MUNDAY, TX, Lic.
#K5525**

On April 7, 2006, the Board and Dr. Finley entered into an Agreed Order requiring Dr. Finley to complete 25 hours of continuing medical education in emergency medicine. The action was based on allegations that Dr. Finley failed to meet the standard of care because of an inadequate evaluation of one patient who presented to the emergency room where he was the on-call physician.

**FRUGE, LLOYD MASON, M.D., ATLANTA, TX, Lic.
#G5067**

On December 9, 2005, the Board and Dr. Fruge entered into an Agreed Order requiring Dr.

Fruge to complete a total of at least 20 hours of continuing medical education in emergency medicine and in record keeping/risk management. The action was based on allegations that Dr. Fruge's treatment of one patient fell below the standard of care and that his documentation of the history and physical examination of that patient were inadequate.

KRAM, MARTIN, M.D., GRAND PRAIRIE, TX, Lic. #K5593

On February 3, 2006, the Board and Dr. Kram entered into an Agreed Order requiring the following: that his practice be monitored by another physician for two years; that he obtain an additional 25 hours of continuing medical education in medical record-keeping, risk management and/or treating patients with psycho-pharmaceuticals each year for two years; and that he complete a course of at least 16 hours in treating, prescribing and managing difficult patients within one year. The order was based on allegations that Dr. Kram failed to appropriately manage the treatment of two psychiatric patients, including inappropriate prescribing of amphetamines.

LILAND, DAVID LYNN, M.D., DALLAS, TX, Lic. #G5300

On February 3, 2006, the Board and Dr. Liland entered into a two-year Agreed Order requiring that his practice be monitored by another physician; that he prepare and implement a peer review program similar to the one set out in the Accreditation Association for Ambulatory Health Care *Accreditation Guidebook for Office-Based Surgery*; and that he pay an administrative penalty of \$5,000. The action was based on allegations that Dr. Liland left a sponge in one patient following surgery in 1998 and that another patient suffered a burn as a result of the use of a faulty grounding pad during surgery in 2001.

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

On December 9, 2005, the Board and Dr. Linde entered into an Agreed Order requiring Dr. Linde to complete a course of at least 10 hours

in the area of medical records and to pay an administrative penalty of \$2,500. The action was based on allegations that Dr. Linde administered Midazolam to a patient awaiting a surgical procedure whom he mistakenly believed to be under his care and failed to document his error or inform that patient's physician.

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

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

MARINO, BARBARA DOYLE, M.D., TOMBALL, TX, Lic. #H7724

On April 7, 2006, the Board and Dr. Marino entered into a five-year Agreed Order requiring Dr. Marino's practice to be monitored by another physician; requiring her to complete the National Board of Medical Examiners' Post-Licensure Assessment program at the University of Florida Comprehensive Assessment and Remedial Education Services; and to complete courses of at least 20 hours in gynecological complications. The action was based on allegations that Dr. Marino failed to meet the standard of care with her sequential use of instruments in the delivery of a baby, that she failed to appropriately treat bowel leakage in one patient following surgery, that she failed to document the need for surgery and continued use of hydrocodone in one patient, and that she failed to adequately document complications of surgery for another patient.

MARTIN, DOROTHY VICTORIA BILLS, M.D., RICHARDSON, TX, Lic. #H2565

On February 3, 2006, the Board and Dr. Martin entered into an Agreed Order publicly

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FORMAL COMPLAINTS

The following Formal Complaints have been filed with the State Office of Administrative Hearings regarding the licensees listed below. The cases were unresolved at the time of publication.

Name	License No.	Date filed	Allegations
Paul K. Blissard, M.D.	F6453	5/3/06	Failure to meet the standard of care regarding five patients; failure to maintain adequate medical records; unprofessional conduct.
Louis F. Fabre Jr., M.D.	D5986	4/26/06	Unprofessional conduct; failure to practice consistent with public health and welfare; nontherapeutic prescribing; failure to adequately supervise; delegating to someone not qualified; failure to maintain adequate medical records; failure to meet the standard of care; negligence in performing medical services; failure to safeguard against potential complications.
Robert Christopher Kuhne, M.D.	H2519	5/18/06	Violation of Board Rule 165, relating to the release of medical records; unprofessional conduct.
Medhat S.F. Michael, M.D.	BP20015134	4/17/06	Unprofessional conduct.
David A. Ray, P.A.-C.	PA0267	12/22/05	Unprofessional conduct; violation of P.A. act; committing an act of moral turpitude; failure to practice consistent with public health and welfare; nontherapeutic prescribing; sexual abuse or exploitation of licensee's practice as a P.A.
Russell R. Roby, M.D.	E1255	4/25/06	False, deceptive or misleading advertising; unprofessional conduct.
Timothy Rogler-Brown	K6918	5/10/06	Failure to meet the standard of care; unprofessional conduct; improper billing; failure to keep adequate medical records; disruptive behavior.
Jesus Rodriguez-Aguero, M.D.	D2126	3/10/06	Failure to practice consistent with public health and welfare.
Muhammad Y. Shaikh, M.D.	K4240	1/4/06	Unprofessional conduct; nontherapeutic prescribing; failure to maintain adequate medical records; failure to adhere to established pain guidelines.

reprimanding Dr. Martin, requiring her practice to be monitored by another physician for one year and requiring her to obtain an additional 15 hours of continuing medical education in record-keeping. Additionally, Dr. Martin is not permitted to supervise or delegate prescriptive authority to a physician assistant or advanced nurse practitioner during the one-year term of the order. The action was based on allegations that Dr. Martin failed to adequately manage and document treatment for a patient for whom she was prescribing Cylert, including a failure to obtain baseline and biweekly liver function tests.

McBATH, J. MARK, M.D., HOUSTON, TX, Lic. #G8265

On April 7, 2006, the Board and Dr. McBath entered into an Agreed Order publicly reprimanding Dr. McBath; requiring him to complete at least 20 hours of courses per year for three years in the areas of pre-operative and post-operative complications and medical record-keeping; and assessing an administrative penalty of \$15,000. The action was based on allegations that Dr. McBath failed to practice medicine in an acceptable professional manner in his treatment of four surgical patients. As a mitigating factor, the incidents occurred from 1997 through 1999 and Dr. McBath engaged in additional study following these cases.

McCRORY, BEAU LAWSON, M.D., COMANCHE, TX, Lic. #K7823

On April 7, 2006, the Board and Dr. McCrory entered into an Agreed Order requiring Dr. McCrory to complete 10 hours of continuing medical education in the area of medical record-keeping and prohibiting him from performing non-emergency gynecological surgery until such time as he obtains acceptable additional training or otherwise demonstrates to the Board that he is qualified for such surgery. Dr. McCrory may assist other qualified surgeons in emergency surgery with the approval and informed consent of the patient. The action was based on allegations that Dr. McCrory failed to meet the standard of care for one patient by not

maintaining adequate medical records, by undertaking surgery without giving sufficient time for iron supplements to work, by failing to discuss with the patient other available treatment options, by failing to adequately disclose that he had not been formally trained in obstetrics/gynecology, by failing to perform an endometrial biopsy prior to surgery, by ordering a blood transfusion in an otherwise healthy woman and by continuing surgery once the pelvic adhesions presented a significant problem for the surgeons.

MORENO, FRANCISCO E., M.D., KATY, TX, Lic. #F1838

On January 10, 2006, the Board and Dr. Moreno entered into an Agreed Order requiring Dr. Moreno to complete 10 hours of ethics courses; complete within one year the Physician Assessment and Clinical Education (PACE) course in medical records offered by the University of California, San Diego, School of Medicine; and refrain from treating his immediate family while subject to the order, which terminates on completion of the other requirements. The action was based on allegations that Dr. Moreno violated the standard of care in that he prescribed medication to close family members with scant documentation and no evidence of follow-up and review of the medications.

O'NEAL, KENNETH W., M.D., ABILENE, TX, Lic. #D6119

A Temporary Suspension Order Without Notice was entered on November 28, 2005, temporarily suspending Dr. O'Neal's license due to evidence that the physician's continuation in the practice of medicine would constitute a continuing threat to public welfare. The Temporary Suspension Order shall remain in effect until such time as it is superseded by a subsequent order of the Board. The action was based upon allegations that Dr. O'Neal's treatment of three patients fell below the standard of care, resulting in the patient's deaths.

Nondisciplinary Rehab Orders an Option for Impaired Physicians

Physicians who have received their Texas licenses fairly recently may not be aware of nondisciplinary rehabilitation orders.

Established by the Legislature in 1995, rehab orders allow a physician who is impaired by illness or addiction to self-report to the board, seek rehabilitation and care, and often return to or remain in practice without any disciplinary mark on his or her record.

Sections 164.202-164.204 of the Texas Occupations Code authorize the Board to use a nondisciplinary, confidential order for physicians who seek help from the Board for their drug or alcohol abuse problems. Unless the intemperate use of drugs or alcohol is a direct result of habituation due to treatment by another physician, the intemperate use must be self-reported to qualify for a nondisciplinary order.

Rehabilitative orders differ from traditional disciplinary orders in that they are not subject to the Open Records Act. However, the rehabilitative order can include the full range of actions of a disciplinary order, including revocation, cancellation, suspension and various terms and conditions of probation. The most common rehabilitation order for a physician who self-reports is probation for a number of years under certain terms and conditions. These conditions are intended to not only monitor a physician in recovery, but also to rehabilitate the physician. These conditions may include mandatory admittance into a drug treatment program, attendance at weekly AA meetings, random drug screens, etc. Physicians under rehabilitative orders are as tightly monitored as physicians under a disciplinary order. The terms of the orders are tailored to fit the circumstances of the physician and typically take into consideration the physician's cooperation and efforts to obtain help.

Confidential nondisciplinary orders are permitted for the following:

- intemperate use of drugs or alcohol directly resulting from habituation or addiction caused by medical care or treatment provided by another physician;
- self-reported intemperate use of drugs or alcohol during the last five years immediately preceding the report which could adversely affect the physician's ability to practice medicine safely, but only if the reporting individual has not previously been the

subject of a substance abuse related order of the board,

- judgment by a court of competent jurisdiction that the individual is of unsound mind; or
- finding of impairment based upon a mental or physical examination offered to establish such impairment in an evidentiary hearing before the Board with opportunity for opposition in full by such individual, or admissions by the individual indicating that the licensee or applicant suffers from a potentially dangerous limitation or an inability to practice medicine with reasonable skill and safety by reason of illness or as a result of any physical or mental condition.

The Board will not offer a confidential rehabilitation order if there is a determination that a violation of the standard of care was a result of the intemperate use of drugs or alcohol. The board shall have complete discretion to determine whether any violation of the standard of care was a result of the intemperate use of drugs or alcohol.

More information on rehabilitation orders is available under Chapter 180 of the Board Rules at www.tmb.state.tx.us/rules/rules/180.php

Anyone wishing to self-report an impairment in order to enter into a rehab order may do so by submitting the following information:

- the approximate dates of intemperate use;
- the extent of intemperate use;
- the substance(s) used;
- the method(s) of ingestion;
- all history of substance abuse treatment to include approximate dates of treatment and the specific locations where treatment was received; and
- a description of any incident that a reasonably prudent physician would believe could result in an allegation of the physician's violation of the standard of care that occurred during the time of intemperate use or, if no violation of the standard of care has occurred, a statement that no violation of the standard of care occurred during the time of intemperate use. Send to

Complaints and Investigations Department
MC-263
Texas Medical Board
P.O. Box 2018
Austin TX 78768



ORLOV, ALEXANDER, D.O., LUFKIN, TX, Lic. #J4402

On April 7, 2006, the Board and Dr. Orlov entered into an Agreed Order requiring Dr. Orlov to complete a course in risk management/medical records of at least 20 hours and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Orlov failed to ensure that a patient with lesions determined to be squamous cell carcinoma followed up for treatment. As mitigating factors, Dr. Orlov did make attempts to contact the patient, who had a caregiver because of mental deficiencies, and whose caregiver was aware of the patient's medical condition. However, Dr. Orlov's duty to this patient was higher due to her mental deficiencies and inability to care for herself.

ORTIZ, AURELIO ANTONIO, M.D., MIAMI, FL, Lic. #F7870

On April 7, 2006, the Board and Dr. Ortiz entered into an Agreed Order publicly reprimanding Dr. Ortiz; suspending his medical license; staying the suspension and placing him on probation for three years; requiring that he obtain 10 hours of ethics courses; pass the Medical Jurisprudence Examination within one year; and assessing an administrative penalty of \$3,000. The action was based on allegations that Dr. Ortiz did not examine a patient admitted to the emergency room for which he was the assigned physician.

PEARCE, DAVID EARL, M.D., CORPUS CHRISTI, TX, Lic. #G9510

On December 9, 2005, the Board and Dr. Pearce entered into an Agreed Order requiring Dr. Pearce to complete 10 hours of courses in each of the areas of medical record keeping and risk management. The action was based on allegations involving the removal of a laparotomy pad by Dr. Pearce after an abscess formed following surgery and Dr. Pearce's lack of immediate notification of this fact to the patient or the patient's family.

SANFORD, DAVID BRUCE, M.D., HOUSTON, TX, Lic. #H6575

On February 3, 2006, the Board and Dr. Sanford entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Sanford, in 2001 and 2002, continued a patient on Procrit after the patient's hemoglobin level was above 12, and it should have been discontinued, though it did not cause harm to the patient.

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

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

SHIN, HYON-HO, M.D., AUSTIN, TX, Lic. #J6724

On April 7, 2006, the Board and Dr. Shin entered into an Agreed Order requiring Dr. Shin to complete a course in risk-management of at least 10 hours and assessing an administrative penalty of \$2,000. The action was based on allegations that Dr. Shin performed a right inguinal hernia repair after he had diagnosed a left inguinal hernia. As mitigating factors, the

patient did in fact also have a right inguinal hernia, the hospital staff incorrectly identified the site, Dr. Shin immediately notified the patient of the error and offered to perform the left inguinal hernia repair for no charge, did not bill the patient for the right inguinal hernia repair and had changed his procedures to avoid similar incidents.

**SIEWERT, RICKY ALLEN, D.O.,
PERRYTON, TX, Lic. #G2576**

On April 7, 2006, the Board and Dr. Siewert entered into an Agreed Order requiring Dr. Siewert's practice to be monitored by another physician for the time period required by the monitor to complete and submit four quarterly reports; and requiring Dr. Siewert to attend at least 20 additional hours of continuing medical education, at least 10 of which must be in medical record-keeping. The action was based on allegations that Dr. Siewert failed to practice medicine in an acceptable professional manner in his treatment of one patient who was later admitted to the hospital for sepsis and an incarcerated hernia.

**THARAKAN, DAVID K., M.D., SAN
ANTONIO, TX, Lic. #L0646**

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

**WALLACE, BRENT HOLMES, M.D.,
CLEBURNE, TX, Lic. #F2093**

On December 9, 2005, the Board and Dr. Wallace entered into an Agreed Order requiring Dr. Wallace to complete 20 hours of continuing medical education in the area of medical record

keeping and risk management. The action was based on allegations that Dr. Wallace, through an oversight, failed to ensure that a follow-up X-ray was ordered for a patient for whom an X-ray some nine months later revealed adenocarcinoma.

**WILLIAMS, MICHAEL DAVID, D.O., CEDAR
HILL, TX, Lic. #H2907**

On February 3, 2006, the Board and Dr. Williams entered into an Agreed Order limiting Dr. Williams to performing only those procedures in his office or on an outpatient basis that require only local anesthesia, stating that he may not perform any cosmetic office surgical procedures until he has completed a surgical residency training program. In addition, the order requires him to attend 10 hours of continuing medical education in record-keeping or risk management and requires that his practice be monitored by another physician for 24 months. The action was based on allegations concerning Dr. Williams' performing a breast augmentation in his office, and his use of office-based narcotic and sedative medication anesthesia during the procedure.

**ACTIONS BASED ON UNPROFES-
SIONAL CONDUCT:**

**ADAIR, MAUREEN LENORE, M.D.,
AUSTIN, TX, Lic. #F6376**

On April 7, 2006, the Board and Dr. Adair entered into an Agreed Order requiring Dr. Adair to complete a course in the area of risk management and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Adair failed to provide properly requested medical records within 15 business days and failed to timely respond to correspondence from the Board.

**AHMAD, NASIHA, M.D., CARROLLTON, TX, Lic.
#G9703**

On April 7, 2006, the Board and Dr. Ahmad entered into an Agreed Order requiring Dr. Ahmad to complete a course in ethics of at least

Be Prepared for Pandemic Flu

As the U.S. and Texas prepare for a possible influenza pandemic, both state and federal governments have made information available for physicians and other health care professionals to help prepare for and, if necessary, manage a situation in which as much as half of the work force could be unavailable because of illness or caring for a sick family member.

There were three flu pandemics during the 20th Century: the 1918 Spanish flu; the Asian flu in 1957; and the Hong Kong flu in 1968. The 1918 pandemic killed more than half a million people in the U.S. and 20 million worldwide. (About 36,000 people die from seasonal flu in the U.S. every year.)

The world is overdue for a flu pandemic. The strain of bird flu that is circulating is Influenza A subtype H5N1, and it is a close relative of the 1918 flu.

A pandemic is like a rolling natural disaster; it is progressive and prolonged, and occurs in multiple locations. A wave lasts 2-12 weeks and can recur multiple times. Secondary waves are usually worse. The relatively small SARS “epidemic” in Toronto in 2003 consisted of 352 cases and put hospitals at surge capacity, while shutting down churches and schools, causing widespread hysteria.

The intent of the various state and federal agencies involved in flu pandemic preparedness is to inform and prepare health care professionals and the public, rather than inflame and cause panic. Prepared-

ness can mitigate the disastrous effects of a pandemic. The goals of pandemic preparedness planning are to reduce illness and death rates, to minimize the spread of the disease, to ensure business continuity, to attempt to maintain essential services, and to limit the economic and social consequences of an outbreak.

Information available to healthcare practitioners includes tool kits for medical offices and clinics to develop an influenza preparedness plan. The federal government’s site, <http://www.pandemicflu.gov/> has a wealth of current information on where H5N1 outbreaks have occurred, updates on vaccine availability, definitions, and links, including the link to healthcare planning at <http://www.pandemicflu.gov/plan/tab6.html>, which includes PDF files of toolkits for clinics, home healthcare, hospitals and other facilities. The Texas Department of State Health Services provides additional information at http://www.dshs.state.tx.us/preparedness/pandemic_flu/professionals/

In addition to these resources, simple common-sense tips for pandemic flu preparedness include:

- Stay informed
- Promote hand-washing
- Contain coughs
- Stay home and encourages others to do so if sick
- Have a business continuity plan. ♦

10 hours and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Ahmad failed to adequately disclose to the board her hospital practice history in her Medical Practice Questionnaire.

BEAR, RONALD LYNN JR., M.D., SAN ANTONIO, TX, Lic. #BP20020214

On April 7, 2006, the Board and Dr. Bear entered into an Agreed Order requiring Dr. Bear to complete 10 hours of ethics courses and assessing an administrative penalty of \$500. The action was based on allegations that Dr. Bear failed to disclose his arrest for assault in 2004 on

his application for renewal of his physician training permit. As a mitigating factor, the charges were dismissed and Dr. Bear believed the arrest had been expunged.

COMEAX, TAMYRA YVETTE, M.D., HOUSTON, TX, Lic. #L0096

On December 9, 2005, the Board and Dr. Comeaux entered into an Agreed Order requiring Dr. Comeaux to provide satisfactory evidence that she is acting as medical director of a specified fetal ultrasound facility, that another physician is providing supervision at the facility, or that the ultrasound equipment is no longer

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being used; requiring her to complete 20 hours in courses or programs in ethics/risk management; and requiring her to pay an administrative penalty of \$5,000. The action was based on allegations that Dr. Comeaux failed to supervise the use of a prescription medical device, specifically ultrasound equipment, leased under her name.

**CUNADO, CARLOS DOMINGO, M.D.,
PEARLAND, TX, Lic. #K6556**

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

**DE WET, PIETER JUAN, M.D., TYLER, TX, LIC.
#J0470**

On December 9, 2005, the Board and Dr. De Wet entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. De Wet caused the dissemination of false, deceptive, or misleading advertising concerning the benefits of chelation therapy.

**FERRUZZI, GIANCARLO ROBERTO, M.D., SAN
ANTONIO, TX, Lic. #H9924**

On February 3, 2006, the Board and Dr. Ferruzzi entered into an Agreed Order requiring Dr. Ferruzzi to obtain an additional 20 hours of courses in ethics and risk management and assessing an administrative penalty of \$2,000. The action was based on allegations that Dr. Ferruzzi read the file of a person with whom a physician-patient relationship no longer existed.

**FLORES, DENNIS R., M.D., NEW
BOSTON, TX, Lic. #F3124**

On February 3, 2006, the Board entered a Final Order assessing an administrative penalty of

\$1,200. The action was based on Dr. Flores' conviction of a federal misdemeanor for failing to file federal income tax returns, which is a violation of the Medical Practice Act.

**GHELBER, OSCAR, M.D., HOUSTON, TX, Permit.
#40245**

On April 7, 2006, the Board and Dr. Ghelber entered into an Agreed Order assessing an administrative penalty of \$250. The action was based on allegations that Dr. Ghelber administered Fentanyl as the anesthetic to a child even though his mother objected to the use of Fentanyl, mistakenly believing her child was allergic to it. As a mitigating factor, Dr. Ghelber did discuss the use of Fentanyl with the mother and thought she understood Fentanyl was acceptable for use in the child's surgery.

**GHRAOWI, MOHAMAD AYMAN, M.D., CORPUS
CHRISTI, TX, Lic. #J6958**

On February 3, 2006, the Board and Dr. Ghraowi entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that an advertisement for Dr. Ghraowi's practice incorrectly showed that his institute was affiliated with M.D. Anderson.

**GRUESBECK, CLAY, M.D., SAN
ANTONIO, TX, Lic. #H7749**

On April 7, 2006, the Board and Dr. Gruesbeck entered into an Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Gruesbeck failed to disclose on his annual registration form that he had been arrested for a class C misdemeanor and had paid a \$200 fine.

**HEIN, ROBERT MATHEW, M.D.,
BURLESON, TX, Lic. #BP20011780**

On February 3, 2006, the Board and Dr. Hein entered into an Agreed Order requiring Dr. Hein to perform 10 hours of community service work for a non-profit charitable organization. The action was based on his arrest and conviction for driving while intoxicated.

Governor Reappoints Acupuncture Board Members

Governor Rick Perry announced the reappointment of Meng-Sheng Linda Lin of Plano and Pedro V. Garcia Jr. of Frisco to the Texas State Board of Acupuncture Examiners.



Ms. Lin

Ms. Lin is the owner of Meng-Sheng Lin Acupuncture Center and has more than 35 years of experience in teaching and practicing acupuncture and Chinese herbal healing. She received her medical degree from Peking Union Medical College in

Beijing, and was a postdoctoral fellow at the China Academy of Traditional Chinese Medicine in Beijing

and the World Health Organization in Houston. Her term will expire January 31, 2007.

Mr. Garcia is a banker with Chase Bank. He is a member of the Knights of Columbus in Frisco and formerly served as chair of the public relations committee of Fiestas Del Llano, Inc. He received a bachelor's degree from Wayland Baptist University. His term will expire January 1, 2009.



Mr. Garcia

These appointments are subject to Senate approval during the 2007 Regular Session.



ISERN, REUBEN A., M.D., BEAUMONT, TX, Lic. #E8585

On December 9, 2005, the Board entered a Final Order assessing an administrative penalty of \$10,000. The action was based on a determination of Dr. Isern's failure to comply with the Board's subpoena of medical records; failure to correspond with the Board regarding the matter in question; failure to appear at an informal settlement conference; failure to respond to a complaint filed with the State Office of Administrative Hearings; and apparent willful disregard for the Board's authority in that he is attempting to thwart the Board's ability to investigate and monitor him and ensure that he is safe to practice medicine. Continued non-cooperation by Dr. Isern may result in further disciplinary action by the Board. Dr. Isern did not file a motion for rehearing; therefore, the order was final effective February 24, 2006.

LEWIS, PERRY CARTER, M.D., LONGVIEW, TX, Lic. #H8210

On February 3, 2006, the Board and Dr. Lewis entered into an Agreed Order publicly

reprimanding Dr. Lewis, requiring the following for one year: that he continue to receive care from his therapist at least once a week; that he continue to receive care from his treating psychiatrist at least once a month; that he complete an anger management course of at least 16 hours; and that he pay an administrative penalty of \$2,500. The action was based on allegations that Dr. Lewis was arrested and charged with the Class A misdemeanor offense of assault with injury for hitting his wife and was sentenced to 15 months of deferred adjudication. In addition, action was based on Dr. Lewis' admission that he had engaged in verbal and physical abuse toward his wife and had sometimes engaged in verbal abuse in his workplace.

LINAN, LUIS ENRIQUE, M.D., EL PASO, TX, Lic. #H8214

On April 7, 2006, the Board and Dr. Linan entered into an Agreed Order requiring Dr. Linan to successfully complete the Anger Management for Healthcare Professionals course provided by the University of California, San Diego, School

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of Medicine Physician Assessment and Clinical Education Program, or substantially similar course approved by the Executive Director. The action was based on allegations that Dr. Linan slapped a surgical assistant on the hand during an emergency cesarean section.

MONZON, MIGDALIA, M.D., ODESSA, TX, Lic. #K8354

On December 9, 2005, the Board and Dr. Monzon entered into an Agreed Order requiring Dr. Monzon to provide to the Board a copy of her revised patient termination notice; to complete an additional 10 hours of continuing medical education in the area of dealing with difficult patients; and to pay an administrative penalty of \$500. The action was based on allegations that Dr. Monzon terminated care of a patient without providing reasonable notice to the patient.

MOORE, CHARLES THOMAS, M.D., AUSTIN, TX, Lic. #E4539

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

QUINTANA, JOSEPH ANTHONY JR., M.D., EL PASO, TX, Lic. #H3733

On February 3, 2006, the Board and Dr. Quintana entered into an Agreed Order publicly reprimanding Dr. Quintana and requiring the following: that he complete 25 hours of continuing medical education in ethics, medical records and conscious sedation; that he pass the Medical Jurisprudence Examination within one year; that he complete an Advanced Cardiac Life Support Course and obtain ACLS certification within three months; and that he pay an administrative penalty of \$5,000. The action was based on allegations that an interventional cardiac procedure was completed on one of Dr. Quintana's patients by unlicensed hospital personnel without Dr. Quintana being present.

PIERCE, DAMON SCOTT, M.D., DALLAS, TX, Lic. #BP30021144

On April 7, 2006, the Board and Dr. Pierce entered into an Agreed Order assessing an administrative penalty of \$250. The action was based on allegations that Dr. Pierce failed to disclose on his 2004-2005 postgraduate training permit renewal application a 1998 arrest for criminal mischief relating to damage to a restaurant's table and chair. Dr. Pierce erroneously thought the 1998 arrest had been expunged.

RODRIGUEZ, PAUL LOPEZ, M.D., WICHITA, KS, Lic. #K9889

On April 7, 2006, the Board and Dr. Rodriguez entered into an Agreed Order suspending Dr. Rodriguez's medical license, staying the suspension and placing him on probation for five years; requiring that he complete 20 additional hours of continuing medical education each year in the area of ethics or risk management; prohibiting him from supervising physician assistants, advanced practice nurses or surgical assistants; and assessing an administrative penalty of \$10,000. The action was based on allegations that Dr. Rodriguez failed to notify the Board on his license renewal form that he had been suspended by the Oklahoma State Board of Medical Licensure and Supervision for six months in 2004 and placed on probation by the

Medical Board of California. The action of the Oklahoma Board was based on Dr. Rodriguez allowing an unlicensed individual to prescribe to patients and operate a laser for hair removal owned by Dr. Rodriguez. The California Board action was based on the Oklahoma Board action.

**TALLAPUREDDY, SREEDHAR REDDY, M.D.,
WICHITA FALLS, TX, Lic. #BP30020971**

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

**TREVINO, ROGELIO, M.D., McALLEN, TX, Lic.
#BP20019970**

On April 7, 2006, the Board and Dr. Trevino entered into an Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Trevino failed to disclose on his Postgraduate Resident Permit Applications that he had been arrested in 1990 for driving while intoxicated.

**WILLOWS, BARBARA JEAN, D.O., COLUMBUS,
OH, Lic. #E8918**

On April 7, 2006, the Board and Dr. Willows entered into an Agreed Order accepting the voluntary and permanent surrender of Dr. Willows' medical license. The action was based on Dr. Willows' wish to surrender her Texas medical license as she has no intention of returning to Texas to practice, and followed the indefinite suspension of her Ohio medical license for a conviction for operating a motor vehicle while intoxicated and for alcohol abuse.

**ACTIONS BASED ON INAPPROPRIATE
CONDUCT INVOLVING PHYSICIAN-
PATIENT RELATIONSHIP:**

**GRUHLKEY, JAY LOYD, M.D., NEW
BRAUNFELS, TX, Lic. #K7750**

On April 7, 2006, the Board and Dr. Gruhlkey entered into a one-year Agreed Order requiring Dr. Gruhlkey to complete "A Continuing Education Course for Physicians Who Cross Sexual Boundaries" presented by the Center for Professional Health at the Vanderbilt Medical Center; to complete 10 hours of continuing medical education in each of the areas of ethics and risk management; to speak to three local county medical society meetings on the topic of maintaining proper boundaries; and assessing an administrative penalty of \$10,000. The action was based on allegations that Dr. Gruhlkey was sexually involved with a patient, who was also an employee, while functioning as the physician for her and her two small children

**KUHNE, ROBERT CHRISTOPHER, M.D.,
RICHARDSON, TX, Lic. #H2519**

On April 7, 2006, following a rehearing granted to Dr. Kuhne, the Board issued a Final Order publicly reprimanding Dr. Kuhne and requiring him to write a letter of apology to a patient acknowledging that his conduct was improper and to complete within one year "A Continuing Education Course for Physicians Who Cross Sexual Boundaries" presented by the Center for Professional Health at the Vanderbilt Medical Center and the "Maintaining Professional Boundaries and Managing Difficult and Frustrating Patients" course offered by the Texas Medical Association's Committee on Physician Health and Rehabilitation. The action was based on a finding by an Administrative Law Judge of the Texas State Office of Administrative Hearings that Dr. Kuhne, while examining a patient seeking treatment of FSD (female sexual dysfunction) made a comment relating to oral sex that was unprofessional and dishonorable.

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MUNOZ, ALEJANDRO, M.D., IOWA PARK, TX, Lic. #G8549

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

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

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

ROUNTREE, RANDOLPH WINSLER, M.D., SAN ANGELO, TX, Lic. #F7123

On April 7, 2006, the Board and Dr. Rountree entered into an Agreed Order suspending Dr. Rountree's medical license until such time as he demonstrates to the Board that he is safe and competent to practice medicine. The action was based on allegations that Dr. Rountree sexually assaulted a patient and had inappropriate sexual contact with three other patients.

STINNETT, JAMES TAYLOR III, M.D., COMMERCE, TX, Lic. #D3411

On December 9, 2005, the Board and Dr. Stinnett entered into an Agreed Order suspending Dr. Stinnett's license, staying the suspension and placing him on probation for five years under

the following terms and conditions: he must have a chaperone present any time he sees a female patient; he must complete a course in physician-patient boundaries of at least 10 hours; he may not perform massage therapy on any of his psychiatric patients; and he must undergo psychiatric evaluation. If recommended by the evaluating psychiatrist, he must undergo continued psychiatric care and treatment. He was also assessed an administrative penalty of \$2,500. The action was based on allegations that Dr. Stinnett touched a patient in an intimate manner while demonstrating massage techniques in the massage room in his home.

XIQUES, PABLO L., M.D., GRAND PRAIRIE, TX, Lic. #E3823

On February 3, 2006, the Board and Dr. Xiques entered into an Agreed Order publicly reprimanding Dr. Xiques and assessing an administrative penalty of \$3,000. The action was based on allegations on unprofessional conduct by Dr. Xiques during the course of his treatment of one patient.

ACTIONS BASED ON NONTHERAPEUTIC PRESCRIBING:

BASPED, BEAUFORD JR., D.O., FORT WORTH, TX, Lic. #E3813

On December 9, 2005, the Board and Dr. Basped entered into a Mediated Agreed Order revoking Dr. Basped's license, staying the revocation and placing him on probation for 15 years under the following terms and conditions: Dr. Basped must surrender his controlled substances registration certificates; limit his practice to a group or institutional setting approved in advance by the Executive Director of the Board; complete each year 10 hours of courses in ethics and 30 hours in risk management; have his practice monitored by another physician; pass the Special Purpose Examination and the Medical Jurisprudence Examination within one year; obtain a written assessment from the

RULE CHANGES

The Board has adopted the following proposed rule changes that were published in the *Texas Register*:

Chapter 161, General Provisions, to reflect statutory name changes and the composition of the board.

Chapter 163, Licensure, to include examination attempts and limits on time to complete an examination.

Chapter 172, Temporary Licenses, to include the addition of Faculty Temporary License.

Chapter 175, Fees, Penalties, and Forms

- Increased penalty fees for physician assistants and increased renewal and/or penalty fees for acupuncturists, surgical assistants, acudetox specialists, non-certified radiological technicians, and non-profit health organizations.

- Mandated Texas Online fee increase for physician and physician-in-training renewals.

- Fee requirements for Office-Based Anesthesia site registration.

Chapter 178, Complaints, to include amendments to 178.2 Definitions, 178.4 Complaint Initiation, 178.5 Complaint Evaluation, 178.6 Complaint Filing, 178.7 Complaint Resolution, and 178.8 Appeals regarding the process for complaint initiation, preliminary investigation and filing.

Chapter 179, Investigations, to include amendments to 179.2 Definitions 179.3 Confidentiality, 179.4 Request for Information and Records from Physicians, and 179.6 Time Limits, regarding clarification on response time for requests for medical records and time limits for completion of an investigation of a complaint.

Chapter 180, Rehabilitation Orders, regarding requirements and limitations on eligibility for rehabilitation orders.

Chapter 182, Use of Experts, to include 182.3 Definitions, 182.4 Use of Consultants, 182.5 Expert Panel, new 182.5.1 Expert Physician Reviewers, 182.7 regarding selection, use and removal of members of

the Expert Panel.

Chapter 183, Acupuncture, relating to changes mandated by SB 419.

Chapter 187, Procedural Rules, to include Subchapter A, General Provisions and Definitions, 187.1 Purpose and Scope, 187.2 Definitions, 187.4 Agreement to be in Writing, 187.9 Board Actions; Subchapter B, Informal Board Proceedings, 187.10 Purpose, new 187.14.1 Informal Resolution of Administrative Violations, 187.16 Informal Show Compliance Proceedings (ISCs), 187.18 Informal Show Compliance Proceeding, 187.20 Board Action, 187.21 Board and District Review Committee Members Participation; Repeal of 187.12 Notice; repeal of 187.17 Informal Show Compliance Proceeding Based on Written Information, Subchapter C, Formal Proceedings at SOAH, 187.23 General Provisions, 187.26 Service in SOAH Proceedings, 187.27 Written Answers in SOAH Proceedings and Default Orders, 187.28 Discovery, 187.29 Mediated Settlement Conferences, 187.30 Reporter and Transcripts, 187.31 Evidence, 187.33 Proposals for Decision, Repeal of 187.32 Motions, repeal of 187.34 Exceptions and Replies, Subchapter D, Formal Board Proceedings, 187.36 Interlocutory Appeals and Certification of Questions, 187.37 Final Decisions and Orders, 187.42 Recusals, Subchapter E, Proceedings Relating to Probationers, 187.43 Proceedings for the Modification/Termination of Agreed Orders and Disciplinary Orders, new 187.45 Probationer Appearances, and Subchapter F, Temporary Suspension Proceedings, 187.56 Convening a Disciplinary Panel regarding process and revised options for board orders, composition of ISC panel, roles of ISC participants, and revisions to reflect APA requirements.

Chapter 190, Disciplinary Guidelines, to include Subchapter B, Violation Guidelines, 190.8 Violation Guidelines; Subchapter C, Sanction Guidelines, 190.14 Disciplinary Sanction Guidelines and 190.16 Administrative Penalties regarding clarification

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Center for Personalized Education for Physicians (CPEP); perform 50 hours of community service each year; and pay an administrative penalty of \$10,000. Dr. Basped is not permitted to supervise or delegate prescriptive authority to a physician assistant or advanced practice nurse. The action is based on allegations that Dr. Basped prescribed narcotics without conducting a proper history or physical examination to support the need for narcotics. The allegations arose after an undercover officer from the narcotics task force posed as a patient and was prescribed drugs by Dr. Basped.

WOMACK, ROBERT, M.D., AMARILLO, TX, Lic. #G6773

On April 7, 2006, the Board entered a Final Order revoking Dr. Womack's medical license. The action was based on findings of the Board that a Formal Complaint was filed with the State Office of Administrative Hearings on August 22, 2005, alleging that Dr. Womack prescribed for himself nontherapeutic doses of hydrocodone, doxycycline/vibramycin, erythromycin, diflucan/fluconazole, neomycin, amoxil/amoxicillin and phentermine and that no adequate medical records or documentation of need were maintained, and that he additionally nontherapeutically prescribed phentermine for his wife. Dr. Womack did not respond to the complaint or to correspondence from the Board and on February 17, 2006, the Board's Hearings Counsel issued a Determination of Default that was served on Dr. Womack in accordance with law. Dr. Womack did not respond to the complaint within 20 days and all facts alleged in the complaint were deemed to have been admitted. Dr. Womack did not file a Motion for Rehearing so the order dated April 7, 2006, was final effective May 22, 2006.

ACTIONS BASED ON INADEQUATE MEDICAL RECORDS:

CRANDALL, DORABUSBY, M.D., NEW BRAUNFELS, TX, Lic. #G5884

On December 9, 2005, the Board and Dr. Crandall entered into a five-year Mediated Agreed Order

requiring Dr. Crandall to complete a course of at least two days in the area of appropriate prescribing of controlled substances; to complete 10 hours of continuing medical education in medical records; and requiring that her practice be monitored by another physician during the term of the order. The action was based on allegations that, with regard to three patients, Dr. Crandall's records were sparse, poorly kept, and did not contain adequate information.

DOTT, KENNETH WAYNE, D.O., IRVING, TX, Lic. #H8008

On February 3, 2006, the Board and Dr. Dott entered into an Agreed Order publicly reprimanding Dr. Dott; assessing an administrative penalty of \$1,000; requiring that Dr. Dott obtain 10 hours of continuing medical education in each of the areas of record keeping/documentation, practice management and the use of controlled substances/pain management; requiring that his practice be monitored by another physician for up to one year; and requiring him to pass the Medical Jurisprudence Examination. The action was based on allegations that, for eight patients, Dr. Dott failed to maintain adequate medical records and/or appropriate documentation of treating for intractable pain.

DUARTE, LUIS E, M.D., SAN ANGELO, TX, Lic. #K2451

On April 7, 2006, the Board and Dr. Duarte entered into an Agreed Order publicly reprimanding Dr. Duarte; requiring him to complete the medical record-keeping course and physician-patient communication course provided by the University of California, San Diego, School of Medicine Physician Assessment and Clinical Education Program; to complete an additional course in record-keeping or risk management of at least 10 hours; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Duarte's documentation failed to provide sufficient information of the continued care he provided to two spinal surgery patients.

**HEINEMANN, JEFFREY JOHN, M.D.,
HOUSTON, TX, Lic. #L0818**

On April 7, 2006, the Board and Dr. Heinemann entered into an Agreed Order requiring Dr. Heinemann to obtain 10 hours of continuing medical education in risk management and record-keeping. The action was based on allegations that Dr. Heinemann failed to maintain an adequate anesthesia medical record for one surgery patient.

**KOPPERSMITH, DANIEL LEONCE, M.D., TIKI
ISLAND, TX, Lic. #H3691**

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

**LONG, JAMES MICHAEL, M.D., WACO, TX, Lic.
#K1753**

On April 7, 2006, the Board and Dr. Long entered into an Agreed Order requiring that Dr. Long refrain from treating or otherwise serving as a physician for his immediate family, prescribing or refilling by telephone or permitting any individual under his supervision or control to prescribe or refill any prescription for narcotics or employing any family members in his medical practice or office; requiring that he maintain adequate medical records and complete 15 hours of continuing medical education in medical records, ethics and appropriate prescribing practices. The action was based Dr. Long's failure to maintain adequate medical records when prescribing to family members.

**LUECKE, JAMES DAVIS, M.D., FORT DAVIS,
TX, Lic. #H4504**

On April 7, 2006, the Board and Dr. Luecke entered into an Agreed Order requiring Dr. Luecke to complete 20 hours of continuing medical education in the areas of record-

keeping and risk management; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Luecke's nurse practitioner failed to document vital signs and physical examination for one patient, that Dr. Luecke failed to document home visitations for one patient, and that his medication log did not reflect the administration of all medications.

**MASSINGILL, GEORGE SEALY, M.D., FORT
WORTH, TX, Lic. #H0609**

On February 3, 2006, the Board and Dr. Massingill entered into an Agreed Order requiring Dr. Massingill to complete a course of at least 10 hours in record-keeping and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Massingill failed to appropriately document and/or ensure that his resident physician documented the occurrences of the delivery of an infant.

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

On December 9, 2005, the Board and Dr. Miller entered into an Agreed Order requiring Dr. Miller to complete a course in pain management of at least 10 hours. The action was based on allegations that Dr. Miller's medical records for one patient did not reflect an adequate treatment plan for management of that patient's pain.

**NAAMAN, ADAM, M.D., HOUSTON, TX, Lic.
#E3591**

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

**NGUYEN, SON KIM, M.D., HOUSTON, TX, Lic.
#G9040**

On December 9, 2005, the Board and Dr. Nguyen entered into a two year Agreed Order requiring that Dr. Nguyen establish and adopt a pain

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management protocol complying with Board Rule 170; that his practice be monitored by another physician; that he obtain 20 hours of continuing medical education in record keeping; and that he pay an administrative penalty of \$5,000. The action was based on allegations that Dr. Nguyen inadequately documented his treatment of one patient and thereby violated Board Rule 170 regarding the treatment of pain with respect to that patient.

**SCHRAPPS, JEROME FRANCIS, M.D.,
BEAUMONT, TX, Lic. #J2907**

On April 7, 2006, the Board and Dr. Schrapps entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Schrapps failed to maintain adequate medical records for two patients.

**SINGH, HARRY PERSAD, M.D., SILSBEE, TX, Lic.
#G1310**

On April 7, 2006, the Board and Dr. Singh entered into an Agreed Order requiring Dr. Singh's practice to be monitored by another physician for one year and requiring him to complete a course of at least eight hours in medical records. The action was based on allegations that Dr. Singh failed to keep adequate medical records due to illegible handwriting and not providing information necessary for patient continuity.

**WILLIAMS, GWENEVERE EVETTE, M.D.,
KINGWOOD, TX, Lic. #H7587**

On April 7, 2006, the Board and Dr. Williams entered into an Agreed Order requiring Dr. Williams to obtain at least 10 additional hours of continuing medical education in the area of risk management, billing or record-keeping; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Williams' medical records lacked sufficient information in relation to the service rendered.

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

On December 9, 2005, the Board and Dr. Zepeda entered into an Agreed Order assessing an

administrative penalty of \$1,000. The action was based on allegations that Dr. Zepeda failed to keep adequate medical records for a number of patients from 2002 through February of 2003.

**ACTIONS BASED ON IMPAIRMENT
INVOLVING DRUGS OR ALCOHOL:**

**CIGARROA, JOSIE ANN, M.D., SAN
ANTONIO, TX, Lic. #F0317**

On February 3, 2006, the Board and Dr. Cigarroa entered into a seven-year Agreed Order limiting Dr. Cigarroa's practice to a group or institutional setting and requiring that she do the following: abstain from the consumption of alcohol or drugs not prescribed by another physician; submit to screening for alcohol and drugs; obtain a complete forensic evaluation from a board-approved psychiatrist and follow any treatment recommendations; continue to participate in the activities of the Bexar County Physicians Rehabilitation Committee; continue to attend two Alcoholics Anonymous meetings and one Caduceus meeting per week; not treat her immediate family; and complete 20 hours of continuing medical education in ethics. The action was based on allegations that Dr. Cigarroa, from January, 2001, to October, 2003, prescribed Adderall, Dexedrine and Concerta to her children and husband, who is also a physician, for treatment of attention deficit disorder, and that during this time period Dr. Cigarroa prescribed the same drugs to herself under alias names of other family members. She voluntarily sought inpatient treatment in November, 2003.

**CONNER, PATRICK TRAVIS, M.D., SPRINGFIELD,
MO, Lic. #G3243**

On April 7, 2006, the Board and Dr. Conner entered into an Agreed Order whereby the Board accepted the voluntary surrender of Dr. Conner's medical license. The action was based on Dr. Conner's disability due to drug addiction and bipolar disorder.

**COTTER, JOHN KERN, M.D.,
SHREVEPORT, LA, Lic. #G5883**

On December 9, 2005, the Board and Dr. Cotter entered into an Agreed Order suspending Dr. Cotter's license until such time as he appears before the Board and provides clear and convincing evidence and information that, in the discretion of the Board, adequately indicates that he is physically, mentally, and otherwise competent to safely practice medicine. The action was based on allegations of Dr. Cotter's substance abuse. Dr. Cotter was arrested and pled guilty to the third degree felony of unlawfully obtaining a controlled substance.

**DEMBERG, JAMES HAROLD, M.D.,
TYLER, TX, Lic. #F3096**

On April 7, 2006, the Board and Dr. Demberg entered into a 10-year Agreed Order requiring Dr. Demberg to abstain from the consumption of prohibited substances, including alcohol; submit to screenings for drugs and alcohol; continue to participate in Alcoholics Anonymous at least five times per week; complete eight hours of continuing medical education in anger management; continue psychotherapy; and limit his medical practice to a group or institutional setting approved by the Executive Director. The order also prohibits him from supervising a physician assistant, advanced practice nurse or surgical assistant. The action was based on Dr. Demberg's admission that he is an alcoholic and on allegations that he was arrested for driving while intoxicated and that his privileges were suspended by the East Texas Medical Center for inappropriate behavior.

**DUNCAN, CHRISTOPHER W., M.D., SAN
ANTONIO, TX, Lic. #G3314**

On April 7, 2006, the Board and Dr. Duncan entered into an Agreed Order suspending Dr. Duncan's license for an additional six months, at a minimum, and until he demonstrates to the Board he is safe and competent to practice medicine, and requires him to abstain from the consumption of drugs and alcohol and to submit to screening for drugs and alcohol as requested by the Board for a period of 15 years

from the date of staying his suspension, if his suspension is stayed by future Board action. The action was based on Dr. Duncan's positive test for cocaine and his admission of relapse on cocaine during the Christmas 2005 holiday.

**GARZA, GUMARO xxx, M.D., EDINBURG, TX, Lic.
#E7943**

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

**JOHNSON, GAIL IRENE, M.D., WICHITA
FALLS, TX, Lic. #G1444**

On February 3, 2006, the Board and Dr. Johnson entered into a three-year Agreed Order publicly reprimanding Dr. Johnson, and requiring that she do the following: obtain a complete forensic evaluation from a board-approved psychiatrist and comply with any recommended treatment; abstain from the consumption of alcohol and drugs not prescribed for a legitimate purpose; submit to drug and alcohol screening; and pay an administrative penalty of \$3,000. The action was based on allegations that Dr. Johnson took a call and went to the hospital after having consumed alcohol and that her speech and behavior at the hospital exhibited signs of intoxication.

**JONES, JAMES STEPHEN, M.D.,
LUBBOCK, TX, Lic. #M1806**

On December 9, 2005, the Board and Dr. Jones entered into an Agreed Order suspending his

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

**KESSELER, RANDALL GENE, D.O.,
SANGER, TX, Lic. #G8212**

On April 7, 2006, the Board and Dr. Kessler entered into an Agreed Order in which Dr. Kessler agreed to the voluntarily suspension of his medical license until such time as he demonstrates to the Board that he is physically, mentally and otherwise competent to practice medicine. The action was based on Dr. Kessler's self-reported chemical dependence and his desire to enter a voluntary suspension of his medical license while seeking treatment.

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

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

**PATT, RICHARD BERNARD, M.D.,
HOUSTON, TX, Lic. #J5440**

On April 6, 2006, a disciplinary panel of the Board temporarily suspended Dr. Patt's medical license following a temporary suspension hearing without notice. The action was based on a finding by the panel that Dr. Patt is a real danger to the health of his patients or to the public due to his impaired status and that there was an imminent peril to the public health, safety, or welfare that required immediate effect of the Order of Temporary Suspension. As findings of fact, the panel also found that Dr. Patt had been suspended from St. Luke's Episcopal Hospital based upon indications that he was impaired in the operating room as reported by nursing staff. A brief physical examination of Dr. Patt revealed what appeared to be needle marks in his antecubital fossae. A drug screen from a urine specimen provided the same day tested positive for amphetamine, methamphetamine, oxazepam and morphine and alcohol, proving he was acting in an intemperate manner that could endanger a patient's life.

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

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

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

On December 9, 2005, the Board and Dr. Sayers entered into an Agreed Order suspending his medical license for a minimum of 24 months and until he demonstrates that he is physically, mentally, and otherwise competent to safely practice medicine. During the period of Dr. Sayers' active suspension he is required to abstain from the consumption of alcohol and drugs

and undergo alcohol and drug screening. The action was based on Dr. Sayers' arrest for possession of cocaine, his plea of guilty for possession of a controlled substance, and subsequent receipt of deferred adjudication.

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

On December 7, 2005, a panel of the Texas Medical Board temporarily suspended Dr. Warr's license after determining that his continuation in the practice of medicine constitutes a continuing threat to the public welfare. The action was based on the finding that Dr. Warr has a mental and/or physical condition that impairs his ability to safely practice medicine, as evidenced by his erratic behavior while employed as a radiologist, self-prescribing of multiple medications, refusal to submit to a physical or psychiatric evaluation, testimony that he was making errors in his work, failure to report to the Board in his renewals of his license his treatment for depression; and his dismissal by his employer. On December 22, 2005, the Board and Dr. Warr entered into an Agreed Order suspending Dr. Warr's license until such time as he demonstrates to the Board that he is competent to safely practice medicine. The action was based on allegations that Dr. Warr has a mental or physical impairment that is affecting his ability to practice medicine.

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

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

ACTIONS BASED ON IMPAIRMENT DUE TO PHYSICAL OR MENTAL CONDITIONS:

BAILEY, SHIRLEY, M.D., RUSK, TX, Lic. #D9330

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

HENSHAW, CLYDE VERNON JR., D.O., FORT WORTH, TX, Lic. #H0446

On April 7, 2006, the Board and Dr. Henshaw entered into an Agreed Order whereby the Board accepted Dr. Henshaw's voluntary and permanent surrender of his medical license. The

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action was based on allegations that Dr. Henshaw failed to meet the standard of care in his treatment of one patient and because Dr. Henshaw has found it difficult to practice medicine with reasonable skill and safety because of illness.

TORRES, ARTURO A., M.D., HOUSTON, TX, Lic. #H2085

On March 24, 2006, a disciplinary panel of the Texas Medical Board entered an Order of Temporary Suspension that temporarily suspended Dr. Torres' medical license, effective immediately. The action was based on a finding by the panel that Dr. Torres' practice of medicine constitutes a continuing threat to the public welfare because of his impaired status or lack of competence.

VON HENNER, CHARLES MASON, M.D., SAN MARCOS, TX, Lic. #C2803

On April 7, 2006, the Board and Dr. Von Henner entered into an Agreed Order whereby Dr. Von Henner voluntarily surrendered his medical license. Dr. Von Henner wished to retire and surrender his medical license as a result of his concern regarding age-related physical changes that could possibly impact the future treatment of his patients.

ACTIONS BASED ON VIOLATIONS OF PROBATION OR PRIOR ORDERS:

BUI, TONY TRUONG, M.D., DALLAS, TX, Lic. #K2314

On February 3, 2006, the Board and Dr. Bui entered into a Mediated Agreed Order publicly reprimanding Dr. Bui and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Bui violated his prior board order by late reporting of unintentional ingestion of alcohol.

BROWN, MICHAEL GLYN, M.D., HOUSTON, TX, Lic. #G3190

On March 1, 2006, the Board revoked Dr. Brown's license. The action followed an Informal Show Compliance Proceeding/

Modification Hearing at which representatives of the Board determined that Dr. Brown had violated the terms of his December 18, 2002, agreed order by testing positive for cocaine, and directed the Executive Director to execute an Order of Revocation pursuant to the mandatory revocation provisions of the December 18, 2002, Order.

KLEIN, IRA, M.D., HOUSTON, TX, Lic. #E3574

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

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

On December 9, 2005, the Board entered a Final Order revoking Dr. Lee's medical license. The action was based on Dr. Lee's failure to respond to a complaint filed with the State Office of Administrative Hearings alleging that she has not complied with the requirements of an agreed order she entered into with the board on April 5, 2002. Dr. Lee did not file a Motion for Rehearing; therefore, the order was final effective February 6, 2006.

RANELLE, JOHN B., D.O., HARLINGEN, TX, Lic. #E9349

On April 5, 2006, the Board, acting through its Executive Director, entered an order suspending Dr. Ranelle's medical license for at least 60 days, at which time he must personally appear before the Board and provide a practice plan before the suspension may be lifted. The action was based on Dr. Ranelle's admission that he signed another physician's name on patient charts at the request of Wellcare Clinic administrators for purposes of billing the Texas Workers Compensation Commission, thereby violating the terms of his December 1, 2003, agreed order. That agreed order required Dr. Ranelle to

Easy Ways to Avoid Disciplinary Actions

Last issue, the Medical Board Bulletin provided some common violations that can lead to an administrative penalty or other disciplinary action. Another issue of concern is prescribing to family members. Chapter 190 of the Board Rules provides the following grounds for disciplinary action based on such prescribing.

§190.8 Violation Guidelines

“When substantiated by credible evidence, the following acts, practices, and conduct are considered to be violations of the Act...

“(M) inappropriate prescription of dangerous drugs or controlled substances to oneself, family members, or others in which there is a close personal relationship that would include the following:

(i) prescribing or administering dangerous drugs or controlled substances without taking an adequate history, performing a proper physical examination, and creating and maintaining adequate records; and

(ii) prescribing controlled substances in the absence of immediate need. “Immediate need” shall be considered no more than 72 hours.”

See the full Chapter 198, Disciplinary Guidelines, at <http://www.tmb.state.tx.us/rules/rules/190.php#190.8>

CLARIFICATION

An item in the Fall 2005 issue of the *Medical Board Bulletin* stated: “Board Rule 165 requires physicians to provide properly requested patient records within 15 business days. Proper charges may be billed, but send the records along with the bill; don’t wait for payment.”

Chapter 165 of the Board Rules states: “(b) Deadline for Release of Records. The requested copies of medical and/or billing records or a summary or narrative of the records shall be furnished by the physician within 15 business days after the date of receipt of the request and reasonable fees for furnishing the information.”

Although waiting for payment is permitted, sending the records prior to receipt of payments was intended as a suggestion. ♦

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comply with all of the provisions of the Medical Practice Act and other applicable provisions of law.

SHARY, JOHN H. III, M.D., PLAINVIEW, TX, Lic. #E8903

The Board suspended Dr. Shary’s medical license on March 14, 2006. The suspension is effective until Dr. Shary appears before the Board and demonstrates that he is safe and competent to practice medicine and is authorized to do so by subsequent order of the Board. The action was based on Dr. Shary’s failure to cooperate with the Board in providing observed specimens for drug testing and for refusing to provide further specimens as required by the agreed order entered into by the Board and Dr. Shary on August 28, 1999. The 1999 order followed two

prior suspensions of Dr. Shary, in 1996 and 1998, for cocaine and alcohol use.

YILMAZ, SALIH MEHMET, M.D., NAVASOTA, TX, Lic. #E8237

On January 31, 2006, pursuant to an order entered by its Executive Director, the Board suspended Dr. Yilmaz’s medical license until such time as he passes the Special Purpose Examination (SPEX) and appears before the Board to demonstrate that he is competent to safely practice in Texas. The action was based on Dr. Yilmaz’s failure to pass SPEX as required by his board order dated October 8, 2004.

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ACTIONS BASED ON OTHER STATE BOARD ACTIONS:

**BURKS, WILLIAM RANDOLPH, M.D.,
MARGATE, FL, Lic. #F9257**

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

**CHANDRAN, RANGRAM, M.D.,
MODESTO, CA, Lic. #L2180**

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

**DILSAVER, STEVEN CHARLES, M.D.,
MERCED, CA, Lic. #J3272**

On April 7, 2006, the Board and Dr. Dilsaver entered into an Agreed Order suspending Dr. Dilsaver's medical license until such time as he demonstrates that he has a clear and unconditioned license to practice in California and that he is physically, mentally and otherwise competent to practice medicine. The action was based on the action of the Medical Board of California in placing Dr. Dilsaver on probation relating to his informing that Board that he had bipolar disorder, which has since been diagnosed as being in remission.

**KEH, MILAGROS SY, M.D., AMERICUS, GA, Lic.
#E9735**

On February 3, 2006, the Board and Dr. Keh entered into an Agreed Order requiring her to comply with the terms of a public consent order with the Composite State Board of Medical Examiners of Georgia and subjecting

her to the same terms and conditions as required by the Georgia Board if she returns to practice in Texas before the termination of that order. The action was based on the action of the Georgia Board in placing Dr. Keh on probation for three years under terms and conditions for not properly documenting reasons for prescribing narcotics and inappropriately prescribing narcotics.

**KULUBYA, EDWIN S., M.D., LAREDO, TX, Lic.
#L1100**

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

**JALFON, ISAAC MITRANI, M.D., MEMPHIS, TN,
Lic. #H1885**

On April 7, 2006, the Board and Dr. Jalfon entered into an Agreed Order requiring Dr. Jalfon to appear before the Board before practicing medicine in Texas. The action was based on the action of the Tennessee Board of Medical Examiners placing Dr. Jalfon's license on probation for two years for a self-reported substance abuse problem. Dr. Jalfon practices in Tennessee.

**MEHARRY, LEROY IRWIN, M.D., UMATILLA, OR,
Lic. #F4955**

On April 7, 2006, the Board and Dr. Meharry entered into an Agreed Order publicly reprimanding Dr. Meharry and requiring him to comply with all terms and conditions imposed by an order of the Oregon Board of Medical Examiners. The action was based on the action of the Oregon Board in disciplining Dr. Meharry for issues relating to prescribing and dispensing of controlled substances to staff and

family members without proper documentation and controls.

**NEEDLEMAN, LOUIS J., M.D., CORPUS
CHRISTI, TX, Lic. #J1547**

On November 30, 2005, the Board and Dr. Needleman entered into an Agreed Order requiring Dr. Needleman to complete 25 hours of courses in ethics and to pay an administrative penalty of \$1,000. The action was based on the action of the Massachusetts State Board of Medicine in entering into a consent agreement with Dr. Needleman that contained a reprimand and assessed a \$5,000 fine for failing to respond to inquiries for additional information relating to his registration renewal.

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

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

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

On December 9, 2005, the Board and Dr. Routh entered into a five-year Agreed Order publicly reprimanding Dr. Routh and requiring her to obtain an additional 50 hours of continuing medical education per year divided among the areas of physician/patient relationships, ethics and record keeping, and that she pay an administrative penalty of \$5,000. The Agreed Order additionally requires Dr. Routh's practice to be monitored by another physician if she changes her area of practice from neuro-imaging to another area of practice. The action was based on disciplinary action taken against Dr. Routh by the Alaska Medical Board relating to allegations of unprofessional conduct by the

submission of false or misleading information to the Alaska board; failure to maintain adequate medical records; and violating a regulation of the Alaska board by entering into a dual (financial) relationship with a patient. Dr. Routh reached an agreement with the Alaska board that the allegations would be dismissed if she agreed not to ever reapply for an Alaska license (which had lapsed) and to pay a fine of \$10,000.

**SHIPPEL, ALLAN HENDLEY, M.D.,
ROSWELL, GA, Lic. #G6613**

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

**ACTIONS BASED ON CRIMINAL CON-
VICTIONS:**

**GOTTLIEB, LEWIS RAVENET, M.D.,
SPRING, TX, Lic. #G8538**

On December 9, 2005, the Board entered a Final Order revoking Dr. Gottlieb's medical license. The action was based on Dr. Gottlieb's failure to respond to a complaint filed with the State Office of Administrative Hearings alleging that he was convicted of conspiracy to commit health care fraud on April 1, 2004. Dr. Gottlieb did not file a motion for rehearing; therefore, the order was final January 24, 2006.

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HARRIS, PAUL P., M.D., SUGARLAND, TX, Lic. #J9776

On April 7, 2006, the Board and Dr. Harris entered into an Agreed Order accepting the voluntary surrender of Dr. Harris' medical license and requiring him to cease the practice of medicine as of March 9, 2006. The action was based on Dr. Harris' request that the voluntary surrender of his medical license be accepted by the Board.

PLATT, THOMAS CARROLL, M.D., DEXTER, MI, Lic. #K9872

On April 7, 2006, the Board and Dr. Platt entered into an Agreed Order accepting the voluntary and permanent surrender of Dr. Platt's medical license. The action was based on Dr. Platt's plea of guilty to a final conviction for a felony, committed in Michigan, involving possession of pornography.

WOODS, RONALD ALFRED JR., M.D., SHERMAN, TX, Lic. #H4808

On April 7, 2006, the Board and Dr. Woods entered into a five-year Agreed Order publicly reprimanding Dr. Woods and requiring him to be evaluated by a Board-appointed psychiatrist; to follow any continued care recommendations and to have any continued treatment and care monitored by the psychiatrist; to continue counseling as directed by 336th District Court of Grayson County; to keep a log of community service as required by the court; to comply with all other terms and conditions of his court-ordered probation; to have a chaperone, or parent or legal guardian, present in the examination room any time he examines a patient 18 years of age or younger; to attend at least 25 hours per year of continuing medical education in ethics, risk management and maintaining proper boundaries; and assessing an administrative penalty of \$5,000. The action was based on an Order of Deferred Adjudication; Community Supervision from the 336th District Court for the offense of obscenity, a felony. The order resulted from an incident in which Dr. Woods videotaped his 11 year-old daughter and two of her friends playing and dancing in the

nude and performing excretory functions at his home.

ACTION BASED ON PEER REVIEW ACTIONS:

LORENTZ, RICK GENE, M.D., SPRING, TX, Lic. #J2169

On February 3, 2006, the Board entered a Final Order suspending Dr. Lorentz's license, immediately staying the suspension and placing him on probation for three years under the following terms and conditions: that Dr. Lorentz shall demonstrate strict compliance with all staff bylaws and regulations at all facilities at which he has or obtains clinical privileges; that he obtain a complete forensic evaluation from a Board-approved psychiatrist and follow recommendations for treatment; that he have his practice monitored by another physician; that he obtain 10 hours of ethics courses and 20 hours of risk management courses; that he complete the course in the area of medical malpractice, risk management and communication sponsored by the Oregon Medical Association; and that he pay an administrative penalty of \$40,000. The action was based on findings by an Administrative Law Judge of the Texas State Office of Administrative Hearings that two hospitals had disciplined Dr. Lorentz as the result of formal peer review actions. Dr. Lorentz did not file a Motion for Rehearing; therefore, the order was final March 6, 2006

MAEWAL, HRISHI KESH, M.D., FORT WORTH, TX, Lic. #E7175

On April 7, 2006, the Board and Dr. Maewal entered into an Agreed Order restricting Dr. Maewal's license for three years under the following terms and conditions: Dr. Maewal is not to perform interventional cardiac procedures until he has completed a period of training in interventional cardiology to consist of a minimum of 100 proctored cases with a proctor approved by the Executive Director. The order also requires Dr. Maewal to obtain at least 50 hours of continuing medical education in the area of invasive cardiology. The action

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was based on the action of the board of trustees for Plaza Medical Center in Fort Worth in suspending Dr. Maewal's interventional cardiac catheterization privileges based on the care of two patients.

**NEPPER, LEONARD GAYLON, D.O.,
BROWNWOOD, TX, Lic. #J9240**

On April 7, 2006, the Board and Dr. Nepper entered into a Mediated Agreed Order requiring Dr. Nepper to pay an administrative penalty of \$3,000 and to complete continuing medical education in the areas of boundaries, ethics, and record-keeping. The action was based on action taken against Dr. Nepper by Brownwood Regional Medical Center for an alleged violation of the Medical Center's personnel policies. Dr. Nepper denies the underlying allegations, but entered into this order in lieu of litigation.

VOLUNTARY SURRENDERS:

ATLAS, JOE, M.D., HOUSTON, TX, Lic. #C1799

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

**CORONEOS, EMMANUEL, M.D.,
PITTSBURGH, PA, Lic. #J9649**

On February 3, 2006, the Board and Dr. Coroneos entered into an Agreed Order accepting the voluntary surrender of Dr. Coroneos' license. The action was based on Dr. Coroneos' desire to not respond in Texas to an action taken by the West Virginia Board of Medicine relating to medical record documentation issues, as he does not intend to return to Texas to practice.

**OLOFSSON, SHATHA M., M.D., CORPUS
CHRISTI, TX, Lic. #J2459**

On December 9, 2005, the Board and Dr. Olofsson entered into an Agreed Order accepting the voluntary surrender of Dr. Olofsson's medical license. The action was based

on Dr. Olofsson's desire to surrender her license because of her continued physical disability.

**PATE, ROBERT JOYCE, M.D., MISSION, TX, Lic.
#D5585**

On February 3, 2006, the Board and Dr. Pate entered into an Agreed Order whereby the Board accepted the voluntary and permanent surrender of Dr. Pate's medical license. The action was based on Dr. Pate's desire to surrender his license due to medical conditions that leave him unable to continue in the practice of medicine.

**SEIDEL, CLIFFORD CHARLES, M.D.,
DALLAS, TX, Lic. #C1355**

On December 9, 2005, the Board and Dr. Seidel entered into an Agreed Order whereby Dr. Seidel, who is 82 years of age, voluntarily surrendered his medical license.

**TRIPLETT, RICHARD DANIEL, M.D.,
SPRING, TX, Lic. #J3251**

On December 9, 2005, the Board and Dr. Triplett entered into an Agreed Order accepting the voluntary surrender of his medical license. Dr. Triplett's license was suspended by an agreed order with the Board in 2001 and he has not practiced since that time. He now wishes to surrender his license because he is physically unable to satisfactorily practice medicine.

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

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

MINIMAL STATUTORY VIOLATIONS:

The following licensees agreed to enter into orders with the Board for minimal statutory violations such as failure to send medical records within 15 business days or failure to complete required continuing medical education.

Aldape, Adolfo Alejandro, M.D., Laredo, TX, Lic. #K9971

Adams, Phillip Reese, M.D., Houston, TX, Lic. #E6201

Al-Shalchi, Najah Muhamad, M.D., San Antonio, TX, Lic. #G1809

Alexander, Bill, M.D., Eagle Pass, TX, Lic. #D4009

Cabansag, Remedios Rosario, M.D., Fort Worth, TX, Lic. #D9958

Cantu, George, M.D., Raymondville, Tx, Lic. #J5271

Chavez, Armando, M.D., Houston, TX, Lic. #J8487

Clayton, Gary Randall, M.D., Beaumont, TX, Lic. #H5430

Cross, Cartrell James, M.D., Houston, TX, Lic. #E0869

Gardner, James Francis III, M.D., San Antonio, TX, Lic. #G3382

Harris, Cynthia Ellis, M.D., Austin, TX, Lic. #H8934

Janjua, Aamer Wali, M.D., Beaumont, TX, Lic. #L8385

Kuri, Jose A., M.D., Brownsville, TX, Lic. #E3723

Leahey, Edward William, M.D., Baytown, TX, Lic. #E9763

Orzeck, Eric A., M.D., Houston, TX, Lic. #D6513

Polinger, Iris Sandra, M.D., Stafford, TX, Lic. #E8117

Pucek, Mark Douglass, M.D., Dickinson, TX, Lic. #G3707

Roefler, Glenda Sue, D.O., Corpus Christi, TX, Lic. #L6606

Rose, Dennis Eric, M.D., Port Arthur, TX, Lic. #G8966

Saifee, Nafees Fatima, M.D., Fort Worth, TX, Lic. #E3762

Tarkenton, Tom Allen, D.O., Mineral Wells, TX, Lic. #J4552

Zaks, Alexander, M.D., Sherman Oaks, Ca, Lic. #L9969

Physician Assistants

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

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

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

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

2006 Board Meetings

Medical Board	Acupuncture Board	PA Board
August 24-25 October 5-6 December 7-8	July 14 October 27	July 28 November 3

2007 Board Meetings

February 15-16 April 12-13 June 7-8 August 23-24 October 4-5 November 29-30	March 2 May 18 July 27 November 9	February 2 May 4 July 13 October 26
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Physicians Should Be Aware of Reporting Requirements

In Texas, there are several laws that determine which diseases must be reported, as well as the method and timeline for reporting them and the penalty for the failure to report. The majority of these laws are found in the Texas Health and Safety Code, specifically in chapters 81, 84, 88, 89, and 92. (HIPAA allows sharing of medical information when it is required by state law or for a public health purpose, and citations are available upon request to the Texas Department of State Health Services.)

The Texas Department of State Health Services web site offers a convenient link, which can be found by visiting the Infectious Disease Control Unit's home page at <http://www.dshs.state.tx.us/idcu/default.asp> and clicking on the link "Disease Reporting," which is found on the left-hand sidebar.

The list of reportable conditions can also be found under the same link. The diseases are too numerous to list here, but include AIDS, Anthrax, Botulism, Brucellosis, Cancer, Chicken Pox, Dengue, Diphtheria, E Coli, Listeriosis, Tuberculosis, and various sexually transmitted diseases. In addition to these conditions, any **outbreaks, exotic diseases, and unusual group expressions of disease** must be reported. All diseases shall be reported by name, age, sex, race/ethnicity, DOB, address, telephone number, disease, date of onset, method of diagnosis, and name, address, and telephone number of physician. Your reports are important to following disease in Texas and in triggering public health investigations when indicated.

Each disease has its own timeline for reporting, which are found in the same table. Health care providers, hospitals, laboratories, schools, and others are all required to report individuals who are suspected of having one of the notifiable conditions. (Per Title 25, Texas Administrative Code, Chapters 37, 91, 97, 99, and 103)

Fortunately, it is quite easy to file these reports, and there are a variety of ways to do so. Most notifiable conditions, or other illnesses that may be of public health significance, should be reported directly to your local health department or to the state. Paper reporting forms can be obtained by calling your local or health service region or by download from the above web site. If necessary, reports can be made by telephone to the state office at (800) 252-8239 or (512) 458-7111. After hours, calls received will be routed to the physician/epidemiologist-on-call. ♦

E.D., continued from page 2

accountable for the treatment of their patients has reached new highs, creating a deterrent for those practitioners who violate the Medical Practice Act. So, where is the bad news in this story? If there is a downside it is that the resources of the agency are stressed. Data for the most recent quarterly report shows that the time to review and approve a licensure application has now increased to 95 days. This delay affects physicians, their employers, and the public, especially people in communities that are medically underserved. The increased vigilance in public protection has also strained resources in the areas of investigations and litigation. While the agency's ability to provide services in required or expected time frames is threatened, the public and the profession can be assured that quality will not be sacrificed. ♦

Rules, continued from page 17

of disciplinary actions based on criminal actions and identification of administrative violations.

Chapter 193, Standing Delegation Orders

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

The full board rules may be viewed and/or downloaded from the TMB web site at http://www.tmb.state.tx.us/rules/rules/bdrules_toc.php ♦

Notice of Address Change

(Please type or print, except for signature)

Name _____

License or Permit Number _____

Signature _____

(required for licensees and permit holders)

Mailing Address:

Street _____

City, State _____ Zip Code _____

Practice Address _____

Street _____

City, State _____ Zip Code _____

Licensees and Permit holders mail to:

Texas Medical Board

MC-241

P.O. Box 2018

Austin TX 78768-2018

Fax: (512) 305-7009 (Attention: Permits)

Non-licensees mail to:

Texas Medical Board

MC-251

P.O. Box 2018

Austin TX 78768-2018

Fax: (512) 305-7051 (Attention: Public Information)

Have You Changed Your Address?

The Board needs to be informed so that licensees receive renewal notices and other communications.

Complete and return the form above any time you change your address.

(Non-licensees may also report address changes with this form.)

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