

# TEXAS MEDICAL BOARD

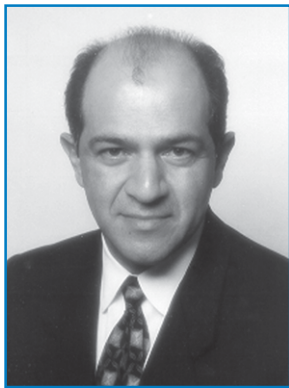
## Bulletin

The Newsletter of the Texas Medical Board

### Governor Appoints New Board Members

Governor Rick Perry has appointed Michael Arambula, M.D., Pharm. D., to the board.

Dr. Arambula is a San Antonio physician. He received a Doctor of Pharmacy from the University of Texas at Austin and his medical degree from the University of Texas Health Science Center at San Antonio, where he completed his residency in psychiatry. He has fellowship training in forensic psychiatry from Rush Medical College in Chicago and is board certified in general psychiatry



Dr. Arambula

and forensic psychiatry. Dr. Arambula is a clinical associate professor of psychiatry at the University of Texas Health Science Center at San Antonio, a member of the American Psychiatric Association Task Force to Revise the Ethics Annotations, and an Associate Editor for the *Journal of the American Academy of Psychiatry and Law*. He

is also a member of the American Medical Association, the Texas Medical Association, the Bexar County Medical Society, the Texas Society of Psychiatric Physicians, the Bexar County Psychiatric Society, and the American Society of Law, Medicine and Ethics.



Drs. Kalafut and Pascua-Lim

Dr. Arambula replaces Elvira Pascua-Lim, M.D., of Lubbock, who resigned from the board. At her last board meeting on October 6, Board President Roberta Kalafut, D.O., presented Dr. Pascua-Lim with a plaque expressing the board's gratitude for her service.

As this issue went to press, Governor Perry appointed Melinda McMichael, M.D., and Timothy Webb,

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### Dr. Fred Honored by Federation of State Medical Boards

Herbert L. Fred, M.D., M.A.C.P., Professor, Department of Internal Medicine, The University of Texas Health Science Center at Houston, wrote an article for the Fall 2004 issue of the *Medical Board Bulletin*, "The Sagging of Medical Professionalism." The article also appeared in the *Journal of Medical Licensure and Discipline*, Volume 92, No. 1.

The Federation of State Medical Boards honored Dr. Fred with the Award for Excellence in Editorial Writing at its annual meeting in San Francisco May 5. See page 2 for more on Dr. Fred. ♦

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# FROM THE EXECUTIVE DIRECTOR

## Herb Fred: Teaching at the Speed of Sound

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

Starting an IV on a head-injured patient early one morning, I heard loud voices in the otherwise sepulchral neurosurgery ward where I was chief resident. I threaded the needle into place, pulled the pre-cut tape off the sheets, secured the hub, and looked up. A throng of white-coated internal medicine residents hove into view, trailing an animated man scurrying at a near-lope toward our isolation ward.

The leader, identified by his shin-length white coat as an attending, stopped suddenly and swung around, his hand in the air. He was nearly mobbed by the crowd piling into one another to avoid hitting him. He snatched the chart off an adjacent bedside table and held it high, gesturing and speaking rapidly and precisely. I had never seen an attending in virtually any specialty in the wee hours of the morning at Ben Taub, let alone one with such a flair for the dramatic. So, knowing that this was probably my one opportunity to view this phenomenon, I edged closer.

The attending turned to the resident who was in charge of the patient and asked, “Well?” The resident began haltingly, obviously intimidated, reciting the mantra of a fairly familiar history.

“This man was brought in stuporous by his family, or someone, placed on a stretcher in the ER and abandoned.”

“OK,” the attending said, then asked, “What happened after that?”

The resident continued, “He was initially thought to be a drunk, because it was payday Friday night, and he wouldn’t respond to any questions. On painful stimulation, he moved his arms appropriately, his pupils were OK, vital signs normal except for a 105 degree rectal temp. His neck was rigid, so we thought. . . .”

“Differential diagnosis?” asked the attending.  
“Intracranial bleed or meningitis, Dr. Fred.”

At last! I was about to meet the famous Dr. Herb Fred – Rice-Hopkins-Utah, Wintrobe-trained internist, intellectual, dynamic teacher, leader, and motivator! I eased a little closer. Dr. Fred led the resident through the differential diagnosis – what kind of intracranial bleed? What form of meningitis? How do you distinguish one from the other? Is it dangerous to do a spinal tap on an unconscious patient with a stiff neck? Why? Why not?

When he had pumped that resident dry, he turned to another, then another, leading them through the history, physical exam, the gamut of diagnostic tests, differential diagnoses – and how you would distinguish one from another - and the various forms of treatment each would require. It was a classic lecture, performed at the bedside using the Socratic method, delivered by a true master at 2 o’clock in the morning. I listened to the dialogue, fascinated by Dr. Fred’s intensity, his precision, and his bringing out the best in his residents – at Mach I speed.

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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 2006 issue of the *Medical Board Bulletin*, the Board has taken disciplinary action on 114 physicians. The following is a summary of those actions.

## QUALITY OF CARE VIOLATIONS

**ANDELMAN, ROBERT PAUL, M.D., PORTLAND, TX, Lic. #K3669**

On December 8, 2006, the Board and Dr. Andelman entered into an Agreed Order requiring that he complete additional continuing medical education in treatment of sepsis, surgical emergencies and radiological studies, and assessing an administrative penalty of \$500. The action was based on allegations that Dr. Andelman failed to meet the standard of care in the treatment of two patients in the emergency room in 1999 and 2003, respectively.

**BERTSCH, NANCY MARIE, M.D., COLLEGE STATION, TX, Lic. #J6334**

On February 16, 2007, the Board and Dr. Bertsch entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Bertsch failed to meet the standard of care because she did not recognize fetal intolerance of labor and nonreassuring fetal status and allowed labor to continue despite a markedly abnormal fetal monitor strip. Mitigating factors were that Dr. Bertsch subsequently completed additional continuing medical education in fetal monitoring, has reviewed the case with her peers at Scott and White, and that the Scott and White setting provides a controlled environment which allows for easy and encouraged consultation of peers.

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## Non-Disciplinary, Non-Public Rehabilitation Orders

*by Robert Simpson, TMB General Counsel*

The Texas Medical Practice Act authorizes the Texas Medical Board to issue rehabilitation orders. A physician may be placed under a rehabilitation order in certain cases of substance abuse or mental or physical impairment. The rehabilitation order is not a disciplinary action of the board. It is intended to foster healing rather than administering punishment or deterrence. In addition to being non-disciplinary, a rehabilitation order is confidential and not subject to disclosure under the Public Information Act.

The purpose of a rehabilitation order is to encourage physicians to report substance abuse and mental and physical impairment to the Board. This increases the Board's awareness of these cases so that the Board can take necessary action to protect the public. A rehabilitation order also allows the physician to receive proper

treatment for the condition without the stigma that may come from public disclosure. As a condition of a non-public rehabilitation order, the Board typically requires that the person obtain treatment. This may include psychiatric therapy, participation in a program such as Alcoholics Anonymous, or medical treatment. These requirements are calculated to lead to recovery or, at least, assure that the impairment is under control.

To issue a nondisciplinary, non-public rehabilitation order, the Medical Practice Act requires the Board to find that one of several situations occurs. If impairment is caused by dependence on or abuse of drugs or alcohol, the statute requires that the Board find that abuse has been caused by medical treatment provided by another physician or that the physician has self-reported the drug or alcohol abuse. If the person has previously

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**DESHAN, PRESTON W., M.D., LEVELLAND, TX, Lic. #D2211**

On April 13, 2007, the Board and Dr. Deshan entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of orthopedics and medical records and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Deshan should have performed follow-up imaging before discharging a patient with a possible hip fracture, instead of relying on his reading of poor quality x-rays.

**EICHELBERGER, PHILIP THEODRIC, M.D., BAYTOWN, TX, Lic. #C6308**

On April 13, 2007, the Board and Dr. Eichelberger entered into a five-year Mediated Agreed Order prohibiting him from prescribing, administering or possessing any anorectic or amphetamine-like action drugs; limiting his prescribing of benzodiazepines and narcotics and requiring reevaluation before prescribing or refilling certain benzodiazepines and narcotics; prohibiting him from treating his immediate family; requiring that his practice be monitored by another physician, that he complete courses on dangerous drugs and in medical records and risk management and/or ethics; and assessing an administrative penalty of \$750. The action was based on allegations that Dr. Eichelberger failed to meet the standard of care in treating two patients when he prescribed medication for weight-loss, anxiety and low back pain without appropriate medical justification and treated a family member without maintaining medical records justifying prescribing controlled substances.

**FORD, RYAN DEAN, M.D., ALBANY, TX, Lic. #L5335**

On February 16, 2007, the Board and Dr. Ford entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of administration of antibiotics and the treatment of infectious diseases and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Ford failed to meet the standard of care in treating one patient with Gentamicin by not monitoring the patient's serum levels of Gentamicin while she was receiving the medication.

**FRANKUM, WILBUR MAX, M.D., FRISCO, TX, Lic.#H5552**

On April 13, 2007, the Board and Dr. Frankum entered into an Agreed Order requiring that he complete additional continuing medical education in infectious disease and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Frankum failed to consider a central nervous system infection as part of his differential diagnosis of a patient in the emergency room.

**GIOIA, ANTHONY ERIC, M.D., DALLAS, TX, Lic. #G9102**

On December 8, 2006, the Board and Dr. Gioia entered into an Agreed Order publicly reprimanding Dr. Gioia, requiring that he complete additional continuing medical education in the area of risk management, and assessing an administrative penalty of \$12,500. The action was based on allegations that Dr. Gioia violated the standard of care by performing wrong-site spine surgery on three patients, one in 1999 and two in 2004.

**HARRON, RAYMOND ANTHONY, M.D., LA MARQUE, TX, Lic. #C9439**

On April 13, 2007, the Board and Dr. Harron entered into an Agreed Order pursuant to which Dr. Harron agreed not to practice medicine in the period before his medical license expires, not to renew his medical license after it expires and not to petition the Board for reinstatement or reissuance of his license. The action was based on allegations related to silica/silicosis litigation and Dr. Harron's determination and signature on x-ray findings of silicosis for numerous silicosis plaintiffs.

**HELDRIDGE, TOD CHARLES, M.D., BEDFORD, TX, Lic. #G8175**

On December 8, 2006, the Board and Dr. Heldridge entered into an Agreed Order requiring that his practice be monitored by another physician for one year, that he complete additional continuing medical education in the areas of cardiac care or critical care and risk management, and assessing an administrative penalty of \$2,500. The action was based on allegations that in 1999 Dr. Heldridge failed to appropriately diagnose a patient presenting with chest and back pain.

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## Governor Appoints Richard Rahr to Physician Assistant Board

Governor Rick Perry appointed Richard R. Rahr, Ed.D., P.A., of Texas City, to the Texas Physician Assistant Board for a term to expire February 1, 2011.

Mr. Rahr is the Dibrell Family Professor at the University of Texas Medical Branch, where he also chairs the department of physician assistant studies. He is a member of the Physician Assistant Education Association, the Texas and American Academies



Richard R. Rahr, Ed.D., P.A.

of Physician Assistants and Pi Alpha, the physician assistant National Honor Society. He is a recipient of the Faculty Excellence Award and the Outstanding Teacher award from the School of Allied Health Sciences.

Mr. Rahr received a bachelor's degree in biological sciences at the University of Texas at Austin, where he participated in the ROTC program. He also received a bachelor's degree from the University of Texas Medical Branch at Galveston, a master's degree from the University of Houston at Clear Lake and a doctoral degree from the University of Houston. ♦

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### INGRAM, ALICE, M.D., SPRING, TX, Lic #K9085

On February 16, 2007, the Board and Dr. Ingram entered into an Agreed Order requiring that she not return to practice until passing the Special Purpose Examination; and that for a period of three years after returning to practice she not resume an obstetrics practice without completing an obstetrics/gynecology mini-residency and complying with additional terms and conditions. The Agreed Order also required that Dr. Ingram complete additional continuing medical education in the area of risk management, and assessed an administrative penalty of \$3,000. The action was based on allegations that Dr. Ingram incorrectly calculated a delivery date for one patient, resulting in an elective C-section, and administered an incorrect dose of methotrexate for a possible ectopic pregnancy in a second patient, who became ill but recovered.

### KOLI, MALATHI VIJAY, M.D., SAN ANTONIO, TX, Lic. #G0624

On December 8, 2006, the Board and Dr. Koli entered into an Agreed Order requiring that his practice be monitored by another physician for one year and that he complete additional continuing medical education in the areas of psychopharmacology and medical records. The action was based on allegations that Dr. Koli prescribed multiple medications for one patient in a manner that created the possibility for drug interactions or for a delirium and did not appropriately document his reasons for the many medication changes.

### KORNELL, BERNARD D., M.D., DUNCANVILLE, TX, Lic. #F2308

On April 13, 2007, the Board and Dr. Kornell entered into an Agreed Order requiring that, for a period of three years, he must ask every female patient if she would prefer a chaperone in the room and to document that the request was made and how it was answered; that any time he performs a full body skin examination or examination of potentially sensitive areas for female patients he must explain the patient's right to decline the examination, and if the patient does not decline, a chaperone must be present; further requiring that Dr. Kornell successfully complete the patient communication course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, or an approved equivalent program; that he complete additional continuing medical education in the areas of medical records; and assessing an administrative penalty of \$3,000. The action was based on allegations that, while Dr. Kornell's full routine comprehensive examination of a female patient's skin was medically appropriate, it was not appropriate for him to conduct the examination when the patient was clearly not comfortable, to comment upon her attractiveness or to conduct a routine comprehensive examination of her skin without a chaperone present and, additionally, on allegations that Dr. Kornell's medical records for another patient were severely inadequate.

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**LIAO, DAVID YING-CHIE, D.O., HEATH, TX, Lic. #K4485**

On December 8, 2006, the Board and Dr. Liao entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of medical records and risk management. The action was based on allegations that Dr. Liao operated on the wrong joint of a patient's finger, though both joints of the finger were affected with severe degenerative joint disease and Dr. Liao believed, as a mitigating factor, that he had obtained consent from the patient to operate on that joint.

**LIM, JAIME CHUNG, M.D., WICHITA FALLS, TX, Lic. #G9147**

On December 8, 2006, the Board and Dr. Lim entered into an Agreed Order extending the term of his existing order by one year and prohibiting him from admitting patients to a nursing home. The action was based on allegations that Dr. Lim failed to timely diagnose post-operative problems of one patient and failed to adequately document his care and treatment of three other patients.

**MACK, SUZANNE EILEEN, M.D., DENTON, TX, Lic. #J3540**

On February 16, 2007, the Board and Dr. Mack entered into a five-year Agreed Order limiting her controlled substance prescribing authority to non-narcotic medications in schedules III, IV and V; requiring that her practice be monitored by another physician; and requiring that she complete additional continuing medical education in the areas of ethics and medical records. Additionally, the Agreed Order prohibits Dr. Mack from practicing pain management or treating chronic pain patients indefinitely, unless and until she appears before the Board and demonstrates she is qualified and safe to practice in this area. The action was based on allegations that Dr. Mack failed to meet the standard of care in treating five patients for pain management.

**MAHAFFEY, ANDREW GLENN, M.D., GEORGETOWN, TX, Lic.#G5326**

On April 13, 2007, the Board and Dr. Mahaffey entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Mahaffey prescribed Dostinex

therapy at seven times the usual starting dose. Mitigating factors were that Dr. Mahaffey admitted his mistake to the patient and has taken steps to avoid future similar incidents, including completing additional continuing medical education, and that there was no patient harm.

**MASSEY, WARNER BARRON, M.D., GRAND SALINE, TX, Lic. #D6084**

On February 16, 2007, the Board and Dr. Massey entered into a three-year Agreed Order requiring that he have an office management audit and implement recommended changes; that his practice be monitored by another physician; that he maintain adequate medical records using a dictation/transcription procedure and maintain a logbook of all prescriptions; that he not prescribe, dispense or administer to his family; that he prescribe, dispense or administer parenteral pain medications only to hospital patients; and that he complete in each year of the order additional continuing medical education in treatment of medical complaints seen in family practice. The action was based on allegations that, for one patient, Dr. Massey failed to document basic information, including a history and physical, and treated the patient with in excess of 50 narcotic pain medication injections for headaches.

**OLIVA, DAMASO ANDRES, M.D., SAN ANTONIO, TX, Lic. #K0968**

On December 8, 2006, the Board and Dr. Oliva entered into an Agreed Order requiring that his practice be monitored by another physician for one year, and that he complete additional continuing medical education in the areas of medical records and recognizing and treating drug addiction in the psychiatric patient. The action was based on allegations that Dr. Oliva failed to quickly recognize drug-seeking behavior in one patient and treat the patient accordingly, and failed to adequately document the treatment provided to the patient.

**PURYEAR, BILLY HOUSTON, D.O., FORT WORTH, TX, Lic. #D6314**

On April 13, 2007, the Board and Dr. Puryear entered into a Mediated Agreed Order restricting his license for five years under terms and conditions

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requiring that he have his controlled substances certificates modified to eliminate Schedules II and III; limiting his prescribing of benzodiazepines and requiring reevaluation before prescribing or refilling certain benzodiazepines and narcotics; prohibiting him from prescribing, administering or possessing any anorectic or amphetamine-like action drugs; requiring that his practice be monitored by another physician; that he pass the Medical Jurisprudence Examination within one year; that he complete courses in risk management, record keeping, treatment of hypertension and/or pediatrics each year of the order; and that the Board is to determine prior to the end of the order whether Dr. Puryear is competent to safely practice medicine without restriction. The action was based on allegations that Dr. Puryear failed to meet the standard of care in 11 patients for one or more of the following reasons: inadequate histories and physical examinations, lack of ancillary tests, inadequate assessments, inadequate treatment plans, inconsistent use of chronic pain management drug contracts, inappropriate use of controlled substances to treat pain and anxiety and lack of attention to other health problems, and violation of his September 7, 2001, Board Order by failing to document the therapeutic necessity for prescribing pain medication to three patients.

**ROGLER-BROWN, TIMOTHY LEE, M.D., SAN BENITO, TX, Lic. #K6918**

On April 13, 2007, the Board and Dr. Rogler-Brown entered into a five-year Mediated Agreed Order requiring that his practice be monitored by another physician; that his billing practice be monitored by a billing auditor; that he complete courses in the areas of risk management, including medical records and practice management, including billing practices and, each year, courses in family medicine; that he pass the Medical Jurisprudence Examination within one year; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Rogler-Brown, in treating eight patients, failed to meet the standard of care for each patient for one or more of the following reasons: his documentation lacked support for the charges that were submitted, he consistently over-

coded claims, he failed to appropriately treat some of the patients' health problems, he performed excessive procedures that were not medically justified and he failed to document appropriately as to patient care.

**SALDIVAR, SALVADOR J., M.D., VANCOUVER, B.C., Lic. #K9652**

On April 13, 2007, the Board and Dr. Saldivar entered into an Agreed Order requiring that he complete additional continuing medical education in ethics; that he pass the Medical Jurisprudence Examination within one year; and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Saldivar prescribed medications for a patient without establishing a proper physician-patient relationship or keeping medical records and that he resigned from his fellowship in lieu of disciplinary action against him.

**SANCHEZ, DAVID WAYNE, M.D., ALPINE, TX, Lic. #J1567**

On February 16, 2007, the Board and Dr. Sanchez entered into an Agreed Order requiring that he complete additional continuing medical education in the area of risk management. The action was based on allegations that Dr. Sanchez failed to meet the standard of care when he did not order a chest x-ray for a patient complaining of shortness of breath, assuming, incorrectly, that one had been done in the emergency room.

**SPURLOCK, WILLIAM MARCUS, M.D., DALLAS, TX, Lic. #J7209**

On April 13, 2007, the Board and Dr. Spurlock entered into an Agreed Order prohibiting him from administering, prescribing or delegating the prescription of intravenous Lidocaine or intravenous Colchicine or their generic counterparts; requiring that he complete additional continuing medical education in the areas of pain management and endocrinology; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Spurlock treated a patient for fibromyalgia with intravenous Lidocaine and Colchicine, neither of which are considered appropriate for the long term treatment of fibromyalgia and both of which present risks to patients, includ-

*continued on page 8*

ing cardiac arrhythmias and cardiac arrest, that outweigh the possible benefit.

**STEVENS, LEE, M.D., SHREVEPORT, LA Lic. #F4564**

On April 13, 2007, the Board and Dr. Stevens entered into an Agreed Order requiring that he complete additional continuing medical education in the area of medical records. The action was based on allegations that Dr. Stevens provided samples of a controlled substance to a family member without maintaining an adequate medical record.

**SUNDARESAN, SANJOY, M.D., WICHITA FALLS, TX, LIC. #K1083**

On December 8, 2006, the Board and Dr. Sundaresan entered into a three-year Agreed Order requiring that his pain management practice be monitored by another physician, that he complete additional continuing medical education each year in the areas of ethics and medical records, and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Sundaresan failed to produce adequate medical records regarding the treatment of his chronic pain patients.

**TADLOCK, HUGH M., M.D., GEORGETOWN, TX, Lic. #G3835**

On December 8, 2006, the Board and Dr. Tadlock entered into an Agreed Order requiring that his practice be monitored by another physician for one year, that he complete additional continuing medical education in the areas of medical records and risk management, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Tadlock failed to meet the standard of care in his evaluation and treatment of a patient's complaints of seizure activity, and a resulting migraine headache.

**THEIN, AUNG MYINT, M.D., BIG SPRING, TX, Lic. #K4814**

On December 8, 2006, the Board and Dr. Thein entered into an Agreed Order requiring that he complete a course in risk management, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Thein failed to meet the standard of care in that he did not identify a non-depressed fracture of a small area of the

skull of a patient and failed to appropriately communicate this finding, when he later discovered it, to the patient's treating physician.

**THOMPSON, PEYTON LEE, M.D., ROCKDALE, TX, Lic. #D9687**

On December 8, 2006, the Board and Dr. Thompson entered into an Agreed Order requiring that he complete additional continuing medical education each year for two years in the areas of acute conditions of the ears, eyes, nose and throat and in medical records. The action was based on allegations that Dr. Thompson failed to meet the standard of care in examining, diagnosing, and treating a patient's eye condition.

**TOMANENG, EDWARD U., M.D., SAN MARCOS, TX, Lic. #G7897**

On February 16, 2007, the Board and Dr. Tomaneng entered into a three-year Agreed Order requiring that his practice be monitored by another physician; that he complete in each year of the order eight hours of continuing medical education in medical records and eight hours in ear, nose and throat; and assessing an administrative penalty of \$25,000. The action was based on allegations that, for eight patients, Dr. Tomaneng performed diagnostic studies that were not warranted for the patients' presentations.

**TRAVIS, JO ANN FLATLEY, M.D., DALLAS, TX, Lic. #E7757**

On December 8, 2006, the Board and Dr. Travis entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Travis failed to ensure that an anesthetic injection was made into the correct eye.

**TRESE, SUSAN COHEN, M.D., GARLAND, TX, Lic#J9480**

On February 9, 2007, the Board and Dr. Trese entered into an Agreed Order requiring that she pass the Medical Jurisprudence Examination and complete additional continuing medical education in risk management, prohibiting her from treating or otherwise serving as a physician for her immediate family and assessing an administrative penalty in the amount of \$2,000. The action was based on allegations that Dr. Trese prescribed Adderall or its

# RULE CHANGES

The board has adopted the following rules and rule changes since the last issue of the *Medical Board Bulletin*:

**Chapter 163, Licensure**, to amend §163.2, Definitions, to correct a reference; §163.5, Licensure Documentation to eliminate the requirement for all applicants to present certain documents to the Board, and §163.6, Examinations Accepted for Licensure regarding the Jurisprudence Examinations.

Repeal of **Chapter 170, Authority of Physician to Prescribe for the Treatment of Pain**.

**Chapter 172, Temporary and Limited Licenses**, new §172.15, Limited License for the Practice of Public Health Medicine.

New Chapter 170, **Pain Management**, to substantially rewrite the current rule. The revised rule sets forth appropriate standards for good medical practice in the treatment of pain.

**Chapter 183, Acupuncture**, to amend §183.2 Definitions, to allow licensing of an applicant who gradu-

ated from an acupuncture school that was a candidate for accreditation by the Accreditation Commission for Acupuncture and Oriental Medicine (ACAOM) at the time of graduation; §183.4 Licensure, to allow a showing of English proficiency by attending an acceptable approved school of acupuncture in the United State or Canada; §183.5 Annual Renewal of License, to provide for the automatic cancellation of a license that has been expired for more than one year; §183.15, Use of Professional Titles, to delete the requirement to include “Texas” in the title; and §183.20, Continuing Acupuncture Education, to delete references to “informal” CAE.

**Chapter 187, Procedural Rules**, to amend §187.28, Discovery, to set forth a procedure for the identification of expert witnesses who may testify in cases before the State Office of Administrative Hearings.

For all the Board rules, go to [http://www.tmb.state.tx.us/rules/rules/bdrules\\_toc.php](http://www.tmb.state.tx.us/rules/rules/bdrules_toc.php)



generic counterpart for a member of her family, and gave a member of her family unused Adderall given to her by another physician, in the absence of immediate need and without documentation.

**WAISMAN, MARGARET, M.D., HOUSTON, TX, Lic. #E1440**

On April 13, 2007, the Board and Dr. Waisman entered into an Agreed Order requiring that she complete additional continuing medical education and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Waisman failed to meet the standard of care for one patient by applying or authorizing the application of two treatments of trichloroacetic acid in one day.

**YUSUF, QAISER JAMAL, M.D., BAYTOWN, TX, Lic. #J1818**

On December 8, 2006, the Board and Dr. Yusef entered into an Agreed Order requiring that his

prescribing authority be modified to eliminate Schedule II drugs; that his practice be monitored by another physician for a period of three years; that he successfully complete the medical record keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, or an approved equivalent program; that he complete a course in pain management; and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Yusef prescribed narcotic medications and benzodiazepines without having adequate medical information or previous medical records for patients and that he failed to meet the standard of care due to nontherapeutic prescribing of narcotics and controlled substances for four patients, some of whom demonstrated drug-seeking behavior.

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## UNPROFESSIONAL CONDUCT VIOLATIONS

### **BATTLE, ROBERT McREE, M.D., HOUSTON, TX, Lic. #D2355**

On December 8, 2006, the Board and Dr. Battle entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Battle terminated a physician-patient relationship in an unprofessional manner.

### **BELLOMO, JOSEPH F., M.D., LANCASTER, TX, Lic. #H2987**

On December 8, 2006, the Board and Dr. Bellomo entered into an Agreed Order requiring that he obtain an independent forensic evaluation from a Board-appointed psychiatrist and undergo any continuing psychiatric care recommended by the evaluating psychiatrist, that he successfully complete the program for distressed physicians offered by the Vanderbilt Medical Center for Professional Health, or an approved equivalent program, and complete 10 hours of ethics courses or programs. The action was based on allegations that there was an incident at a hospital during which Dr. Bellomo's actions were disruptive to staff and to a patient.

### **CAHAN, NINA GALE, M.D., COPPELL, TX, Lic #G6149**

On December 8, 2006, the Board and Dr. Cahan entered into an Agreed Order assessing an administrative penalty of \$1,000 and requiring her to become familiar with Board rules regarding release and transfer of medical records. The action was based on allegations that Dr. Cahan, following the departure of, and a dispute with, another physician employed by Dr. Cahan, instructed her staff to tell the departing physician's patients that they did not know the departing physician's location or telephone number, though this was not true.

### **CANTU, DENNIS DAVID, M.D., LAREDO, TX, Lic. #F1430**

On February 16, 2007, the Board and Dr. Cantu entered into an Agreed Order requiring that he either obtain eight hours of continuing medical education in office management and/or risk management or provide documentary evidence of a Texas Medical Association review of his office management practices and his compliance with any recommendations, and assessing an administrative

penalty of \$500. The action was based on allegations that Dr. Cantu failed to provide properly requested medical records within 15 business days and did not timely respond to a Board investigator's request for records.

### **LAMPLEY, JOSEPH CARVER, D.O., SEMINOLE, TX, Lic. #J9149**

On December 8, 2006, the Board and Dr. Lampley entered into an Agreed Order publicly reprimanding Dr. Lampley, requiring that he pass the Medical Jurisprudence examination within one year, and assessing an administrative penalty of \$10,000. The action was based on allegations that Dr. Lampley, during the process of re-credentialing with an insurance company after his membership in the American Board of Family Medicine had lapsed, did not pursue re-certification by that board, but did submit to the insurance company an altered, fraudulent certificate purportedly from the American Board of Family Medicine to show he was certified by that board.

### **SPENCER, EDWARD E., M.D., KILLEEN, TX, Lic. #H0837**

On February 16, 2007, the Board and Dr. Spencer entered into a five-year Agreed Order requiring that he obtain 10 hours of ethics education and that he perform 100 hours of community service to a low-income or under-served population in the first year of the order and 20 hours each succeeding year, and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Spencer was the registered agent and sole proprietor of a professional association doing business as the Family Practice Clinic, and in that capacity he entered a plea of guilty to charges that the clinic made false statements relating to health care matters and submitted false claims to the U.S. Government, and that Dr. Spencer was untruthful in a statement in his correspondence with the Board regarding this matter.

### **SIMMONS, DONALD RAE, M.D., LINDEN, TX, Lic. #L2010**

On April 13, 2007, the Board and Dr. Simmons entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of ethics and risk management and assessing an administrative penalty of \$1,000. The

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action was based on allegations that Dr. Simmons did not maintain adequate documentation of controlled substances, based on an unannounced inspection that found several controlled substance violations.

**SITOMER, CHARLES I., M.D., HOUSTON, TX, Lic. #G7341**

On April 13, 2007, the Board and Dr. Sitomer entered into a three-year Agreed Order requiring that he obtain an independent forensic evaluation from a Board-appointed psychiatrist and undergo any continuing psychiatric care recommended by the evaluating psychiatrist; that his practice be monitored by another physician; that he complete additional continuing medical education in the areas of risk management and ethics; and that he provide to his patients appropriate information relating to proposed urological procedures. The action was based on allegations that Dr. Sitomer engaged in practice beyond the scope of the treatment authorized by specific informed consent.

**WASHAK, RONALD VICTOR, M.D., WEST BEND, WI, Lic. #J5052**

On February 16, 2007, the Board and Dr. Washak entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of ethics and risk management and assessing an administrative penalty of \$2,000. The action was based on allegations that Dr. Washak, in 2003, saw patients one morning when his physical condition was compromised.

**WELDON, LLOYD KENT, M.D., FORT WORTH, TX, Lic. #E6947**

On April 13, 2007, the Board and Dr. Weldon entered into an Agreed Order requiring that he complete additional continuing medical education in the area of ethics over two years, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Weldon, because of a hole in his pants and because he routinely does not wear underwear, unintentionally exposed his genitals to a patient and her daughter while examining the patient.

**WERNER, JAN REINERT, M.D., AMARILLO, TX, Lic. #E7533**

On April 13, 2007, the Board and Dr. Werner

entered into an Agreed Order requiring that he successfully complete the professional boundaries course offered by the Vanderbilt Medical Center for Professional Health or an approved equivalent program, complete additional courses in the area of ethics, and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Werner used offensive, inappropriate language and gestures directed toward doctors, nursing staff and, at times, in front of non-staff, including patients and patients' family members.

**WILLIAMS, MICHAEL LEE, M.D., PALESTINE, TX, Lic. #H5995**

On April 13, 2007, the Board and Dr. Williams entered into an Agreed Order suspending his medical license until such time as he appears before the Board and demonstrates that he is competent to safely practice medicine. The action was based on allegations that Dr. Williams wrote false prescriptions for a patient who was a known prescription drug abuser and with whom he had a personal relationship, and that he was arrested and charged with prescription fraud.

**INAPPROPRIATE CONDUCT INVOLVING PHYSICIAN-PATIENT RELATIONSHIP**

**DORMAN, JOHN WESLEY, M.D., AMARILLO, TX, Lic. #D5375**

On December 8, 2006, the Board and Dr. Dorman entered into a three-year Mediated Agreed Order requiring that he obtain an independent forensic evaluation from a Board-appointed psychiatrist and undergo any continuing psychiatric care recommended by the evaluating psychiatrist, that any change of his employment that would include the treatment of females must be approved in advance by the executive director of the Board and requiring that he prepare a report regarding what he learned from attending the professional boundaries course at the Vanderbilt Medical Center for Professional Health and how he could apply this training. The action was based on allegations that Dr. Dorman behaved inappropriately during his examination of two female patients.

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**LOFTUS, BRIAN D., M.D., BELLAIRE, TX, Lic. #H9230**

On February 16, 2007, the Board and Dr. Loftus entered into a three-year Agreed Order requiring the following: that he obtain an independent forensic evaluation from a Board-appointed psychiatrist and undergo any continuing psychiatric care recommended by the evaluating psychiatrist; successfully complete either the professional boundaries course offered by the Vanderbilt Medical Center for Professional Health or the similar course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; have a chaperone when examining female patients; develop a policy for e-mail management to ensure all e-mail is placed in the patient's medical record; complete 10 hours of ethics courses each year; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Loftus developed over time through e-mail correspondence a romantic relationship with a patient.

**INADEQUATE MEDICAL RECORDS VIOLATIONS**

**BALAT, ISAM YUSUOF, M.D., HOUSTON, TX, Lic. #E0795**

On December 8, 2006, the Board and Dr. Balat entered into a Negotiated Agreed Order requiring that his practice be monitored by another physician for four quarters, subject to extension if there are continued documentation deficiencies, and that he complete additional continuing medical education in medical records. The action was based on allegations that Dr. Balat failed to maintain adequate medical records from 1997 to 1999.

**BATES, EVAN SCOTT, M.D., DALLAS, TX, Lic. #J1619**

On December 8, 2006, the Board and Dr. Bates entered into a mediated Agreed Order requiring that he complete additional continuing medical education in the area of record keeping/risk management. The action was based on allegations that Dr. Bates failed to adequately document his treatment of one patient.

**FRANKLIN, RODNEY THOMAS, M.D., LUBBOCK, TX, Lic. #H0991**

On December 8, 2006, the Board and Dr. Franklin

entered into a Mediated Agreed Order requiring that he maintain adequate medical records on all patient office visits, consultations, surgeries performed, drugs provided and treatment rendered, that he complete additional continuing medical education in the areas of risk management and/or medical records, and assessing an administrative penalty of \$500. The action was based on allegations that Dr. Franklin violated Board Rule 165, which requires the maintenance of complete medical records.

**FRAZEE, LEWIS JACOB, M.D., PLANO, TX, Lic. #G1289**

On February 16, 2007, the Board and Dr. Frazee entered into an Agreed Consent Order requiring that he complete additional continuing medical education in risk management and assessing an administrative penalty of \$2,000. The action was based on allegations that Dr. Frazee violated Board rule 165.1(a), relating to the contents of a medical record.

**LADD, DANIEL JOSEPH, D.O., AUSTIN, TX, Lic. #L1102**

On February 16, 2007, the Board and Dr. Ladd entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Ladd failed to obtain written informed consent for a surgical procedure for one patient.

**LAHIJI, HOSEIN, M.D., McALLEN, TX, Lic. #J9145**

On February 16, 2007, the Board and Dr. Lahiji entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of risk management and ethics and assessing an administrative penalty of \$2,500. The action was based on allegations that Dr. Lahiji failed to document adequate medical treatment prior to placement of a percutaneous test stimulator and a permanent Interstim, and that he failed to obtain informed consent from the patient for the placement of the stimulator and the permanent Interstim.

**LEAL, ENRIQUE A. III, M.D., SAN AUGUSTINE, TX, Lic. #G8896**

On December 8, 2006, the Board and Dr. Leal entered into an Agreed Order requiring that his

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practice be monitored by another physician for one year, that he maintain adequate medical records on all patient office visits, consultations, surgeries performed, drugs provided and treatment rendered, that he complete additional continuing medical education in medical records, and assessing an administrative penalty of \$500. The action was based on allegations that Dr. Leal failed to maintain adequate medical records for one patient he treated from November of 2004 to September of 2005.

**PALMER, WESLEY DEAN, D.O., BRIDGE CITY, TX, Lic. #G5457**

On February 16, 2007, the Board and Dr. Palmer entered into an Agreed Order requiring that he complete additional continuing medical education in the area of medical records and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Palmer failed to maintain adequate medical records documenting his treatment of two patients for chronic pain and anxiety.

**REDDY, TARAKUMAR B., M.D., HURST, TX, Lic. #J0644**

On February 16, 2007, the Board and Dr. Reddy entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of medical records and risk management and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Reddy failed to provide properly requested medical records within 15 business days and that he failed to appropriately document medical records of one patient.

**SEIF, FAYEZ GAMIL, M.D., GREENVILLE, TX, Lic. #K1055**

On February 16, 2007, the Board and Dr. Seif entered into an Administrative Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Seif's medical records for one patient revealed no specific physical documentation communicating and discussing the patient's abnormal bilirubin of 1.9.

**SOROKOLIT, WALTER THEODORE, M.D., FORT WORTH, TX, Lic. #F2456**

On February 16, 2007, the Board and Dr. Sorokolit entered into an Agreed Order requiring that he

complete additional continuing medical education in the areas of medical records and risk management. The action was based on allegations that Dr. Sorokolit failed to keep adequate medical records for one patient on whom he performed surgery.

**IMPAIRMENT DUE TO ALCOHOL OR DRUGS**

**HALEBIAN, PAUL HRATCH, M.D., DALLAS, TX, Lic. #F4036**

On December 8, 2006, the Board and Dr. Halebian entered into an Agreed Order of Suspension suspending his license until such time as he appears before the Board and demonstrates that he is safe and competent to return to the practice of medicine. The action was based on allegations that Dr. Halebian was arrested for possession of marijuana, including four plants growing in his backyard, and concerns that he has been self-medicating and prescribing without a legitimate medical purpose and without adequate record-keeping.

**MAYS, JEFFRY PATRICK, BRADY, TX, Lic. #J7815**

On December 8, 2006, the Board and Dr. Mays entered into an Agreed Order suspending his medical license for at least 90 days, placing him on probation for 15 years following his return to practice and requiring the following: that he surrender his Drug Enforcement Administration and Texas Department of Public Safety Controlled Substances Registration Certificates; pass the Medical Jurisprudence examination; abstain from consuming prohibited substances, including alcohol and drugs not prescribed for him; participate in the Board's program for testing for drugs and alcohol; continue to participate in the activities of Alcoholics Anonymous at least three times per week; continue to participate in the activities of a county or state medical society committee on physician health and rehabilitation; receive care from a treating psychiatrist; and requiring that his practice be monitored by another physician for one year after he returns to practice. The action was based on allegations of a history of alcohol and drug abuse.

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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
Merrimon W. Baker, M.D. ....	G4807 .....	1/26/07 .....	Failure to comply with a Board order; unprofessional conduct.
Francis X. Burch, M.D. ....	F4774 .....	3/26/07 .....	Failure to practice medicine in an acceptable manner; failure to meet the standard of care; unprofessional conduct; violation of a state or federal law; failure to keep adequate medical records.
Leonard E. Dodson Jr. M.D. ..	G2359 .....	1/26/07 .....	Failure to meet the standard of care; unprofessional conduct.
Steven Allen Doores, M.D. ....	F6582 .....	1/8/07 .....	Unprofessional conduct; failure to meet the standard of care; nontherapeutic prescribing; violation of a Board rule.
Callie O. Hall-Herpin, M.D. ....	K5306 .....	1/8/07 .....	Conviction of a felony; unprofessional conduct.
Kenneth W. O'Neal, M.D. ....	D6119 .....	4/17/07 .....	Failure to meet the standard of care; unprofessional conduct; nontherapeutic prescribing; violation of a Board rule.
Richard J. Pietila, M.D. ....	F3285 .....	1/29/07 .....	Failure to practice medicine in an acceptable manner; nontherapeutic prescribing.
Vladimir Redko, M.D. ....	J1366 .....	1/26/07 .....	Failure to meet the standard of care; unprofessional conduct; nontherapeutic prescribing; improper billing; violation of Board rules.
Oscard M. Reichert, D.O. ....	F7088 .....	11/19/06 ....	Failure to practice medicine consistent with public health and welfare; nontherapeutic prescribing; failure to properly supervise.
Mark R. Rogers, M.D. ....	H0770 .....	1/23/07 .....	Unprofessional conduct; violation of Board rules; failure to comply with a Board order; intemperate use of alcohol or drugs.
Elizabeth A. Rohr, M.D. ....	J3590 .....	2/15/07 .....	Unprofessional conduct; conviction of a felony.
Seth W. Silverman, M.D. ....	F8773 .....	3/20/07 .....	Submitting a false or misleading statement to the board in an application for a license; unprofessional conduct.

**POOLE, REX DARREL, M.D., AUSTIN, TX, Lic. #K0543**

On February 16, 2007, the Board and Dr. Poole entered into an Agreed Order suspending his medical license until such time as he appears before the Board and demonstrates that he is competent to safely practice medicine. The action was based on Dr. Poole's self-report of impairment due to intemperate drug use.

**NONTHERAPEUTIC PRESCRIBING VIOLATIONS**

**RITTENHOUSE, RALPH A., M.D., KINGWOOD, TX, Lic. #E5219**

On December 8, 2006, the Board and Dr. Rittenhouse entered into an Agreed Order requiring that his practice be monitored by another physician for one year, that he complete courses in medical records and management of lipid disorders, and assessing an administrative penalty of \$500. The action was based on allegations that Dr. Rittenhouse refilled a patient's Lipitor prescription at the patient's first visit, but did not order adequate laboratory work or maintain adequate records for the patient.

**OTHER STATES' BOARD ACTIONS**

**ENGSTROM, PAUL FORREST, M.D., ROSWELL, NM, Lic. #G1384**

On February 16, 2007, the Board and Dr. Engstrom entered into an Agreed Administrative Order subjecting Dr. Engstrom to all terms and conditions of an order of the New Mexico Board of Medicine. The action was based on the action of the New Mexico Medical Board in placing Dr. Engstrom on probation for three years based on his failure to maintain medical records and his failure to be able to produce them on proper request.

**HEMPHILL, JOHN MICHAEL, M.D., SAVANNAH, GA, Lic. #E2606**

On December 8, 2006, the Board and Dr. Hemphill entered into an Agreed Order requiring that he comply with any terms and conditions imposed by the Georgia Composite State Board of Medical Examiners. The action was based on the 2004 action of the Georgia Board placing Dr.

Hemphill on probation for five years under various terms and conditions. The action of the Georgia Board was based on allegations relating to Dr. Hemphill becoming romantically involved with a patient in 1999 and prescribing medications to this patient without documenting the prescriptions or treatment from 1999 to 2001.

**MC CREA, ROBERT STANLEY, M.D., CARROLLTON, TX, Lic. #E2712**

On February 16, 2007, the Board and Dr. McCrea entered into an Agreed Order publicly reprimanding Dr. McCrea and assessing an administrative penalty of \$3,000. The action was based on allegations that a Decree of Censure was issued to Dr. McCrea by the Arizona Medical Board for falling below the standard of care by failing to treat vigorously a patient's pregnancy-induced hypertension, and that Dr. McCrea failed to report this to the Board on his medical license renewal form.

**SAMUEL, DONALD RAY, M.D., JASPER, TX, Lic. #H5964**

On December 8, 2006, the Board and Dr. Samuel entered into an Agreed Order with a minimum term of five years, requiring that his practice be monitored by another physician; that he undergo annual evaluations to determine if he is mentally and physically able to practice medicine with reasonable skill and safety; that he arrange for and successfully complete a custom continuing medical education (CME) program in obstetrics and gynecology through the University of California San Diego Physician Assessment and Clinical Education (PACE) program or an equivalent approved program; that he complete each year additional CME in obstetrics and gynecology; that he make detailed written chart notes prior to any non-emergent obstetrics and gynecological surgical procedure or hospital admissions; prohibiting him from supervising physician assistants or advanced nurse practitioners, and assessing an administrative penalty of \$250. The action was based on allegations stemming from the action of the Michigan Board of Medicine suspending Dr. Samuel's license in 2004 based on complaints alleging violations of the standard of care pertaining to a stillborn

delivery in January of 1994 and a maternal death in October of 1998. The administrative penalty was based on allegations that Dr. Samuel failed to provide properly requested medical records within 15 business days.

### **VIOLATIONS BASED ON FAILURE TO PROPERLY SUPERVISE OR DELEGATE**

#### **ARAFILES, ROLANDO GERMAN, M.D., VICTORIA, TX, Lic. #K4855**

On April 13, 2007, the Board and Dr. Arafiles entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of ethics, medical records and treatment of obesity; prohibiting him from supervising physician assistants or advanced nurse practitioners; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Arafiles failed to adequately supervise a physician assistant and failed to make an independent medical professional decision about the protocol developed by the owner of the clinic.

#### **BACON, ROBERT J., M.D., HOUSTON, TX, Lic. #F0861**

On April 13, 2007, the Board and Dr. Bacon entered into an Agreed Order assessing an administrative penalty of \$2,500. The action was based on allegations that Dr. Bacon served, at least at times, as *de facto* medical director of a clinic providing a narcotics treatment program and therefore had some responsibility to ensure that the clinic, cited for several deficiencies following an inspection by the Texas Department of State Health Services, was in compliance with all applicable federal, state and local law regarding the medical treatment of narcotic addiction with a narcotic drug.

#### **COLEMAN, RALPH FRANKLIN, M.D., HOUSTON, TX, Lic. #E6756**

On December 8, 2006, the Board and Dr. Coleman entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of risk management and medical records, and assessing an administrative penalty of \$1,000. The action was based on allega-

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#### *Dr. Fred, continued from page 2*

I had never witnessed a more masterful performance, yet for him it was business as usual and has continued to be business as usual throughout his entire magnificent career.

I was sophisticated enough as a fourth-year resident to know that I was in the presence of a giant. At Ben Taub, we had other tigers as attendings, but seduced by the income of private practice, they left the ranks of teachers to become practitioners.

Herb Fred, on the contrary, has amassed a 55-page abbreviated CV by exceeding the speed of sound as a teacher and chronicler through his entire life. His questions to his students and residents always focused on the patient. "What did your patient tell you? What did you find on examination on your patient? What did you tell your patient?" "Did you sit down?" "Did you touch your patient?"

And the final salient question, "Did you do your best?"

Herb Fred has devoted his life as an academician to teaching students and residents and caring for patients

and he has been honored in many ways, so many that I would not exaggerate by saying he has touched *every* academic base, and has been honored in *every* conceivable way, teaching thousands of residents and students and colleagues. His enthusiasm is legion, his ardor rivals that of Dr. Michael DeBakey, the king of intensity, and we who have had the spiritual experience of being around Dr. Fred know him to be a doctor who has fought mediocrity, despised poor clinical performance, and led by example throughout his career. Many of his students have reached heights they never dreamed they could reach, trying to emulate his excellence.

I can't help but think about all the lives of doctors changed by Herb Fred's dramatic pleas to his residents and students to do their best always. Just floating on the periphery of his charisma, I began driving myself harder, striving to excel rather than being satisfied with just doing my job. If his example worked that well on me, an onlooker rather than a participant, consider the salutary effect he has had on those sitting at his feet for years. ♦

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tions that Dr. Coleman improperly delegated the taking of an x-ray to an unqualified person.

**GANDHI, BHARAT RANGILDAS, M.D., SUGAR LAND, TX, Lic. #J3477**

On December 8, 2006, the Board and Dr. Gandhi entered into a Mediated Agreed Order requiring that, prior to performing or supervising electromyography studies, he must become certified by the American Board of Electrodiagnostic Medicine or the American Board of Physical Medicine and Rehabilitation or the American Board of Psychiatry and Neurology, requiring that he complete additional continuing medical education (CME) in ethics, prepare a paper describing the benefits of ethics CME to his practice, and assessing an administrative penalty of \$2,500. The action was based on findings that Dr. Gandhi delegated to an electrodiagnostic technologist the performance of electromyography and nerve conduction studies on one of his patients, and on allegations that such delegation was improper because Dr. Gandhi was not qualified to supervise the studies and that, even if Dr. Gandhi had been qualified to perform the studies, the delegation to a non-physician was inherently a deviation from the standard of care.

**ROCK, ROBERT LEE, M.D., AUSTIN, TX, Lic. #C9394**

On April 13, 2007, the Board and Dr. Rock entered into a Mediated Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Rock had some responsibility for supervising an office technician who authorized excessive refills of steroid eye drops.

**VENEGAS, CARLOS, M.D., DALLAS, TX, Lic. #K0566**

On December 8, 2006, the Board and Dr. Venegas entered into an Agreed Order requiring that he take and pass the Medical Jurisprudence examination, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Venegas failed to adequately supervise colonic procedures at the Dallas Colon Care Clinic for which he was medical director and was not present when the procedures were performed.

**VLAHAKOS, VICTOR, M.D., AUSTIN, TX, Lic. #E2915**

On February 16, 2007, the Board and Dr. Vlahakos

entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of prescribing practices, supervision of medical personnel, medical records and ethics; prohibiting him from re-applying for his DEA or DPS registrations until completion of the additional continuing medical education; and assessing an administrative penalty of \$500. The action was based on allegations that members of Dr. Vlahakos' office staff ordered large amount of alprazolam, hydrocodone, diazepam and propoxyphene for their family members and for patients who could not afford the medications.

**VIOLATION OF PROBATION OR PRIOR ORDER**

**BARTLEY, MICHAEL ALAN, M.D., IRVING, TX, Lic. #H6033**

On February 15, 2007, the Board, acting through its executive director, revoked Dr. Bartley's license. The action was based on a finding that Dr. Bartley had violated the terms of his order by ingesting cocaine.

**BURROWS, WILLIAMS BRADLEY, D.O., MOUNT PLEASANT, TX, Lic. #J9637**

On February 16, 2007, the Board and Dr. Burrows entered into an Administrative Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Burrows failed to provide a urine sample on the required day in violation of his order.

**GREEN, DEMETRIS ALLEN, M.D., SPRING, TX, Lic. #J4168**

On April 13, 2007, the Board and Dr. Green entered into an Agreed Order requiring that he begin paying the drug testing company used by the Board at least \$100 each month and to reduce the accumulated debt to zero over the period of his residency, or by September 1, 2008, if he has not entered into a residency by September of 2007, and prohibiting him from supervising physician assistants or advanced nurse practitioners. The action was based on allegations that Dr. Green violated his current order by failing to pay the cost of his drug testing.

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J.D., to the board. Dr. McMichael is with the University of Texas Health Services in Austin. Mr. Webb is an attorney with Webb and Associates of Houston. Full biographies and photos will be included in the Fall 2007 issue of the *Texas Medical Board Bulletin* and will be posted soon on the TMB web site at <http://www.tmb.state.tx.us/boards/mbbios.php>. ♦

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*Rehabilitation orders, continued from page 3*

been the subject of a substance abuse-related order of the Board, however, self-reported substance abuse cannot be the basis of a non-public rehabilitation order. It is also unavailable if a violation of the standard of care has resulted from the substance abuse. The board may also issue a rehabilitation order in the case of mental or physical impairment when the person has admitted that he or she suffers from a potentially dangerous condition.

An Independent Medical Evaluation often precedes a rehabilitation order. A physician, usually a psychiatrist, will examine and evaluate the physical and mental condition of the person who is to be placed under a rehabilitation order. The report will guide the board in determining whether a rehabilitation order is appropriate and the terms that should be required.

By issuing a rehabilitation order, the board is able to accommodate a person who is disabled by a physical or mental condition, while placing requirements on the practice of the physician that will protect the public. This allows the board to comply with the Americans with Disabilities Act.

The board is not, however, *required* to issue a non-public rehabilitation order in these circumstances. The

board must exercise its discretion in these matters. When substance abuse has resulted in a criminal conviction, such as a DWI, for example, the board will usually decline to exercise the discretion to issue a non-public order. Since the physician's condition is already public, there is no need for the board's order to be confidential. Thus, the physician's patients can learn of the already public condition by reference to the board's website.

If a physician violates a rehabilitation order, the board may institute disciplinary proceedings. This may result in the non-public order becoming a public record. Violation of a rehabilitation order is also grounds for a temporary suspension proceeding. Furthermore, the board generally requires, as a condition for a non-public substance abuse rehabilitation order, that the physician agree that the board may suspend the physician's license if the physician tests positive for drugs or alcohol. Therefore, the non-public rehabilitation order provides a strong incentive for the physician to remain abstinent. Using this authority, the board can quickly move to protect the public if a physician relapses.

If a licensed physician knows someone who may have a problem that could impair the ability to safely practice medicine and the person is "a continuing threat to the public welfare," the Medical Practice Act requires reporting to the board. A licensee who wants to self-report must do so in writing and can use the complaint form on the TMB website site at <http://www.tmb.state.tx.us/consumers/complain/placecomp.php> or in a letter that may be faxed to (512) 305-7123 or mailed to Texas Medical Board, MC-1028, P.O. Box 2018, Austin TX 78768. ♦

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**Haji, Asha Karim, M.D., Bryan, TX, Lic. #E2220**

On February 16, 2007, the Board and Dr. Haji entered into a Modified Agreed Order extending her Agreed Order by six months, requiring her to complete the medical record keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, or an approved equivalent program, and assessing an administrative penalty of

\$1,000. The action was based on allegations that Dr. Haji had not completed all of the continuing medical education required by the prior order by the deadline.

**Lorentz, Rick Gene, M.D., Sweeny, TX, Lic. #J2169**

On April 13, 2007, the Board and Dr. Lorentz entered into an Agreed Order Modifying Prior Order extending the Agreed Order entered on February 3, 2006, by an additional two years and

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modifying some of the terms of that order. The action was based on allegations that Dr. Lorentz failed to complete on a timely basis all of the requirements of the prior order.

**MALDONADO, CESAR E., M.D., EL PASO, TX, Lic. #K4494**

On April 13, 2007, the Board and Dr. Maldonado entered into an Agreed Order Modifying Prior Agreed Order extending the term of his current order by two years, modifying the requirements for seeing his treating psychiatrist and for attending Alcoholics Anonymous and requiring him to obtain approval from the Executive Director of the Board before expanding the scope of his current practice or including a hospital-based practice. The action was based on allegations that Dr. Maldonado failed to notify the Board that he had been prescribed substances otherwise prohibited under his current order and that his privileges had been suspended by Las Palmas Medical Center because staff had not been able to reach him when they needed to.

**NICHOLS, DWIGHT JAMES, M.D., BRECKENRIDGE, TX, Lic. #D0985**

On February 16, 2007, the Board and Dr. Nichols entered into an Agreed Modification Order extending his existing order for one year, requiring him to have executive director approval to change his practice setting, and deleting the provision of the order relating to the Special Purpose Examination. The action was based on allegations that Dr. Nichols had not met all of the requirements of his order.

**ADVERTISING VIOLATIONS**

**BURNS, THOMAS PATRICK, M.D., AUSTIN, TX, Lic. #H0221**

On April 13, 2007, the Board and Dr. Burns entered into an Administrative Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Burns used the term “board certified” in his advertising materials after his certification had lapsed and was invalid.

**CAQUIAS, JESUS ANTONIO, M.D., BROWNSVILLE, TX, Lic. #F8432**

On April 13, 2007, the Board and Dr. Caquias entered into an Agreed Order requiring that he cease advertising in a manner that would cause confusion to the public or tend to mislead the public and cease advertising using references to organizations not recognized by the American Board of Medical Specialties. The action was based on allegations that Dr. Caquias’ advertisements contained material or representations likely to mislead or confuse the public.

**FEFERMAN, ROBERT SCOTT, M.D., IRVING, TX, Lic. #K4057**

On April 13, 2007, the Board and Dr. Feferman entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Feferman’s advertisements, among other things, made statements not readily verifiable regarding his patients’ responses to treatment, were not limited to statements regarding the treatment he provided, but included critical commentary on other physicians’ medical practices, and compared his billing and insurance policies to those of other physicians without supporting facts.

**LOWN, IRA GENE, M.D., AUSTIN, TX, Lic. #M4308**

On February 16, 2007, the Board and Dr. Lown entered into an Administrative Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Lown used the term “board certified” in advertisements in a manner that created a false and confusing impression to the public that he was board certified in orthopedic medicine when he was instead board certified only in surgery.

**MIESCH, MARY GAIL, M.D., PARIS, TX, Lic. #H7081**

On February 16, 2007, the Board and Dr. Miesch entered into an Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Miesch placed an advertisement in her local paper that created an unjustified expectation about the results of using a particular antioxidant to reverse aging.

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**PILISZEK, THEODORE S., M.D., HOUSTON, TX, Lic. #G1149**

On April 13, 2007, the Board and Dr. Piliszek entered into an Administrative Agreed Order assessing an administrative penalty of \$250. The action was based on allegations that Dr. Piliszek advertised that he is board certified in anti-aging medicine and nutrition, an area that is not certified by a member board of the American Board of Medical Specialties.

**REYES, JOSE, M.D., SAN ANTONIO, TX, Lic. #H6540**

On February 16, 2007, the Board and Dr. Reyes entered into an Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that, in his web-based advertising, Dr. Reyes stated he was board certified in bariatric medicine, notwithstanding that a physician may use the term “board certified” only if the certifying board meets certain qualifications, which the Board of Bariatric Medicine does not meet.

**SAQER, REZIK A., M.D., HOUSTON, TX, Lic. #K2282**

On April 13, 2007, the Board and Dr. Saqer entered into an Administrative Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Saqer advertised, among other things, that he is an “invasive pain specialist” and an “interventional pain management specialist” and that these are areas that the American Board of Medical Specialties does not recognize any certifications or specializations.

**ACTION BASED ON PEER REVIEW ACTIONS**

**CAMPBELL, ODETTE L., M.D., DALLAS, TX, Lic. #H9609**

On February 16, 2007, the Board and Dr. Campbell entered into a two-year Agreed Order requiring that her practice be monitored by another

physician; that she complete additional continuing medical education in the areas of medical records, and assessing an administrative penalty of \$2,500. The action was based on allegations that Dr. Campbell resigned from her place of practice while under review due to documentation concerns.

**ACTION BASED ON CRIMINAL CONVICTIONS**

**GILLILAND, MARK DOUGLAS, M.D., HOUSTON, TX, Lic. #G2088**

On February 16, 2007, the Board and Dr. Gilliland entered into an Agreed Order of Revocation by which Dr. Gilliland’s medical license was revoked. The action was based on Dr. Gilliland’s conviction of a third degree felony, intoxicated assault with a motor vehicle, and his subsequent sentencing to two years confinement in a Texas Department of Criminal Justice facility.

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

On April 13, 2007, the Board and Dr. Rountree entered into an Agreed Order revoking Dr. Rountree’s medical license. The action was based on Dr. Rountree’s arrest and conviction for sexually assaulting a patient.

**VOLUNTARY SURRENDERS**

**ELSTON, STEPHEN FREDRICK A., M.D., BORGER, TX, Lic. #G9344**

On December 8, 2006, the Board and Dr. Elston entered into an Agreed Order accepting the voluntary surrender of Dr. Elston’s medical license. The action was based on allegations that Dr. Elston pre-signed triplicate prescription forms for Schedule II narcotics and that he pled no contest to three felony counts for signing blank prescription forms for narcotics.

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<b>2008 BOARD MEETINGS</b>	Medical Board		Acupuncture Board		Physician Assistant Board	
	February 7-8	August 28-29	February 1	July 11	February 22	July 25
	April 10-11	October 9-10	May 2	October 31	May 16	November 14
	June 26-27	December 11-12				

## Workers' Compensation Update for Texas Physicians

The Texas Department of Insurance, Division of Workers' Compensation has implemented significant changes in health care delivery which may be of interest to Texas physicians. One important change is the creation of workers' compensation health care networks that are included in some insurance policies purchased by Texas employers. For health care provided outside these networks, changes have occurred in the review of health care quality by the Division and in the interaction among physicians, insurance carriers, injured employees and employers during the course of a workers' compensation claim.

### Disability Management

Disability management optimizes health care and return-to-work outcomes for injured employees through the use of treatment and return-to-work guidelines and treatment planning. Disability management brings together all parties, early in the life of a claim, to agree to a plan that best addresses the injury or illness.

The Division has adopted treatment and return-to-work guidelines that were applicable on May 1. Also, new rules will require treating doctors to provide treatment planning for their workers' compensation patients by the end of 2007.

The Division's treatment guidelines establish evidence-based medical standards for use in the delivery of care. Treatment and services included in the Division treatment guidelines are presumed to be health care that is reasonably required. Treatment outside the guidelines requires health care providers to obtain preauthorization from the insurance carrier.

The Division has posted more information for Texas physicians about disability management at: <http://www.tdi.state.tx.us/wc/dm/dmprovider.html>.

### Medical Quality Review

Review of workers' compensation health care quality is carried out by a Medical Quality Review Panel (MQRP). This panel of physicians assists Medical Advisor Howard Smith, M.D., and the Division to ensure that employees in the Texas workers' compensation system receive reasonable and medically necessary health care in a timely and cost-effective manner that facilitates recovery and appropriate return to work.

MQRP physicians make recommendations, based on clinical reviews, regarding the performance of health care providers in the workers' compensation system. In 2005, the Legislature broadened the scope of MQRP reviews to include health care decisions made by insurance carriers and independent review organizations. The Division has revised the MQRP review process to reflect new state law and to more clearly define how system participants are selected for review.

Key features of the workers' compensation medical quality review process can be found at: <http://www.tdi.state.tx.us/wc/mr/mqrpchanges.html>.

An application to serve on the Medical Quality Review Panel can be found at: <http://www.tdi.state.tx.us/commish/legal/lrsfqmgrp.html>

**EVANS, DAVID RONALD, D.O., PLANO, TX, Lic. #D9131**

On February 16, 2007, the Board and Dr. Evans entered into an Agreed Order accepting the voluntary and permanent surrender of Dr. Evans' medical license. The action was based on allegations that Dr. Evans has suffered from a long history of alcohol and opioid abuse and is also disabled due to a stroke and a heart ailment.

**HOUSE, CHARLES HAROLD, M.D., KILLEEN, TX, Lic.#D0390**

On April 13, 2007, the Board and Dr. House entered into an Agreed Order pursuant to which the Board accepted the voluntary and permanent surrender of Dr. House's medical license. The action was based on Dr. House's failure to complete the Colorado Physician Education Program (now the Center for Personalized Education for Physicians), as required by his existing Agreed Order, and his desire to retire from the practice of medicine rather than complete the program.

**HUGHES, KEITH PATRICK, M.D., LINCOLN, NE, Lic. #K3246**

On February 16, 2007, the Board and Dr. Hughes entered into an Agreed Order accepting the voluntary surrender of Dr. Hughes' medical license. The action was based on the revocation of Dr. Hughes' Nebraska medical license by the Nebraska Department of Health and Human Services for failing to abstain from alcohol and ingesting a prescription drug in violation of the terms and conditions of his probation.

**KILPATRICK, HAMILTON WRIGHT, M.D., UVALDE, TX, Lic. #C3109**

On February 16, 2007, the Board and Dr. Kilpatrick entered into an Agreed Order accepting the voluntary surrender of Dr. Kilpatrick's medical license. The Board's representatives discussed with Dr. Kilpatrick allegations pertaining to Dr. Kilpatrick's prescribing of narcotics without adequate documentation for patients he treated as an independent medical contractor for a Houston physician between 2002 and 2005.

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

On December 8, 2006, the Board and Dr. Maewal entered into an Agreed Order accepting the voluntary and permanent surrender of Dr. Maewal's medical license. The action was based on a determination by the Board that Dr. Maewal is unable to practice medicine with reasonable skill and safety to patients because of a mental or physical condition.

**NEWMAN, JOSE, M.D., DALLAS, TX, Lic. #D5803**

On December 8, 2006, the Board and Dr. Newman entered into an Agreed Order accepting the voluntary and permanent surrender of Dr. Newman's medical license. The action was based on allegations that Dr. Newman committed boundary violations against two female patients during his examination of them.

**RUSSOL, FREDERICK JOSEPH, M.D., ODESSA, TX, Lic. #E8876**

On February 16, 2007, the Board and Dr. Russol entered into an Agreed Order accepting the voluntary surrender of Dr. Russol's medical license. Concerns regarding Dr. Russol's physical illness gave rise to his determination that he should retire from the practice of medicine and should voluntarily surrender his medical license.

**VAGEFI, ALI, M.D, DALLAS, TX, Lic. #F7671**

On April 13, 2007, the Board and Dr. Vagefi entered into an Agreed Order pursuant to which the Board accepted the voluntary and permanent surrender of Dr. Vagefi's medical license. The action was based on Dr. Vagefi being arrested and charged with online solicitation of a minor.

**MINIMAL STATUTORY VIOLATIONS**

The following licensees agreed to enter into orders with the Board for minimal statutory violations:

Afridi, Shah Nawaz, M.D., Victoria, TX, Lic. #K7961

Angel, Robert Tate, M.D., Waco, TX, Lic. #C8881  
Garton, Susan Mary, D.O., San Antonio, TX, Lic. #H8061

Harris, Brian Eugene, M.D., Matawan, NJ, Lic. #L8068

Lloyd, Scott M., M.D., Tyler, TX, Lic. #H1799  
 Maggi, Sergio Pasquale, M.D., Austin, TX, Lic. #J2175  
 Malone, Mark Thomas, M.D., Austin, TX, Lic. #G3580  
 Martin, Reg Christopher, M.D., Austin, TX, Lic. #L4053  
 Messenger, Dennis Dwight, M.D., San Antonio, TX, Lic. #F4282  
 Redman, Paul Clark, M.D., Dayton, TX, Lic. #D7266  
 Salinas, Fulgencio P., M.D., Edinburg, TX, Lic. #G7325  
 Wald, Donald Marvin, M.D., Morgantown, WV, Lic. #C3277

Yalavarthi, Ranganayaki, M.D., Odessa, TX, Lic. #G2626  
 Youel, Leisa Sharon, M.D., Longwood, FL, Lic. #G2250

### CORRECTION

The summary of the disciplinary actions taken by the Board against Dr. Robert Cassella appearing in the Fall 2006 issue of the *Medical Board Bulletin* included language indicating that Dr. Cassella's license would be suspended for 90 days, following which the suspension would be stayed and Dr. Cassella placed on probation for 10 years. However, the agreement between the Board and Dr. Cassella was that the suspension would be automatically stayed as of the effective date of the order. ♦

*Visit our web site  
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- Information for all licensees and applicants, including online applications and online registration
- Information for consumers, including a function to search for licensees
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**TEXAS MEDICAL BOARD**



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 Donald Patrick, M.D., J.D., Executive Director

**Our 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.**

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# 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 \_\_\_\_\_

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## 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?

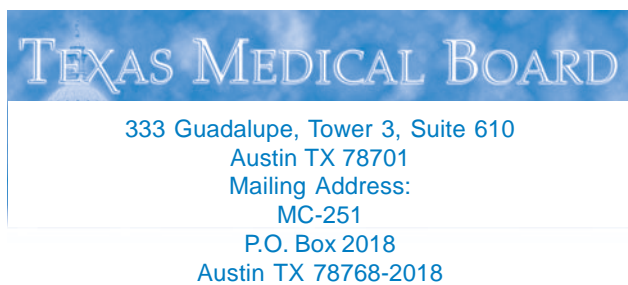
The Board needs to be informed so that licensees receive renewal notices and other communications.

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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