Medical Board Bulletin Fall 2004

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S.B. 104 Implementation Proceeding

Senate Bill 104, passed by the 78th Legislature in 2003, provided TMB with stronger statutes and increased resources of staff and funding to improve regulation of the practice of medicine. The agency has been in high gear to enact all the new provisions, create required new processes, enact required rules and hire and train new staff. The most significant legislative provisions and agency implementation actions from S.B. 104 include the following:

Rules

The TMB Board adopted rules effective in November, 2003, to implement all provisions of S.B. 104, ahead of the January 1, 2004, deadline set in the bill. The new requirements were effective for complaints filed on or after November 1, 2003.

Resources: Increased Funding and Staff

The Legislature provided appropriations, funded by a new $80 physician license surcharge, sufficient to implement S.B. 104 requirements and strengthen regulation.

- The funding covers costs of the Expert Physician Panel and other enforcement activities.
- The bill provided for 20 new FTEs for enforcement. TMB has reorganized agency staffing to effectively utilize the FTEs, increasing investigators from 17 to 26; compliance officers from four to eight; and attorneys from eight to 12. The other new FTEs provide support for investigations, litigation, and compliance.

Enforcement: Greater Effectiveness and Efficiency

S.B. 104 provides stronger authority and more accountability for TMB to identify and discipline physicians who fail to meet the expected standards of professional behavior or competence. TMB has implemented and utilized new rules, procedures, and processes to more aggressively protect the public.

- S.B. 104 sets new statutory deadlines for complaint investigations and litigation and TMB has reorganized staff and revised processes to meet the new deadlines.
- Cases must be set for hearing, either for settlement conference or dismissal, within 180 days after a complaint is filed, unless there is good cause. TMB is meeting the 180-day deadline in at least 97 per cent of cases and the remaining few were extended due to good cause (pending criminal court cases or failure of the respondent to respond to subpoenas).
- The Board must submit an annual report of all complaints that remain pending after one year. The new complaint resolution process allows for six months after investigation for staff attorneys to either obtain an agreed order or file a formal complaint at the State Office of Administrative Hearings. Complaints opened under the new requirements are moving through the system from investigations into litigation.
- At the close of FY 04, there were approximately 300 well-qualified physicians representing a wide variety of specialties who are currently participating in the expert physician panel, established to review standard of care cases. All panel members are board certified and actively practicing medicine in Texas.
- S.B. 104 requires immediate investigation of a violation of a disciplinary order or of a complaint against a license holder under a disciplinary order. TMB has developed a system to provide expedited response to any indications that a licensee is not in compliance with an existing board order and 32 such violations were referred for hearings in FY 04.

Licensure

Significant physician licensure issues in S.B. 104 include:

- implementation of a biennial registration process in 2005; (see story page 22)
- a new $80 license surcharge; and
- revisions to the physician profile reports.

On the Sagging of Medical Professionalism

by Herbert L. Fred, MD, MACP

For the past two decades, medicine has been a profession in retreat, plagued by bureaucracy, by loss of autonomy, by diminished prestige, and by deep personal dissatisfaction. [1] These ills would be bad enough by themselves. But another malady confronts us—the sagging of our professionalism.

Medical professionalism defies precise definition. Fundamentally, however, it boils down to service in the patient's best interest. Among its central elements are (1) commitment to excellence; (2) altruism, with service before self-interest; (3) avoidance of harm; (4) trustworthiness; (5) pursuit of truth based on scientific and humanistic criteria; (6) close cooperation with others in the health care field; and (7) humility. [2]

In this essay, I address our sagging professionalism and offer my thoughts on its clinical manifestations, consequences, causes, and cures.

Clinical Manifestations and Consequences

To me, the most common, and yet most subtle expression of betrayed professionalism is serving ourselves before serving our patients. By doing so, we sacrifice the very core of doctoring—humanism. And as a result, the patient-physician bond becomes weakened—or never even forms. Additional manifestations include abuse of power, arrogance, lack of conscientiousness, and conflicts of interest. [3]

Certain other types of behavior deserve special attention because they are sometimes interpretable as being dishonest. [4] Failure to take charge is a common example. In such cases, the attending physician shirks his or her responsibility, deferring to an army of consultants, each managing a part of the body with no one managing the whole. This buck-passing [5] frequently leads to a host of ill-advised activities—more consultations, inappropriate testing, undocumented diagnoses, over-prescribing of medications, uncalled-for procedures, needlessly prolonged hospitalizations, and unnecessary office visits.

The consultants in these cases commonly shirk their responsibility as well. Although ideally positioned to halt this medical merry-go-round, they ride it instead. Moreover, those with a "gimmick" use it, even when they know it isn't indicated.

And let us not forget the fraudulent reimbursement claims to Medicaid and Medicare or those physicians who, attracted by remuneration and perhaps by a desire for public recognition, serve as expert witnesses even though they clearly are not qualified for the role.

Finally, most physicians simply remain silent when they know or suspect a colleague to be emotionally disturbed, a substance abuser, or just plain incompetent. This reluctance to get involved is particularly deplorable when they know or suspect that an associate is cheating or lying.

Causes

Clearly, numerous factors contribute to our sagging professionalism. Heading the list in my opinion is a change in society's overall priorities and values. Old-fashioned hard work, devotion to duty, and pursuit of excellence have taken a back seat to an emphasis on limited work hours and quests for financial and other types of personal gains. As a result, people at all levels—including many physicians—are satisfied with mediocrity. In fact, mediocrity has become the standard. Given this environment, no wonder our professionalism sags.

External forces largely beyond our control also play a role. Examples are the myriad constraints imposed by insurance companies, the incessant pressures resulting from federally mandated regulations, the glut of "for-profit-not-for-patient" hospital administrators, the lawsuits lurking around every corner, and the reams of paperwork required. Attending to these various demands cuts deeply into the time we could otherwise spend attending to our patients. And complicating the picture are human frailties—especially ignorance, greed, fear of being wrong, and the need for aggrandizement.

Cures

Can we remedy our sagging professionalism? Only insofar as we are willing to be role models of integrity and honesty for each other. Only if we show commitment, compassion, competence, candor, and common sense. Only if we understand and believe that medicine is a calling, not a business. Only if we strive diligently to restore, preserve, and promote the human element in medicine. Only if we look at, listen to, and talk with our patients, working as hard and as long as it takes to ensure their welfare. Only if we always put our patients first.

Final Thought

I leave the reader with a quotation from Béla Schick (1877-1967), renowned Hungarian pediatrician and bacteriologist:

First, the patient, second the patient, third the patient, fourth the patient, fifth the patient, and then maybe comes science. We first do everything for the patient 6

Not only do his words capture the essence of this essay, but they serve to remind us of the ruling principle of our profession.

References

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3) *ibid* , p.14.

4) Fred HL, Robie P. Dishonesty in medicine. *South Med J* 1984; 77:1221-22.

5) Fred, HL. Passing the buck. *South Med J* 1982; 75:1164-65.

6) Strauss MB. Familiar Medical Quotations. Boston, Mass: Little, Brown and Company; 1968:374.

Dr. Fred is a Professor, Department of Internal Medicine, The University of Texas Health Science Center at Houston. He received the American College of Physicians Distinguished Teacher Award for 2004. The Board thanks Dr. Fred for providing this essay.

From the Executive Director

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

More than half of TMB's investigations are based on allegations of a violation of the standard of care.

The initial determination of a possible violation of the standard of care is made by at least two expert panelists. The panel members are board-certified, actively practicing in Texas and have a diverse cultural, gender, and geographic background. We use only those experts practicing in the same or similar specialty as the doctor whose cases are examined

Once the panel has made its recommendation, the Executive Director next reviews all cases that have been found to violate the standard of care by at least two expert panelists. If, in the opinion of the E.D., the Chief of

Litigation, and the Chief of Investigations, the case violates not only the standard of care, but also a provision of the Medical Practice Act, it is sent to the Legal Division. In Legal, a staff attorney determines if the sufficiency of evidence exists for the case to go to an Informal Settlement Conference. (An explanation of the ISC process is covered in a video about TMB produced by the Texas Medical Foundation. The video is available free from TMF at **www.tmf.org** for one hour of CME ethics credit.)

As E.D., I read thousands of pages of factual documentation about alleged shortcomings of our Texas physicians. From that wealth of information, I have highlighted below the areas that I see have the most common problems:

- Lack of experience/training to perform laparoscopic procedures
- Lack of a high enough index of suspicion by emergency physicians and lack of training in diagnosing coronary events, acute abdomens, subarachnoid hemorrhages, and thrombotic or embolic cerebral ischemia
- Extensive spine surgery in the face of minimal or zero indications
- Overzealous coronary arterial interventions and right heart catheterizations
- Lack of vigilance/training in interpreting fetal rhythm strips and intervening in a timely fashion
- Setting up a pain medicine practice without suitable residency training and experience
- Delegating tasks to employees or preceptees that they are not competent to perform
- Inadequate informed consent for diagnostic procedures, invasive procedures, and various treatments

In addition to standard of care cases, the following are the most serious types of non-standard-of-care violations:

- Drug and alcohol abuse
- Drug and alcohol diversion
- Drug and alcohol co-dependency
- Sexual misconduct
- Uncontrolled anger
- Failure to accurately document evaluations, procedures or treatments.

Dr. Roberts Resigns from Board

Joyce A. Roberts, M.D., has resigned from the board in order to be closer to family in New Mexico. She left her practice in Scroggins and began practicing in Fort Sumner, New Mexico, in early November.

At the October 7-8 meeting, Board President Lee Anderson, M.D., read a proclamation thanking Dr. Roberts for her dedication and service to the Board and to the citizens of Texas.

Dr. Roberts was appointed to the Board in July, 1999, and her term would have been completed in April, 2005. The Board and TMB staff are grateful for Dr. Roberts' service and wish her the best in her new home.

Rule Changes

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

Chapter 163, Licensure: Rule review and amendments to §§163.1-163.7, 163.11 and 163.12 concerning eligibility for licensure and general cleanup of the rules. Amendments to §§163.1-163.3, 163.5, 163.6 and repeal of §§163.8 and 163.9 concerning Definitions, Licensure for United States/Canadian Medical School Graduates, Licensure for Graduates of Acceptable Unapproved Medical Schools, Licensure Documentation, and Examinations Accepted for Licensure. Creation of new §163.14, regarding requirements for practicing medicine across state lines (Telemedicine). Creation of new §163.15 concerning permits for applicants practicing under the supervision of a licensed Texas physician for educational purposes or providing charity care to underserved populations in Texas.

Chapter 164, Physician Advertising: Amendments to §164.4 concerning advertising board certification to provide a method for informing the public of the physician's interest and expertise and to identify those physicians possessing board certification.

Chapter 171, Postgraduate Training Permits. Rule review, repeal and replacement of §§171.1-171.7 concerning Purpose, Construction, Physician-in-Training Permits, Board-Approved Postgraduate Fellowship Training Programs, Institutional Permits, Duties of Program Directors to Report Certain Types of Conduct, and Inactive Status.

Chapter 172, Temporary Licenses. Creation of new chapter that authorizes the Board to adopt rules relating to granting certain temporary licenses.

Chapter 174, Telemedicine, repeal of §§174.1-174.17 and new §§174.1-174.5 relating to standards for provision of telemedicine medical services and use of the Internet in transmission of information.

Chapter 175, Fees, Penalties, and Applications: Amendments to §§175.1 and 175.4 concerning increases in application and registration fees for licenses and permits issued by the Board and mandated by Texas Online Authority and increase in physician-in-training fee relating to the length of the permit.

Chapter 177, Certification of Non-Profit Health Organizations, rule review, amendments to §§177.1-177.8, repeal of §§177.9-177.16, and new §§ 177.9-177.13 for general cleanup of the chapter.

Chapter 182, Use of Experts. Rule review and amendments to §182.5 concerning the selection criteria for appointment to the expert panel.

Chapter 183, Acupuncture: Amendment to §183.15 concerning requirement that licensed acupuncturists provide information to the public indicating they are licensed by the Texas State Board of Medical Examiners and that acupuncture is their primary field of practice. Amendments to §§183.2 and 183.16 clarifying that certificates and diplomas are acceptable for acupuncture licensure. Amendments to §183.4 relating to the National Certification Commission for Acupuncture and Oriental Medicine's reformatting of their examination.

Chapter 184, Surgical Assistants, amendments to §184.14 concerning qualifications of supervising physicians.

Chapter 185, Physician Assistants, rule review and amendments to §§185.8, 185.16, and 185.20 regarding inactive status, supervising physicians, employment guidelines, and complaints.

Chapter 186, Supervision of Physician Assistant Students. Rule review with no changes.

Chapter 187, Procedural Rules, amendments to §§187.2 and 187.31; repeal of 187.26, 187.27, and 187.28; and new §§187.26 and 187.27 regarding default judgments by the Board in SOAH administrative proceedings. Amendments to §§187.1, 187.2, 187.4, 187.6-187.9, 187.11-187.14, 187.16-187.20, 187.23-187.27, 187.29, 187.31-187.34, 187.36-187.37, 187.39, 187.43, 187.55, 187.56, 187.58, 187.59, 187.61 and new §187.5 and §187.28 concerning General Provisions and Definitions, Informal Board Proceedings, Formal Board Proceedings at SOAH, Formal Board Proceedings, Proceedings Relating to Probationers and Temporary Suspension Proceedings.

Chapter 190, Disciplinary Guidelines, amendment to §190.8 to clarify the definition of a proper physician/patient relationship for hospice patients. Creation of new §190.16 regarding limits on the amount of administrative penalty assessed with the exception of §190.16(6).

Chapter 192, Office-Based Anesthesia. Amendments to §§192.3-4 relating to compliance with office-based anesthesia rules and registration.

Chapter 193, Standing Delegation Orders: Amendment to §193.6 concerning Delegation of the Carrying Out or Signing of Prescription Drug Orders to Physician Assistants and Advanced Practice Nurses necessary for general cleanup of the section relating to controlled substances and triplicate prescriptions for obstetrical services. Amendments to §193.11, Use of Lasers, regarding continuing education on the use of laser devices.

Chapter 199, Public Information. Rule review and cleanup of §§199.2-199.4. For copies of the rules, go to **www.tmb.state.tx.us** and click on "Board Rules."

Former Board Member Cynthia Jenkins Dies

Condolences to the family and friends of Cynthia L. Jenkins, who died at the age of 53 on October 16. She is survived by her husband, David Jenkins, and her children Jessica and Barkley. She was buried in the Texas State Cemetery in Austin on October 21.

Ms. Jenkins, a public member from Winnie, served on the board from January, 1984, until May, 1997.

DEA Changes Certificates

The Drug Enforcement Administration's Office of Diversion Control has changed the DEA Controlled Substance Registration Certificate. Beginning October 1, the revised Certificate of Registration consists of two parts: a wall certificate and a wallet-size version. The certificate will have an embedded watermark to provide authentication and deter counterfeiting.

Registrants that are currently allowed to renew DEA registration on the Diversion Control Program's web site (retail pharmacies, hospitals, practitioners, mid-level practitioners and teaching institutions) may print their Certificate of Registration upon completion of the registration renewal process as long as no changes have been made to the registration since their last renewal. The web site is at **www.DEAdiversion.usdoj.gov**

DEA will continue to send Certificates of Registration by mail to all new registrants and other renewing DEA registrants.

Acupuncture News

CAE Carryover

In February 2003, rules relating to continuing acupuncture education were enacted to allow acupuncturists to carry over credits earned in previous years to apply to future annual CAE requirements. Under the revised rules, acupuncturists who earn more than 17 hours of CAE in a given year may carry over the excess hours to satisfy licensure renewal requirements for the following two years. No more than a maximum of 34 hours may be carried forward.

Prescriptive Delegation Waivers

In 2002, the Medical Board appointed an advisory committee to review and make recommendations on applications for prescription delegation waivers. Physicians applying for waivers must demonstrate that: (1) they are currently unable to meet requirements set out in the Medical Practice Act and Board rules or that compliance causes an undue burden without a corresponding benefit to patient care; (2) safeguards exist for patient care and for fostering a collaborative practice between the physician and the APNs and PAs; and (3) if the request is for the amount of time the physician is onsite, then the amount of time the physician is onsite with the APN or PA is sufficient for collaboration to occur, taking into consideration other ways they can collaborate. Waiver requests for limitation on the number of APNs or PAs, or on the number of primary or alternate sites **cannot** be waived. Waiver requests are reviewed by the advisory committee and recommendations by the committee are then reviewed by the Medical Board for final approval.

Formal Complaints

Name License No. Date filed Allegations

Merrimon W. Baker, M.D. G4807 6-18-04
Failure to meet the standard of care by performing unnecessary surgery and poor surgical technique.

David B. Barrett, M.D. G7987 10-6-04
Failure to meet the standard of care in performing Cesarean section-hysterectomies on patients and failure to maintain adequate medical records.

Richard W. Berry, M.D. E0814 5-17-04
Impairment due to intemperate use of alcohol and drugs.

Andrew W. Campbell, M.D. G7790 5-11-04
Improper billing; failure to maintain adequate medical records.

Roland F. Chalifoux Jr., D.O. J8953 6-17-04
Failure to meet the standard of care by performing unnecessary surgeries in a negligent manner.

Charles H. House, M.D. D0390 10-14-04
Nontherapeutic prescribing; care and treatment below the standard of care; failure to maintain adequate medical records; overcharging or fraudulent billing

Donald D. Hughes, M.D. E8575 8-6-04
Sexually inappropriate behavior with juvenile patients.

Hamid R. Jalali, D.O. H0491 5-11-04
Failure to meet the standard of care by inappropriately prescribing narcotics.

Michelle J. Lea-Stokes, M.D. G6672 10-14-04
Disciplinary action by peers; knowingly filing false statements with the board; care and treatment below the standard of care; altering medical records.

Michael J. Methner, D.O. L1669 3-5-04
Impairment due to alcohol abuse.

Thomas S. Parker, M.D. F1884 8-9-04
Failure to comply with Agreed Order requiring a practice monitor, requiring CME, cooperating with board staff; inappropriate advertising of a nonexistent medical specialty.

Piyush V. Patel, M.D. G2452 9-14-04
Surgical and medical treatment of a patient that was outside the standard of care during and after an angioplasty procedure.

Donald Earl Payne, M.D. C5348 9-8-04
Falsely recording an examination that had not been done on a three-year-old child suspected of being abused.

Michael C. Scally, M.D. G0066 4-26-04
Paying or promising to pay rewards for securing or soliciting a patient or patronage.

Tasca Darlene Snow, M.D. L3836 10-5-04
Failure to notify the board of change in practice or mailing address within 30 days.

Michael David Williams, D.O. H2907 9-8-04
Failure to meet the standard of care in performing a breast augmentation procedure.

Registration Updates

Several laws passed by the Legislature during the 78th session have mandated increases in physician fees beginning next year. S.B. 104 appropriated more than $6 million to the Texas State Board of Medical Examiners' biennial budget, all dedicated to the agency's enforcement functions.

The bill also changed physician registration from annual to biennial, beginning in 2005. Half of all physician licensees will be switched to biennial registration the first year.

In addition, H.B. 2985 created an Office of Patient Protection, to be established by the Health Professions Council, to represent the interests of consumers in matters before health licensing agencies. The office will be funded by licensure and registration fee increases to licensed health professionals. Initial licensure fees are increased by $5, and renewal fees are increased by $1 for each year for which the license is renewed.

Biennial Registration

One half of the current licensees with expiration dates in 2005, those with odd license numbers, will register for two years, making their registrations valid through 2007. The other half, those with even license numbers, will register for one year in 2005, then for two years in 2006, making their registrations valid through 2008 and spreading the workload evenly through the biennium.

Two-year registration for odd license numbers:

Registration Fee	$260.00
Professional Fee	$400.00
S.B. 104 Surcharge	$ 80.00
TexasOnline Surcharge	$ 8.00
Office of Patient Protection Surcharge	$ 2.00
Total	**$750.00**

One-year registration for even license numbers (to be eliminated in 2006):

Registration Fee	$130.00
Professional Fee	$200.00
S.B. 104 Surcharge	$ 80.00
TexasOnline Surcharge	$ 4.00
Office of Patient Protection Surcharge	$ 1.00
Total	**$415.00**

CME Requirements

CME requirements don't change, but the carryover rules were slightly rewritten to accommodate the biennial registration. See Board Rules, Chapter 166, §166.2(b).

> (1) A licensee may carry forward CME credit hours earned prior to a registration report which are in excess of the 24-hour annual requirement and such excess hours may be applied to the following years' requirements.
>
> (2) A maximum of 48 total excess credit hours may be carried forward and shall be reported according to the categories set out in subsection (a) of this section.
>
> (3) Excess CME credit hours of any type may not be carried forward or applied to a report of CME more than two years beyond the date of the registration following the period during which the hours were earned.

(4) A licensee under a two-year permit who timely registers may apply CME credit hours retroactively to the preceding year's annual requirement; however, those hours may be counted only toward one registration period. A maximum of 24 hours may be applied retroactively.

Online Registration Benefits

Last fiscal year, 77 percent of physician licensees registered online. Here are the benefits of registering online:

- The registration process can be completed in about 30 minutes, and payment is made with a credit card or an electronic check. Registering on paper takes about five working days to complete.
- A receipt is printed showing registration is completed, rather than waiting for a permit to be mailed. The receipt can be presented to organizations, such as hospitals, willing to recognize the receipt until the permit is received.
- Anticipated new feature: Healthcare entities will be able to pay registration fees in a single payment for multiple physicians, making online registration available to more physicians.

Disciplinary Actions

The board has taken the following disciplinary actions since publication of the Spring 2004 *Medical Board Bulletin* against 131 physicians. The Texas State Board of Physician Assistant Examiners took disciplinary action against six physician assistants, and the Texas State Board of Acupuncture Examiners disciplined one acupuncturist.

Aboloye, Pius Ayodele Dupe, M.D., Arlington, TX, Lic. #BP10002194

An Agreed Order was entered on April 2, 2004, revoking Dr. Aboloye's Physician In Training permit number. The action was based on Dr. Aboloye's falsely denying he had ever been convicted of a felony on his licensure application when in fact he had two previous felony convictions (one for mail fraud and one for forgery) and a third felony conviction for possession of fraudulent identification. Dr. Aboloye was sentenced to four years in prison.

Almand, James Raymond, Jr., M.D., Grand Prairie, TX, Lic. #C5989

On August 13, 2004, the Board and Dr. Almand entered into an Agreed Order placing Dr. Almand on probation for two years including monitoring of his practice, maintaining adequate medical records, obtaining 20 hours of Category 1 CME in general records keeping and institution of a Health

Maintenance Record for each of Dr. Almand's new patients. The action was based on allegations that Dr. Almand failed to take a proper history and physical and failed to order appropriate tests and follow up with a patient.

Armendariz, Rafael, D.O., El Paso, TX, Lic. #J9953

On June 4, 2004, the Board and Dr. Armendariz entered into a Mediated Agreed Order assessing an administrative penalty of $5,000. The action was based on allegations that Dr. Armendariz failed to properly supervise a clinical assistant who performed a medical procedure on a patient.

Armstrong, Davill, M.D., Houston, TX, Lic. #F3025

On August 13, 2004, the Board and Dr. Armstrong entered into an Agreed Order requiring a board-approved monitor to review records for three years, and requiring that Dr. Armstrong enroll in and successfully complete 30 hours of CME in documentation/record-keeping and/or risk management. The action was based on allegations that Dr. Armstrong failed to properly evaluate a 12-year-old patient with reported seizures before prescribing Dilantin therapy and failed to monitor the patient after she began the therapy.

Ash, Steven Patterson, M.D., Grapevine, TX, Lic. #H2219

On August 13, 2004, the Board and Dr. Ash entered into an Agreed Order publicly reprimanding Dr. Ash, requiring successful completion of a course on medical errors of at least 20 hours in duration to be completed within one year, and assessing an administrative penalty of $3,000. The action was based on allegations that Dr. Ash removed the wrong kidney from a patient.

Bailey, Shirley, M.D., Longview, TX, Lic. #D9330

On August 13, 2004, the Board and Dr. Bailey entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations of poor office management, including failure to timely supply medical records.

Baisden, Clinton Eugene, M.D., San Antonio, TX, Lic. #F0378

On October 8, 2004, the Board and Dr. Baisden entered into an Agreed Order publicly reprimanding Dr. Baisden, requiring him to complete a boundary violations course, and ordering him to pay a $3,000 administrative penalty. This action was based on allegations that Dr. Baisden made sexually inappropriate remarks and overtures to two co-

workers and an individual conducting business at Dr. Baisden's place of employment.

Barber, Carey Robert, M.D., Daytona Beach, FL, Lic. #L7654

On August 13, 2004, the Board and Dr. Barber entered into an Agreed Order in which Dr. Barber voluntarily and permanently surrendered his license. The action was based on Dr. Barber's violation of his prior board order for intemperate use of alcohol. The violation involved Dr. Barber's failure to disclose his ingestion of a prescription medication as mandated by his order.

Barklis, Sam Steven, M.D., Fort Worth, TX, Lic. #D6702

On June 4, 2004, the Board and Dr. Barklis entered into an Agreed Order in which Dr. Barklis voluntarily and permanently surrendered his license. The action was based on Dr. Barklis' nontherapeutic prescribing of drugs to a patient, and Dr. Barklis being diagnosed with a physical or mental condition that precludes his practice of medicine.

Beene, Ronda Lawaine, D.O., Arlington, TX, Lic. #J1871

On June 4, 2004, the Board and Dr. Beene entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. Beene failed to timely provide a patient's medical records on request.

Beaubrun, Yvon, M.D., Irving, TX, Lic. #F4753

On August 13, 2004, the Board and Dr. Beaubrun entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. Beaubrun had failed to timely acquire required CME.

Bennett, John Scott, D.O., Luling, TX, Lic. #G4820

On October 8, 2004, the Board and Dr. Bennett entered into an Agreed Order wherein Dr. Bennett voluntarily surrendered his license. This action was based on allegations of nontherapeutic prescribing.

Bergman, Stuart Alonzo Jr, M.D., San Antonio, TX, Lic. #D5914

A Temporary Suspension Order was entered by the Board on July 27, 2004, temporarily suspending Dr. Bergman's license due to evidence that Dr. Bergman's continuation in the practice of medicine presents a continuing threat to public welfare. The order remains in effect until such

time as it is superseded by a subsequent order of the Board. The suspension was based on allegations that included terroristic threats made by Dr. Bergman to a staff attorney of the Board of Medical Examiners, failure to keep complete and accurate records of purchases and disposal of controlled substances, and prescribing or administering a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is administered or prescribed.

Boyles, Rick A., M.D., Baytown, TX, Lic. #J6345

A Temporary Suspension Order was entered on September 9, 2004, temporarily suspending Dr. Boyles' license without notice due to evidence that the physician's continuation in the practice of medicine would constitute a continuing threat to public welfare. The allegations that led to the Temporary Suspension Order will be the subject of a Temporary Suspension Hearing with notice as soon as possible after proper notice. The Temporary Suspension Order shall remain in full force and effect until such time as it is superseded by a subsequent order of the Board. The action was based on intemperate use of drugs.

Brinkman, Diane Loise, M.D., Austin, TX, Lic. #G3985

On August 13, 2004, the Board and Dr. Brinkman entered into an Agreed Order requiring Dr. Brinkman to obtain 10 hours of CME in documentation/record-keeping, and assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Brinkman failed to adequately document her procedures and surgical techniques during an operation (a left salpingo-oophorectomy.)

Burleson, James Dewain, M.D., Stamford, TX, Lic. #H1932

On July 7, 2004, the Board and Dr. Burleson entered into an Agreed Order suspending Dr. Burleson's license for six months followed by probation of 10 years under terms and conditions including continuing care contract with Metro Atlanta Recovery Residences, passage of the SPEX exam within one year, random drug screening, and attendance at AA at least three times a week. The action was based on allegations that Dr. Burleson self-injected morphine.

Calderon, Guido Jose, M.D., San Marcos, TX, Lic. #K4008

On June 4, 2004, the Board and Dr. Calderon entered into an Agreed Order publicly reprimanding Dr. Calderon. The action was based on allegations that Dr. Calderon failed to admit a patient who presented to the emergency room with symptoms of small bowel obstruction, which delayed the timely diagnosis and treatment of the patient's disease.

Carcamo, Benjamin, M.D., El Paso, TX, Lic. #J0881

On June 4, 2004, the Board and Dr. Carcamo entered into an Agreed Order suspending Dr. Carcamo's license for 45 days, completion of 20 hours of CME in chemotherapy, visitation at an oncology hospital for one week, and preparation of a chemotherapy verification protocol. The action was based on allegations that Dr. Carcamo failed to note that a patient received incorrect doses (10 times normal) of Ara-C during a chemotherapy protocol.

Carreno, Fernando, M.D., Corpus Christi, TX, Lic. #K3695

On October 8, 2004, the Board and Dr. Carreno entered into an Agreed Order requiring Dr. Carreno to pay a $1,000 administrative penalty. This action was based on allegations that Dr. Carreno failed to timely provide medical records to a patient's attorney.

Chalifoux, Roland F. Jr, D.O., South Lake, TX, Lic. #J8953

On June 4, 2004, the Board revoked Dr. Chalifoux's license. The action was based on allegations that Dr. Chalifoux failed to practice medicine in an acceptable professional manner as regards his surgery on and treatment of three patients. Dr. Chalifoux filed an appeal at District Court on August 12.

Chaparala, Sukumar, M.D., Blackwell, OK, Lic. #J3446

On April 2, 2004, the Board and Dr. Chaparala entered into an Agreed Order publicly reprimanding Dr. Chaparala, restricting Dr. Chaparala from practicing in Texas until he is released or terminated from the Oklahoma Agreed Order and appears before the Texas Medical Board and is granted permission to practice in Texas. Dr. Chaparala was also assessed an administrative penalty in the amount of $3,000. The action was based on allegations that Dr. Chaparala falsely completed his Texas Physician Annual Registration regarding the question concerning his arrest history.

Chavez, Bennie, M.D., Amarillo, TX, Lic. #J6089

On August 13, 2004, the Board and Dr. Chavez entered into an Agreed Order suspending Dr. Chavez's license but probating the suspension for three years, and requiring attendance at a course at Vanderbilt University in Nashville, Tennessee, on physician/patient boundary issues. The action was based on allegations that Dr. Chavez had a one-occurrence sexual relationship with an employee/patient.

Cobb, Tyson King, M.D., Bettendorf, IA, Lic. #J3297

On June 4, 2004, the Board and Dr. Cobb entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. Cobb had failed to timely renew his Texas license and had failed to ensure that his required CME included an hour of ethics.

Crim, John, D.O., Arlington, TX, Lic. #J8976

On August 13, 2004, the Board and Dr. Crim entered into an Agreed Order suspending Dr. Crim's license, but probating the suspension for two years, requiring his attendance at a course at Vanderbilt University in Nashville, Tennessee, on physician/patient boundary issues, completion of 10 hours of Category 1 CME in record-keeping, and assessing an administrative penalty of $2,000. The action was based on allegations that Dr. Crim nontherapeutically prescribed controlled substances to a patient and became financially involved with that patient.

Cronk, John Arthur, D.O., Quinlan, TX, Lic. #H7006

On April 2, 2004, the Board and Dr. Cronk entered into an Agreed Order suspending Dr. Cronk's license until such time as he can show that he is physically and mentally competent to safely practice medicine. The action was based on allegations of Dr. Cronk's habitual use of the controlled substance methamphetamine.

Cumberbatch, Karyn-Anne B., M.D., Stockbridge, GA, Lic. #J1642

On April 2, 2004, the Board and Dr. Cumberbatch entered into an Agreed Order assessing an administrative penalty in the amount of $1,000. The action was based on allegations of Dr. Cumberbatch's failure to provide documentation for CME on one hour of ethics training for the period June 1, 2001, to May 31, 2002.

Dominguez, Jorge E., M.D., Brownsville, TX, Lic. #H3561

On April 2, 2004, the Board and Dr. Dominguez entered into an Agreed Order requiring that Dr. Dominguez obtain eight hours of education in interpersonal communications, complete a one-hour course on physician stress and burnout, and pay an administrative penalty in the amount of $5,000. The action was based on allegations that Dr. Dominguez's privileges had been suspended by two hospitals for unprofessional conduct involving verbal altercations with three fellow physicians.

Easter, Thomas Glenn, II, M.D., El Paso, TX, Lic. #G7801

On August 13, 2004, the Board and Dr. Easter entered into an Agreed Order restricting Dr. Easter's license for seven years under the same

terms and conditions that are a part of his deferred adjudication, and publicly reprimanding Dr. Easter. The action was based on Dr. Easter entering of a plea of guilty in 2001 and being placed on a deferred adjudication for 10 years for improperly prescribing narcotic drugs.

Ende, Maurice Joseph, M.D., Houston, TX, Lic. #G1646

On April 2, 2004, the Board and Dr. Ende entered into a Mediated Agreed Order subjecting Dr. Ende to chart monitoring for three years and assessing an administrative penalty in the amount of $500. The action was based on allegations that Dr. Ende failed to properly interpret five X-rays.

Evans, Patricia Rae, M.D., Kingman, AZ, Lic. #K2459

On April 2, 2004, the Board and Dr. Evans entered into an Agreed Order suspending Dr. Evans' license until such time as she personally appears before the Board and provides evidence and information which, in the discretion of the Board, indicates that she is physically, mentally and otherwise competent to safely practice medicine. The action was based on disciplinary action taken by Arizona regarding Dr. Evans' abuse of the drug Fentanyl.

Fath, Steven Wade, M.D., Seguin, TX, Lic. #K8144

On June 4, 2004, the Board and Dr. Fath entered into an Agreed Order suspending his license for three years, but probating the suspension for three years. The action was based on Dr. Fath's plea of *nolo contendere* to a charge of driving while intoxicated.

Fielder, Randal Lee, M.D., Portland, TX, Lic. #K7532

On August 13, 2004, the Board and Dr. Fielder entered into an Agreed Order suspending Dr. Fielder's license until such time as he personally appears before the Board and provides evidence and information which, in the discretion of the Board, indicates that he is physically, mentally and otherwise competent to safely practice medicine. The action was based on allegations of inadequate medical decision-making and skills in the emergency room, and the termination of Dr. Fielder's emergency room privileges.

Fleming, Forney Withers III, M.D., Port Arthur, TX, Lic. #D5989

On April 2, 2004, the Board and Dr. Fleming entered into a Mediated Agreed Order publicly reprimanding Dr. Fleming and restricting his license for three years under terms and conditions including Dr. Fleming's

implementation of a communications system for his practice, monitoring of his practice, obtaining 25 hours of CME in risk management and skeletal radiographic studies, and assessing an administrative penalty in the amount of $7,500. The action was based on allegations that Dr. Fleming failed to diagnose an osteosarcoma.

Franklin, Stanley Felix, M.D., Lewisville, TX, Lic. #F8755

On August 13, 2004, the Board and Dr. Franklin entered into an Agreed Order publicly reprimanding Dr. Franklin, suspending his license, but probating the suspension for five years, requiring 50 hours of CME, of which at least 25 hours shall be in the area of high-risk obstetrics, and assessing an administrative penalty of $50,000. The action was based on allegations that Dr. Franklin failed to properly monitor a baby during the last stages of delivery, improperly used Cytotec to induce labor when contraindications existed, and failed to timely perform a C-section, all of which resulted in an emergency hysterectomy to the mother, and brain damage to the child.

Gant, James Curtis, M.D., Jacksonville, NC, Lic. #G5074

On June 4, 2004, the Board and Dr. Gant entered into an Agreed Order publicly reprimanding Dr. Gant and requiring that he personally appear before the Board before returning to Texas and resuming practice. The action was based on disciplinary action by the North Carolina Medical Board for failure to diagnose and treat a VP shunt malfunction in a 13-year-old girl, who subsequently died.

Garcia, Joseph, M.D., Tarpon Springs, FL, Lic. #G5076

On April 2, 2004, an Agreed Order was entered publicly reprimanding Dr. Garcia and requiring that he successfully complete an approved course in risk management. The action was based on allegations that Dr. Garcia failed to recognize that a cardiac patient was in imminent danger due to inadequate information and failed to follow up after scheduling surgery on the patient.

Garner, John Edward, D.O., Groves, TX, Lic. #F3133

On August 13, 2004, the Board and Dr. Garner entered into an Agreed Order suspending Dr. Garner's license until such time as he personally appears before the Board and provides evidence and information which, in the discretion of the Board, indicates that he is physically, mentally and otherwise competent to safely practice medicine. The action was based on allegations of intemperate use of alcohol.

Gehring, Del E., M.D., Davenport, IA, Lic. #H1089

On June 4, 2004, the Board and Dr. Gehring entered into an Agreed Order in which Dr. Gehring voluntarily and permanently surrendered his license. The action was based on allegations of alcohol dependency and depression and Dr. Gehring's desire to cease the practice of medicine.

Gonzalez, Javier Antonio, M.D., Rosenberg, TX, Lic. #K0045

On August 13, 2004, the Board and Dr. Gonzalez entered into an Agreed Order requiring that Dr. Gonzalez obtain 20 hours of CME in record-keeping and pharmacology in young children, and assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Gonzalez did not meet the standard of care by treating an infant with Phenergan for a prolonged period of time.

Greenberg, Arthur Paul, M.D., San Antonio, TX, Lic. #K4906

On August 13, 2004, the Board and Dr. Greenberg entered into an Agreed Order requiring Dr. Greenberg to enroll in and successfully complete 30 hours of CME (10 hours in record-keeping and 20 hours in charting histories and physicals), and assessing an administrative penalty of $2,000. The action was based on allegations that Dr. Greenberg prescribed Viagra via the Internet to four patients without establishing a physician-patient relationship.

Grover, Pawan, M.D., Missouri City, TX, Lic. #H8932

On August 13, 2004, the Board and Dr. Grover entered into an Agreed Order requiring Dr. Grover to obtain 10 hours of CME in the area of medical record-keeping and requiring Dr. Grover to complete a discussion paper on the topic "identifying deceptive pain patients." The action was based on allegations of inadequate record-keeping.

Glasgow, Mark Lawrence, M.D., Floyds Knobs, IN, Lic. #H5888

On April 2, 2004, the Board and Dr. Glasgow entered into an Agreed Order suspending Dr. Glasgow's license until such time as he can show he is physically and mentally competent to safely practice medicine. The action was based on allegations that Dr. Glasgow was disciplined by Kentucky due to his abuse of Fentanyl.

Habenicht, David William, M.D., Austin, TX, Lic. #H5241

On August 13, 2004, the Board and Dr. Habenicht entered into an Agreed Order assessing an administrative penalty of $500. The action was based on a violation of patient-doctor confidentiality.

Hartin, Richard B. Jr., M.D., Cedar Park, TX, Lic. #G6524

On April 2, 2004, the Board and Dr. Hartin entered into an Agreed Order requiring that Dr. Hartin comply with all provisions of his October 4, 2002, Agreed Order including providing a copy of said Order to all employers or supervising physician(s). The action was based on allegations that Dr. Hartin had violated his existing Agreed Order of October 4, 2002, which involved allegations of drug abuse.

Hairston, R. Keith, M.D., Texarkana, TX, Lic. #K1458

On June 4, 2004, the Board and Dr. Hairston entered into an Agreed Order in which Dr. Hairston voluntarily and permanently surrendered his license. The action was due to a mental or physical condition that precluded Dr. Hairston's ability to practice medicine.

Hood, Charles Hardin, M.D., San Antonio, TX, Lic. #D1150

On June 4, 2004, the Board and Dr. Hood entered into an Agreed Order assessing an administrative penalty in the amount of $3,000. The action was based on allegations that Dr. Hood failed to meet the standard of care by improperly evaluating a patient who reported to the emergency room with wheezing and pain in her chest from a fall.

Hinojosa, Jose Luis, M.D., Mission, TX, Lic. #H0450

On April 2, 2004, the Board and Dr. Hinojosa entered into an Agreed Order assessing an administrative penalty in the amount of $500. The action was based on allegations of Dr. Hinojosa's failure to use a certified X-ray technician to operate radiation equipment in his facility.

Hughes, Donald Duane, M.D., Fort Worth, TX, Lic. #E8575

A Temporary Suspension Order was entered on May 13, 2004, temporarily suspending Dr. Hughes' license without notice 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 full force and effect until such time as it is superseded by a subsequent order of the Board. The action was based on allegations of sexual misconduct with adolescent patients. A Temporary Suspension Order With Notice was entered on July 13, 2004, upholding the Board's May 13, 2004, order, which temporarily suspended

Dr. Hughes' medical license. The order remains in effect until such time as it is superseded by a subsequent order of the Board. The suspension was based on allegations that included sexual misconduct with adolescent patients.

Jaikaran, Jacques S., M.D., Kingwood, TX, Lic. #F2731

On April 2, 2004, the Board revoked Dr. Jaikaran's license. The action was based on allegations that Dr. Jaikaran refused to comply with the terms and conditions of his 2002 Agreed Order requiring him to obtain an approved monitor. Dr. Jaikaran filed an appeal at District Court on September 2, 2004.

Jarem, Bohdan John, M.D., Houston, TX, Lic. #D9829

On June 4, 2004, the Board and Dr. Jarem entered into an Agreed Order in which Dr. Jarem voluntarily and permanently surrendered his license. The action was due to a mental or physical illness that precluded Dr. Jarem's ability to practice medicine.

Jennings, Leslie Desmond, M.D., Dallas, TX, Lic. #F9619

On April 2, 2004, the Board and Dr. Jennings entered into an Agreed Order assessing an administrative penalty in the amount of $750. The action was based on allegations of substandard care by operating on a knee that was not originally planned for surgery.

Jimenez, Robert Leo, M.D., San Antonio, TX, Lic. #D3283

On August 13, 2004, the Board and Dr. Jimenez entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. Jimenez failed to timely provide a patient's medical records.

John, Paul William, M.D., Austin, TX, Lic. #J0887

On October 8, 2004, the Board and Dr. John entered into an Agreed Order assessing a $1,000 administrative penalty. This action was based on allegations that Respondent provided blank prescriptions to a pharmaceutical representative.

Khan, Wasim Mohammad, M.D., Lufkin, TX, Lic. #J9729

On April 2, 2004, the Board and Dr. Khan entered into an Agreed Order requiring Dr. Khan to pass the Medical Jurisprudence Examination within one year and assessing an administrative penalty in the amount of $1,000.

The action was based on allegations that Dr. Khan was operating a retail pharmacy, charging excessive fees, and representing himself as a specialist in "men's health."

Kelley, Jared Lee, M.D., Irving, TX, Lic. #F1701

On October 8, 2004, the Board and Dr. Kelley entered into an Agreed Order suspending Dr. Kelley's license. This action was based on allegations that Dr. Kelley violated his prior Agreed Order by relapsing into Vicodin abuse and failing to properly participate in the Board's drug testing program.

Kim, Dong Soo, M.D., Houston, TX, Lic. #G1689

On August 13, 2004, the Board and Dr. Kim entered into an Agreed Order restricting Dr. Kim from treating any existing chronic pain patients or accepting any new chronic pain patients until further order of the Board, and 50 hours of CME in record-keeping and pain management for three years. Dr. Kim was under a previous board order for failure to adequately document his providing narcotics to patients. The action was based on allegations that Dr. Kim again prescribed narcotics without adequate documentation supporting the type and amounts of narcotics prescribed.

King, John Anderson, D.O., Orlando, FL, Lic. #J5803

On June 4, 2004, the Board and Dr. King entered into an Agreed Order in which Dr. King voluntarily and permanently surrendered his license. The action was based on suspension of clinical privileges by a peer organization.

King, Michael William, M.D., Port Arthur, TX, Lic. #F1709

On April 2, 2004, the Board and Dr. King entered into an Agreed Order publicly reprimanding Dr. King, restricting him from prescribing controlled substances or dangerous drugs with addictive potential or potential for abuse to himself or his immediate family, and assessing an administrative penalty in the amount of $5,000. The action was based on allegations that Dr. King was abusing and prescribing drugs to family members and his failure to provide the Board with medical records in a timely fashion.

Klein, Ira, M.D., Houston, TX, Lic. #E3574

On October 8, 2004, the Board and Dr. Klein entered into an Agreed Order publicly reprimanding Dr. Klein, assessing a $25,000 administrative penalty, and restricting his license for five years as follows: he may only provide, administer or charge for such medications that are needed for

acute care; he must maintain adequate medical records on all office visits; medical records must be available for inspection by Board employees; he must complete 10 hours of CME in billing and coding each year; his practice will be monitored; and he will perform 80 colonoscopies, free of charge, to 80 indigent persons. This action was based on allegations that Dr. Klein improperly billed his patients.

Kristiansen, Sonja Bohn, M.D., Houston, TX, Lic. #H7623

On August 13, 2004, the Board and Dr. Kristiansen entered into an Agreed Order publicly reprimanding Dr. Kristiansen, requiring Dr. Kristiansen to notify any patient prior to a procedure as to the estimated costs that will be billed to the insurance carrier versus the patient's estimated responsibility, requiring that Dr. Kristiansen refrain from billing an office visit code with a procedure unless documented as a separate service, and assessing an administrative penalty of $5,000. The action was based on allegations that Dr. Kristiansen failed to adequately document the services provided for the charges billed.

Lane, Frank Elmer, M.D., Dallas, TX, Lic. #G3541

On August 13, 2004, the Board and Dr. Lane entered into an Agreed Order assessing an administrative penalty in the amount of $500. The action was based on allegations of failing to timely release patient medical records.

Le, Nhi P., M.D., Port Lavaca, TX, Lic. #K9105

On October 8, 2004, the Board and Dr. Le entered into an Agreed Order publicly reprimanding Dr. Le. The action was based on a hospital's suspension of Dr. Le's privileges.

Ledley-Lewis, Annmarie McRena, D.O., Farmers Branch, TX, Lic. #K6640

On June 4, 2004, the Board approved a Final Order on Dr. Ledley-Lewis' license following a contested case hearing including a Public Reprimand, a $9,500 administrative penalty, an additional 50 hours of CME, passage of the Medical Jurisprudence examination, development and provision to the Board of a billing practices report, and payment of $3,298.30 for the cost of the hearing transcript. The action was based on Dr. Ledley-Lewis' failure to return to the hospital to deliver a stillborn infant and directing a nurse to deliver the stillborn infant.

Lewis, Harold Ray, M.D., Dallas, TX, Lic. #D8323

On August 13, 2004, the Board and Dr. Lewis entered into an Agreed Order prohibiting Dr. Lewis from performing any cardiac procedures, whether for diagnostic or interventional purposes, without a Board-approved proctor for the first 100 catheterization procedures, and requiring Dr. Lewis to obtain 10 hours of CME in record-keeping. The action was based on allegations that Dr. Lewis failed to meet the standard of care in four cardiac cases by failing to include all relevant information in the medical records.

Liegel, Joyce M., M.D., Kingwood, TX, Lic. #J9592

A Temporary Suspension Order was entered on February 12, 2004, temporarily suspending Dr. Liegel'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 on allegations that Dr. Liegel violated patient boundaries by borrowing money from a patient, interfered with patient family relationships and breached patient confidentiality by revealing a patient was HIV positive.

Lim, Jaime Chung, M.D., Wichita Falls, TX, Lic. #G9147

On June 4, 2004, the Board and Dr. Lim entered into an Agreed Order extending Dr. Lim's October 3, 2003, board order from three years to three and one half years and assessing an administrative penalty in the amount of $5,000. The action was based on Dr. Lim's failure to investigate and properly diagnose a patient's medical condition and giving injections to the patient without documented medical necessity.

Lyde, Paul Daniel, M.D., Coppell, TX, Lic. #H0586

On October 8, 2004, the Board and Dr. Lyde entered into an Agreed Order assessing a $3,000 administrative penalty. The action was based on allegations that Dr. Lyde failed to diagnose kidney dysfunction that resulted in patient harm.

MacKenzie, Sean Patrick, M.D., Rockford, IL, Lic. #K8314

On August 13, 2004, the Board and Dr. Mackenzie entered into an Agreed Order assessing an administrative penalty of $500. The action was based allegations on excessive charges billed by Dr. Mackenzie for medical records to a patient.

Mailman, Douglas Raymond, M.D., Kerrville, TX, Lic. #J7350

A Temporary Suspension Order was entered on October 6, 2004, temporarily suspending Dr. Mailman's license without notice due to evidence that the physician's continuation in the practice of medicine would constitute a continuing threat to public welfare. The suspension was based on Dr. Mailman's failure to comply with an Agreed Order entered in October 2002 that revoked his license, stayed the revocation, and placed him on probation for 10 years in order to monitor substance abuse problems. The allegations that led to the Temporary Suspension Order will be the subject of a Temporary Suspension Hearing with notice to be held at a date to be determined. The Temporary Suspension Order shall remain in full force and effect until such time as it is superseded by a subsequent Order of the Board. The action was based on violation of a previous order by relapse into drug abuse and allegations of sexual misconduct with a patient.

Martin, Pamela Marie, M.D., Chandler, AZ, Lic. #H8232

On August 10, 2004, the Board entered an order suspending Dr. Martin's license. The action was based on allegations that Dr. Martin had failed to comply with her 2003 board order which required passage of the Texas Medical Jurisprudence exam.

McDougall, Clair L., M.D., Casa Grande, AZ, Lic. #D7449

On October 8, 2004, the Board and Dr. McDougall entered into an Agreed Order accepting the voluntary and permanent surrender of Dr. McDougall's license. The action was based on allegations that Dr. McDougall was disciplined by the Arizona medical board for drug misuse, conduct that harmed a patient, and failing to provide a urine specimen for drug testing purposes when ordered to do so.

McKown, Michael Wayne, D.O., Corpus Christi, TX, Lic. #K2243

On August 13, 2004, the Board revoked Dr. McKown's license. The action was based on allegations that Dr. McKown violated compliance with the terms and conditions of his 2002 Agreed Order requiring drug testing. Dr. McKown may file a Motion for Rehearing within 20 days of the order. If a Motion for Rehearing is filed and the Board denies the motion, the order is final. If a Motion for Rehearing is filed and the Board grants the motion, the order is not final and a hearing will be scheduled.

McMinn, Monty Ruey, M.D., San Antonio, TX, Lic. #E2422

On June 4, 2004, the Board and Dr. McMinn entered into an Agreed Order in which Dr. McMinn retired from the practice of medicine and voluntarily and permanently surrendered his license.

Miro, Aurelio, M.D., Lubbock, TX, Lic. #J5230

On June 4, 2004, the Board and Dr. Miro entered into an Agreed Order in which Dr. Miro voluntarily and permanently surrendered his license. The action was based on allegations that Dr. Miro had improper sexual contact with a female patient.

Moore, Charles Thomas, M.D., Austin, TX, Lic. #E4539

On April 2, 2004, the Board and Dr. Moore entered into an Agreed Order placing Dr. Moore on probation for seven years, and requiring a board-approved monitor to review certain patient records. The Board also assessed an administrative penalty in the amount of $10,000. The action was based on allegations that Dr. Moore failed to maintain adequate medical records, ordered extensive laboratory tests without adequate charting and charged fees that were excessive in light of the medical records.

Mora, Alexander III, M.D., San Antonio, TX, Lic. #G5972

On April 2, 2004, the Board and Dr. Mora entered into an Agreed Order publicly reprimanding Dr. Mora, requiring that Dr. Mora enroll in and successfully complete an approved course in CPT coding, requiring that Dr. Mora obtain 10 hours of CME in ethics and assessing an administrative penalty in the amount of $5,000. The action was based on allegations that Dr. Mora improperly billed a patient's insurance plan by charging the plan for each individual laboratory test rather than submitting one claim for the panel of tests, a practice commonly known as unbundling.

Morales, Freddie Miguel, M.D., Killeen, TX, Lic. #G6081

On August 13, 2004, the Board and Dr. Morales entered into an Agreed Order assessing an administrative penalty in the amount of $5,000. The action was based on allegations that Dr. Morales had failed to timely complete medical records and had ignored Board requests for information.

Muncrief, Kim Ivan, D.O., Sallisaw, OK, Lic. #G7284

On February 6, 2004, the Board and Dr. Muncrief entered into an Agreed Order restricting Dr. Muncrief's license to preclude his practice of medicine in Texas until such time as he requests permission in writing to resume the practice of medicine, appears before the Board and provides sufficient evidence and information which, in the discretion of the Board, adequately indicates that Dr. Muncrief is physically, mentally and otherwise competent to safely practice medicine. The action was based on Dr. Muncrief's

prescribing Oxycontin in 2001 to a teenage patient without checking medical records of the patient and determining a valid medical necessity for the drug.

Murrell, Brian Scott, M.D., Odessa, TX, Lic. #H5595

On August 13, 2004, the Board and Dr. Murrell entered into an Agreed Order placing terms and conditions on Dr. Murrell's license for five years including evaluation and treatment from a Board-approved psychologist regarding anger management and interpersonal skills and assessing an administrative penalty of $5,000. The action was based on allegations of disciplinary action taken by a hospital regarding inappropriate comments made by Dr. Murrell.

Nichols, Dwight James, M.D., Breckenridge, TX, Lic. #D0985

On October 8, 2004, the Board and Dr. Nichols entered into an Agreed Order requiring a practice monitor, a prescription logbook, an agreement not to treat any new chronic pain patients, 50 hours of CME, passage of the Special Purpose Exam, and payment of a $5,000 administrative penalty. The action was based on allegations that Dr. Nichols had prescribed controlled substances without proper evaluations and diagnoses.

Olusola, Benedict Oladipo, M.D., DeSoto, TX, Lic. #J7118

On October 8, 2004, the Board and Dr. Olusola entered into an Agreed Order publicly reprimanding Dr. Olusola and assessing an administrative penalty of $1,000. The action was based on allegations that Respondent entered into a deferred adjudication order for a misdemeanor domestic disturbance.

Pang, Shing Yip, M.D., Arlington, TX, Lic. #J1124

On April 2, 2004, the Board and Dr. Pang entered an Agreed Order accepting Dr. Pang's voluntary and permanent surrender of his license. The action was based on allegations that Dr. Pang violated a prior board order by consuming prohibited drugs and presenting forged medical records to the Board in an attempt to cover up his drug use while on vacation.

Patel, Dipakkumar Dhanjibhai, M.D., Midland, TX, Lic. #H1170

On October 8, 2004, the Board revoked Dr. Patel's license. The action was based on Dr. Patel's incarceration due to aiding and abetting in mail fraud. Dr. Patel may file a Motion for Rehearing within 20 days of the

order. If a Motion for Rehearing is filed and the Board denies the motion, the order is final. If a Motion for Rehearing is filed and the Board grants the motion, the order in not final and a hearing will be scheduled.

Patel, Chandrakant G., M.D., Beaumont, TX, Lic. #J3872

The Board and Dr. Patel entered into an Agreed Order assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Patel failed to timely provide a patient's medical records to an insurance carrier even after he received payment for the records.

Patel, Vinodkumar C., M.D., Austin, TX, Lic. #F8980

On June 4, 2004, the Board and Dr. Patel entered into an Agreed Order assessing a $1,000 administrative penalty. The action was based on allegations that Dr. Patel failed to timely release a patient's medical records on request.

Payne, Steven Mathieu, M.D., Houston, TX, Lic. #J0184

On April 2, 2004, the Board and Dr. Payne entered into an Agreed Order revoking Dr. Payne's license. The action was based on allegations that Dr. Payne conducted an inappropriate examination of a female patient.

Perez, Oscar, M.D., Wausau, WI, Lic. #BP10007037

On April 2, 2004, the Board and Dr. Perez entered into an Agreed Order placing terms and conditions on Dr. Perez's license for three years including psychiatric treatment and successful completion of an approved course regarding boundary violations. The action was based on the fact that Dr. Perez was terminated from a residency program due to allegations of unprofessional conduct, boundary issues, unethical conduct, tardiness and absenteeism.

Perry, Robert Roland, M.D., Allen, TX, Lic. #J8712

On October 8, 2004, the Board and Dr. Perry entered into an Agreed Order assessing a $20,000 administrative penalty and requiring Dr. Perry to continue with his drug abuse recovery plan outlined in an August 15, 2003, Agreed Order. This action was based on allegations that Dr. Perry took Tramadol or Ultracet, alleging he had mistaken it for Aleve.

Peters, Alonzo III, M.D., Houston, TX, Lic. #F4696

A Temporary Suspension Order was entered on September 10, 2004, temporarily suspending Dr. Peters' license due to evidence that the

physician's continuation in the practice of medicine would constitute a continuing threat to public welfare. The action was based on Dr. Peters' failure to comply with an Agreed Order of October 24, 2003, that required him to maintain a log of prescribing medication for pain and nontherapeutic prescribing. The Temporary Suspension Order shall remain in full force and effect until such time as it is superseded by a subsequent order of the Board.

Pherwani, Rakesh, D.O., Spring, TX, Lic. #BP30008437

On April 2, 2004, an order was entered suspending Dr. Pherwani's Texas Postgraduate Resident Permit. The action was based on Dr. Pherwani's conviction of sexual offenses and incarceration in a state penitentiary for 15 years.

Pruett, Jack Ridings, M.D., Sour Lake, TX, Lic. #D8389

On June 4, 2004, the Board and Dr. Pruett entered into an Agreed Order in which Dr. Pruett agreed to eliminate his prescriptive authority for all Schedule II, III, and IV drugs within seven days of the entry of the order. The action was based on allegations that Dr. Pruett prescribed controlled substances without documentation to support any medical necessity for such drugs.

Ramirez, Daniel Angel, M.D., Plano, TX, Lic. #F4402

On October 8, 2004, the Board and Dr. Ramirez entered into an Agreed Order publicly reprimanding Dr. Ramirez, requiring him to attend a course on professional boundaries, and assessing a $2,000 administrative penalty. The action was based on allegations that Dr. Ramirez had prescribed controlled substances to a habitual user with whom he was romantically involved.

Rana, Athar Niaz, M.D., Odessa, TX, Lic. #F8628

On October 8, 2004, the Board and Dr. Rana entered into an Agreed Order suspending his license. This action was based on allegations that Dr. Rana was convicted of felony healthcare fraud.

Rhodes, Ernesto Philip, M.D., Midland, TX, Lic. #J3886

On August 13, 2004, the Board and Dr. Rhodes entered an Agreed Order suspending Dr. Rhodes' license through October 30, 2004, then staying the suspension and placing him on probation including attendance of AA, NA, or SLAA not less than five times per week, requiring random drug screens, a forensic evaluation for substance abuse by a Board- approved

psychiatrist, and a complete examination by a Board-approved physician. The action was based on allegations that Dr. Rhodes abused drugs by ingesting cocaine while seeing patients.

Robinson, Luke Elgene, M.D., Victoria, TX, Lic. #E4642

On June 4, 2004, the Board and Dr. Robinson entered into an Agreed Order in which Dr. Robinson voluntarily and permanently surrendered his license. The action was based on Dr. Robinson's intemperate use of alcohol.

Rocha, Ricardo A., M.D., Dallas, TX, Lic. #D3385

On July 20, 2004, an order was entered suspending Dr. Rocha's license. The action was based on evidence that Dr. Rocha had violated compliance with the terms and conditions of his 2003 Agreed Order requiring passage of the SPEX examination and successful completion of 10 hours of CME in risk management.

Rose, Fran Jean, M.D., Frisco, TX, Lic. #H9704

On August 13, 2004, the Board and Dr. Rose entered into an Agreed Order suspending Dr. Rose's license for three years, probating the suspension except for the first 60 days, requiring a Board-approved physician monitor and an endocrinologist's approval for the treatment of patients with thyroid and/or adrenal therapy. The action was based on allegations of nontherapeutic prescribing and improper treatment of endocrine disorders.

Roy, Pradeep Kumar, M.D., Kingwood, TX, Lic. #H3160

On October 8, 2004, the Board and Dr. Roy entered into an Agreed Order requiring Dr. Roy to complete a one-day course in the area of medical record keeping. The action was based on allegations that Dr. Roy failed to keep adequate medical records on a chronic pain patient.

Ruffier, Juan Carlos, M.D., El Paso, TX, Lic. #G6006

A Temporary Suspension Order was entered on March 22, 2004, temporarily suspending Dr. Ruffier's license without notice due to evidence that Dr. Ruffier's continuation in the practice of medicine would constitute a continuing threat to the 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 on allegations that Dr. Ruffier acted unprofessionally or dishonorably by performing unnecessary cardiac procedures and failed to practice to the standard of

care in the treatment of about 29 patients by performing such procedures as to cause patient harm.

Rutledge, David Elmo, M.D., Harlingen, TX, Lic. #E1730

On June 4, 2004, the Board and Dr. Rutledge entered into an Agreed Order in which Dr. Rutledge retired and voluntarily and permanently surrendered his license. The action was based on a mental or physical impairment which precludes Dr. Rutledge from practicing medicine.

Sanchez-Leal, Henry Richard, M.D., Wichita Falls, TX, Lic. #G0052

On April 2, 2004, the Board and Dr. Sanchez-Leal entered into an Agreed Order publicly reprimanding Dr. Sanchez-Leal, and requiring that Dr. Sanchez-Leal obtain 20 hours CME in proper billing and coding procedures or in medical office management. The action was based on allegations relating to improper billing statements to third-party payers.

Sargent, Charles Hunt, M.D., San Antonio, TX, Lic. #H3342

On 4-2-04 the Board and Dr. Sargent entered into an Agreed Order publicly reprimanding Dr. Sargent and suspending his license; however, the suspension was stayed and Dr. Sargent was placed on probation for two years under terms and conditions, including psychiatric evaluation, abstaining from drugs, submitting to random drug testing, requiring Dr. Sargent to complete certain identified CME, and assessing an administrative penalty in the amount of $20,000. The action was based on Dr. Sargent's self-prescribing of controlled substances and dangerous drugs and prescribing controlled substances and dangerous drugs to a former girlfriend and her son.

Sarkar, Ankur, M.D., El Campo, TX, Lic. #K3450

On June 4, 2004, the Board and Dr. Sarkar entered into an Agreed Order suspending Dr. Sarkar's license for one year, but probating the suspension for one year, requiring 15 hours of additional CME, and assessing a $3,000 administrative penalty. The action was based on allegations that Dr. Sarkar failed to properly assess and order the hospitalization of a nursing home patient.

Sayers, Stephen Charles, M.D., Center, TX, Lic. #G5574

A Temporary Suspension Order was entered on June 29, 2004, temporarily suspending Dr. Sayers' license without notice due to evidence that Dr. Sayers' continuation in the practice of medicine would constitute a continuing threat to public welfare. The order shall remain in effect until

such time as it is superseded by a subsequent order of the Board. The action was based on Dr. Sayers' arrest for possession of a controlled substance identified as cocaine.

Shay, Jed, M.D., Houston, TX, Lic. #H9568

On October 8, 2004, the Board and Dr. Shay entered into an Agreed Order assessing a $5,000 administrative penalty. The action was based on allegations that Dr. Shay allowed his physician assistant to use presigned prescription pads, which resulted in a prescribing error, causing harm to a patient.

Siropaides, Michael Pericles, M.D., Cleveland, TX, Lic. #H5065

On April 2, 2004, the Board and Dr. Siropaides entered into an Agreed Order publicly reprimanding Dr. Siropaides and requiring Dr. Siropaides to complete curriculum prescribed for him by the Pine Grove Professional Enhancement Program in Mississippi. The action was based on allegations of disruptive behavior with hospital personnel (striking a nurse while on duty).

Skripka, Charles Frank Jr., M.D., Tomball, TX, Lic. #D4308

On April 2, 2004, the Board and Dr. Skripka entered into an Agreed Order converting a prior confidential order to a public order, and extending restrictions on Dr. Skripka's license for two years under terms and conditions requiring that Dr. Skripka obtain a psychiatric evaluation and follow any recommendations, requiring Dr. Skripka to participate in an assessment at the Center for Personalized Education for Physicians, and passing the Special Purpose Examination and the Texas Medical Jurisprudence Examination. The action was based on allegations that Dr. Skripka violated his prior order by failing to maintain a current address with the Board, failing to ensure that his treating physician provided required reports to the Board, and failing to inform the Board of his employment status.

Sloan, Crawford J., M.D., Cooper, TX, Lic. #F2014

On June 4, 2004, the Board and Dr. Sloan entered into an Agreed Order publicly reprimanding Dr. Sloan, requiring that Dr. Sloan either take and pass the SPEX exam within two years of the date of the order or enter and complete a formal ACGME-approved training program, requiring Dr. Sloan to obtain an additional 20 hours of CME in acute cardiology care and six hours in EKG training, and restricting his license in that he shall not apply for hospital privileges until all conditions of the order are met. The action was based on allegations that Dr. Sloan failed to properly diagnose and

treat a patient presenting in the emergency room with symptoms and lab results diagnostic of myocardial infarction.

Smola, Jeremy Ray, D.O., Sweetwater, TX, Lic. #H8416

On August 13, 2004, the Board and Dr. Smola entered into an Agreed Order suspending Dr. Smola's license, but probating the suspension for five years, and requiring 20 additional hours of CME in ethics and HIPAA, attendance at a Vanderbilt course on boundaries, and assessing an administrative penalty of $1,000. The action was based on allegations of Dr. Smola's unprofessional conduct by having a sexual relationship with a patient.

Stanton, James Michael, M.D., Houston, TX, Lic. #E3779

On August 13, 2004, the Board and Dr. Stanton entered an Agreed Order suspending the physician's license for 10 years, but probating the suspension for all but three months from January 1 until March 30, 2005, under various terms and conditions including psychiatric evaluation and treatment, abstaining from drugs, submitting to random drug testing, eliminating his prescriptive authority for all Schedule II, III, and IV drugs, taking and passing the SPEX examination, and assessing an administrative penalty of $5,000. The action was based on Dr. Stanton's self prescribing Ultracet (tramadol) in violation of a prior Agreed Order for abuse of prescription drugs.

Stewart, Kerby James, M.D., Austin, TX, Lic. #J3623

On October 8, 2004, the Board and Dr. Stewart entered into an Agreed Order extending his probated suspension for an additional 10 months. This action was based on allegations that Dr. Stewart violated his previously assessed probation by failing to submit to a drug screen.

Stuntz, Homer Clyde, M.D., Orange, TX, Lic. #C3227

On June 4, 2004, the Board and Dr. Stuntz entered into an Agreed Order in which Dr. Stuntz voluntarily and permanently surrendered his license. The action was based on allegations that Dr. Stuntz prescribed narcotics to known drug abusers without maintaining adequate medical documentation to show any therapeutic or medical necessity for the drugs.

Suits, Charles Wesley, D.O., Wichita Falls, TX, Lic. #G6765

On June 4, 2004, the Board and Dr. Suits entered into an Agreed Order in which Dr. Suits voluntarily and permanently surrendered his license. The

action was based on his conviction of felony charges of possession of methamphetamine in the state of Idaho.

Swift, Leon Joseph, D.O., Arlington, TX, Lic. #H4739

On August 13, 2004, the Board and Dr. Swift entered into an Agreed Order suspending Dr. Swift's license until such time as he personally appears before the Board and provides sufficient evidence and information that adequately indicates he is physically, mentally and otherwise competent to safely practice medicine. The action was based on allegations that Dr. Swift received a 10-year deferred adjudication for felony assault of his former partner during a psychotic episode.

Talmage, Edward Arthur, M.D., Houston, TX, Lic. #D2722

On October 8, 2004, the Board and Dr. Talmage entered into an Agreed Order restricting Dr. Talmage's license, requiring him to comply with any limitations placed on his privileges by the West Houston Medical Center and requiring annual neuro-psychological evaluations. This action was based on allegations that his practice was restricted by the Medical Center due to neuro-psychological deficits.

Taylor, Eugene Madison, M.D., Denton, TX, Lic. #D1078

On October 8, 2004, the Board and Dr. Taylor entered into an Agreed Order assessing a $1,000 administrative penalty. The action was based on allegations that Dr. Taylor prescribed medications for a family member without maintaining any medical records.

Tesoro, Leonard Jordan Jr., M.D., Pharr, TX, Lic. #D6194

On August 13, 2004, the Board and Dr. Tesoro entered into an Agreed Order requiring Dr. Tesoro to take and pass the Medical Jurisprudence Examination, and assessing an administrative penalty of $2,500. The action was based on allegations that Dr. Tesoro prescribed Viagra for 26 patients over the Internet without establishing a proper doctor-patient relationship.

Thompson, James Byron, M.D., Georgetown, TX, Lic. #H8460

On April 2, 2004, the Board and Dr. Thompson entered an Agreed Order assessing an administrative penalty in the amount of $2,000. The action was based on Dr. Thompson's failure to obtain required CME hours.

Thompson, John Paul, D.O., Arlington, TX, Lic. #E8963

On June 4, 2004, the Board and Dr. Thompson entered into an Agreed Order requiring that Dr. Thompson recertify with Advanced Trauma Life Support within 180 days, requiring Dr. Thompson to obtain an additional 10 hours CME in record-keeping and charting, submitting an emergency room protocol, including a plan for documentation and record-keeping that meets or exceeds the Joint Commission of Accreditation of Healthcare Organizations standard and the standard set forth by the American College of Emergency Room Physicians, and assessing an administrative penalty in the amount of $5,000. The action was based on allegations that Dr. Thompson failed to diagnose and treat multiple and severe internal injuries suffered by a patient involved in an unrestrained roll-over automobile accident.

Vera, Angel Gustavo, M.D., Abilene, TX, Lic. #BP10004969

On October 8, 2004, the Board revoked Dr. Vera's Texas Postgraduate Resident Permit. The action was based on allegations that Dr. Vera failed to report that he was under investigation by the New York Board of Medical Examiners and that he had resigned from his previous residency program. Dr. Vera may file a Motion for Rehearing within 20 days of the order. If a Motion for Rehearing is filed and the Board denies the motion, the order is final. If a Motion for Rehearing is filed and the Board grants the motion, the order is not final and a hearing will be scheduled.

Watson, David Gregory, M.D., Tyler, TX, Lic. #K4605

A Temporary Suspension Order was entered on August 11, 2004, temporarily suspending Dr. Watson's license with notice due to evidence that Dr. Watson's continuation in the practice of medicine would constitute a continuing threat to public welfare. The action was based on allegations of cocaine use and a positive drug test for cocaine. The Temporary Suspension Order shall remain in full force and effect until such time as it is superseded by a subsequent order of the Board.

Werner, Timothy H., D.O., Farmers Branch, TX, Lic. #G4508

On August 13, 2004, the Board and Dr. Werner entered into an Agreed Order suspending Dr. Werner's license for not less than six months and until such time as he personally appears before the Board and provides sufficient evidence and information that adequately indicates he is physically, mentally and otherwise competent to safely practice medicine. The action was based on allegations that Dr. Werner suffered from drug or alcohol abuse as well as depression.

Wheeler, Douglas Wayne, M.D., Port Neches, TX, Lic. #F8731

On April 2, 2004, the Board and Dr. Wheeler entered into an Agreed Order restricting Dr. Wheeler's license for five years under certain terms and conditions, including restricting Dr. Wheeler from practicing obstetric medicine in Texas, limiting his medical practice to a group or institutional setting, attending Board-approved CME, performing 100 hours per year of community service for an indigent health care clinic, and assessing an administrative penalty in the amount of $5,000. The action was based on disciplinary action by a hospital as a result of Dr. Wheeler's substandard care resulting in a neonatal death due to abruption of the placenta.

Whitt, Winston Arnett, M.D., Lubbock, TX, Lic. #J4612

On October 8, 2004, the Board and Dr. Whitt entered into Agreed Order publicly reprimanding Dr. Whitt and requiring 30 hours of CME in pain management, 10 hours in record keeping, 10 hours in risk management, and 30 hours in general medicine. This action was based on allegations that Dr. Whitt maintained inadequate records and failed to communicate with other personnel concerning the medical condition of one patient.

Williams, Kenneth Reese Jr., M.D., Galveston, TX, Lic. #BP30007933

On June 4, 2004, the Board and Dr. Williams entered into an Agreed Order publicly reprimanding Dr. Williams. The action was based on allegations of Dr. Williams' substance abuse, which occurred while he was in a residency program from which he has subsequently been terminated.

Wilson, Gerald Leslie Tweddell, M.D., Lubbock, TX, Lic. #E7321

On June 4, 2004, the Board and Dr. Wilson entered into an Agreed Order in which Dr. Wilson voluntarily and permanently surrendered his license. The action was based on Dr. Wilson's desire to discontinue his compliance program with the Board.

Woodham, Robert Lee, M.D., Houston, TX, Lic. #F2999

On April 2, 2004, the Board and Dr. Woodham entered into an Agreed Order placing certain terms and conditions on Dr. Woodham's license for one year including Dr. Woodham to be subject to chart monitoring, maintaining a logbook of prescriptions and refills, and assessing an administrative penalty in the amount of $2,000. The action was based on allegations of inadequate medical record keeping.

Yilmaz, Salih Mehmet, M.D., Navasota, TX, Lic. #E8237

On October 8, 2004, the Board and Dr. Yilmaz entered into an Agreed Order requiring Dr. Yilmaz to pass a medical skills exam, complete 50

hours of CME, and pay a $5,000 administrative penalty. This action was based on allegations that Dr. Yilmaz was arrested and subsequently indicted for delivery of hydrocodone to a confidential informant.

Zayas, Raul, M.D., El Paso, TX, Lic. #G9904

On October 8, 2004, the Board and Dr. Zayas entered into an Agreed Order publicly reprimanding Dr. Zayas, assessing an administrative penalty of $2,000, and requiring Dr. Zayas to complete within one year a Board-approved course in ethics and professional responsibility and a course on professional boundaries. The action was based on allegations of unprofessional conduct in which Dr. Zayas performed a physical examination on a female patient without a chaperone present.

Zepeda, Luis Ernesto, M.D., Houston, TX, Lic. #K1739

On October 8, 2004, the Board and Dr. Zepeda entered into an Agreed Order placing Dr. Zepeda on probation for three years, requiring a board-approved chart monitor, and requiring 50 hours of CME each year. This action was based on allegations that Dr. Zepeda failed to properly supervise his delegates.

Zimmerman, Erika Irene, M.D., Briarcliff, TX, Lic. #J6829

On June 4, 2004, the Board and Dr. Zimmerman entered into an Agreed Order extending the term of Dr. Zimmerman's prior confidential board order to six years and making that order public. The action was based on Dr. Zimmerman's failure to meet the requirements of her prior board order, which was entered due to Dr. Zimmerman's mental condition of depression.

Physician Assistants

Dickinson, Ronald B., Linden, TX, Lic. #PA00237

On February 27, 2004, the Board and Mr. Dickinson entered into an Agreed Order publicly reprimanding Mr. Dickinson and assessing an administrative penalty in the amount of $4,000. The action was based on allegations that Mr. Dickinson's self-prescribed the controlled substance Didrex between March 21, 2001, and September 30, 2002.

Holmes, Donald Gene, Cleveland, TX, Lic. #PA02171

On February 27, 2004, the Board and Mr. Holmes entered into an Agreed Order publicly reprimanding Mr. Holmes and assessing an administrative penalty in the amount of $2,000. The action was based on allegations that

Mr. Holmes practiced without sufficient oversight from supervising physicians, and maintained an inappropriate financial relationship with two supervising physicians.

Houseman, Thad William, Garland, TX, Lic. #PA01862

On February 27, 2004, the Board and Mr. Houseman entered into an Agreed Order suspending Mr. Houseman's license; however, the suspension was stayed and Mr. Houseman was placed on probation for five years under terms and conditions including psychiatric treatment, abstaining from alcohol or drugs, submitting to random drug testing, and restricting Mr. Houseman from treating his immediate family or friends or prescribing controlled substances or dangerous drugs to himself or his immediate family or friends. The action was based on allegations of drug abuse.

Morgan, Kevin Daniel, San Antonio, TX, Lic. #PA00930

An Order was entered July 21, 2004, suspending Mr. Morgan's physician assistant license for a minimum of six months. The suspension shall remain in effect until such time as he requests in writing to have the suspension stayed or lifted and personally appears before the Board and provides clear and convincing evidence and information which, in the discretion of the Board, adequately indicates that Mr. Morgan is physically, mentally and otherwise competent to safely practice as a physician assistant. The action was based on violation of his Agreed Order regarding substance abuse.

Royster, Willie Keith, May, TX, Lic. #PA01361

On February 27, 2004, the Board and Mr. Royster entered into an Agreed Order revoking Mr. Royster's license. The action was based on allegations that Mr. Royster violated his current board order by consuming Tramadol, a prohibited substance. Mr. Royster's order involved allegations of writing false prescriptions.

Vanderlaan, Joan Gray, McAllen, TX, Lic. #PA01486

On July 30, 2004, the Board revoked Ms. Vanderlaan's physician assistant license. The action was based on allegations that Ms. Vanderlaan violated a previous order of the Board. Ms. Vanderlaan may file a Motion for Rehearing within 20 days of the order. If a Motion for Rehearing is filed and the Board denies the Motion, the order is final. If a Motion for Rehearing is filed and the Board grants the Motion, the order is not final and a hearing will be scheduled.

Acupuncturist

Tsai, Shelley Yang, Richardson, TX, Lic. #AC00140

On June 4, 2004, the Board and Shelley Tsai entered into an Agreed Order assessing an administrative penalty of $250. The action was based on allegations that Ms. Tsai failed to practice acupuncture in an acceptable manner consistent with public health and welfare in the treatment of a patient.

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