Texas Medical Board Press Release

FOR IMMEDIATE RELEASE
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TMB disciplines 61 physicians at August meeting, adopts rule changes

At its August 28, 2015 meeting, the Texas Medical Board disciplined 61 licensed physicians and issued one cease and desist order. The disciplinary actions included: twenty orders related to quality of care violations, seven orders related to unprofessional conduct, seven revocations, ten voluntary surrenders, three orders related to other states' actions, one order related to nontherapeutic prescribing, four orders related to violation of Board rules, two orders related to failure to properly supervise or delegate, three orders related to impairment, two orders related to violation of prior Board order, one order related to advertising violations, and one order related to inadequate medical records.

The Board issued 225 physician licenses at the August meeting, bringing the total number of physician licenses issued in FY15 to 4,295.

RULE CHANGES ADOPTED

CHAPTER 175. FEES AND PENALTIES

§175.1, Application and Administrative Fees
The Amendments to §175.1, relating to Application and Administrative Fees, decreases physician licensure application fees, by removing the occupations tax, in accordance with the repeal of Texas Occupations Code, §153.053 by House Bill 7, 84th Legislature, Regular Session (2015). The amendments further add language stating that for the license types that confer the authority to prescribe controlled substances and access the Prescription Drug Monitoring Program described by §§481.075, 481.076, and 481.0761 of the Texas Health and Safety Code, the Board shall charge an additional reasonable and necessary fee sufficient to cover the Board's responsible portion for costs related to the Texas Pharmacy Board's establishment and implementation of the drug monitoring program, with the fee amount being calculated in accordance with the appropriation match amount assigned to the Board under Article IX, §18.55 of House Bill 1, 84th Legislature, Regular Session (2015).

§175.2, Registration and Renewal Fees
The Amendments to §175.2, relating to Registration and Renewal Fees, decreases physician registration and renewal fees, by removing the occupations tax, in accordance with the repeal of Texas Occupations Code, §153.053 by House Bill 7, 84th Legislature, Regular Session (2015). The amendments further add language stating that for the license types that confer the authority to prescribe controlled substances and access the Prescription Drug Monitoring Program described by §§481.075, 481.076, and 481.0761 of the Texas Health and Safety Code, the Board shall charge an additional reasonable and necessary fee sufficient to cover the Board's responsible portion for costs related to the Texas Pharmacy Board's establishment and implementation of the drug monitoring program, with the fee amount being calculated in accordance with the appropriation match amount assigned to the Board under Article IX, §18.55 of House Bill 1, 84th Legislature, Regular Session (2015). The amendments will enable the agency to carry out its statutory mandates related to individuals under its jurisdiction.

CHAPTER 190. DISCIPLINARY GUIDELINES

§190.14, Disciplinary Sanction Guidelines
The Amendment to §190.14, relating to Disciplinary Sanction Guidelines, revises the graphic table in 22 TAC §190.14(9)

to update the range and scope of sanctions for certain violations of the Medical Practice Act. The amendments will better ensure consistency when the Board takes disciplinary action against licensees.

DISCIPLINARY ACTIONS

QUALITY OF CARE

Ahmed, Faiz, M.D., Lic. No. J4683, Sugarland

On August 28, 2015, the Board and Faiz Ahmed, M.D., entered into an Agreed Order requiring Dr. Ahmed to within 30 days contact the Texas A&M Health Science Center Knowledge, Skills, Training, Assessment, and Research (KSTAR) program to schedule an assessment and complete any and all training recommendations; and within one year complete at least 24 hours of in-person CME, divided as follows: 16 hours in diagnosing and treating acute coronary syndrome and eight hours in medical recordkeeping. The Board found Dr. Ahmed failed to document relevant history regarding the patient's chest pain and burping, and his evaluation was inadequate to support proper diagnoses; failed to explore other diagnoses and failed to order standard screening tests that were readily available to him.

Arauzo, Arturo C., M.D., Lic. No. G2896, Plano

On August 28, 2015, the Board and Arturo C. Arauzo, M.D., entered into an Agreed Order requiring Dr. Arauzo to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 16 hours of CME, divided as follows: eight hours in risk management and eight hours in prescribing controlled substances and appropriate monitoring of patients; and within 60 days pay an administrative penalty of $3,000. The Board found Dr. Arauzo failed to properly monitor a patient to whom he was prescribing medications who was living out of state and failed to periodically evaluate the patient in-person while continuing to prescribe controlled substances and dangerous drugs.

Armstrong, Henry Rhinehart, M.D., Lic. No. G4795, Dallas

On August 28, 2015, the Board and Henry Rhinehart Armstrong, M.D., entered into an Agreed Order requiring Dr. Armstrong to within one year complete at least eight hours of CME, divided as follows: four hours in anti-coagulation therapy and four hours in medical recordkeeping; and within 90 days pay an administrative penalty of $3,000. The Board found Dr. Armstrong failed to document his reason for discontinuing a patient's anticoagulant therapy who later suffered a stroke and died. The patient had multiple health problems and was under the care of another physician for approximately two years before being transferred to Dr. Armstrong's care. The patient's records did not indicate the reason for initiation of Coumadin therapy but do indicate that the therapy was continued due to a history of atrial fibrillation.

Bianco, Joseph Anthony, D.O., Lic. No. D8661, Dallas

On August 28, 2015, the Board and Joseph Anthony Bianco, D.O., entered into an Agreed Order publicly reprimanding Dr. Bianco and requiring him to within 60 days contact the Colorado Physicians Education Program (CPEP) or the University of California San Diego Physician Assessment and Clinical Education (PACE) program to schedule an assessment and comply with any recommendations; within 60 days complete the PACE medical recordkeeping course; for the next 100 surgical procedures, Dr. Bianco shall: obtain a written consultation and pre-approval from a licensed Texas physician monitor and obtain a written consultation and/or review from the monitor within 72 hours of the procedure for any emergent surgery; and within one year complete at least eight hours of CME in post-operative complications with at least one hour in hemostatic management. The Board found Dr. Bianco performed an unnecessary laparoscopic cholecystectomy on a patient without adequately reviewing the patient's history and failed to address a surgical complication for another patient.

Blissard, Paul King, M.D., Lic. No. F6453, Austin

On August 28, 2015, the Board and Paul King Blissard, M.D., entered into an Agreed Order requiring Dr. Blissard to have his practice monitored by another physician for 12 consecutive monitoring cycles; within 90 days contact the Texas A&M Health Science Center Knowledge, Skills, Training, Assessment, and Research (KSTAR) program to schedule an assessment and complete any and all training recommendations; within one year and three attempts pass the Medical Jurisprudence Exam; and within one year complete at least 28 hours of CME, divided as follows: eight hours in risk management, eight hours in medical recordkeeping, eight hours in screening and diagnosis of cancer and four hours in

ethics. The Board found Dr. Blissard failed to meet the standard of care for one patient by not documenting a discussion with the patient who was suffering from a chronic cough about the risks of choosing not to proceed with the recommended chest x-ray, and failed to document the patient's continued noncompliance with recommendations. Dr. Blissard should have referred the patient to a specialist for more specialized care or terminated the patient for non-compliance. For a second patient, Dr. Blissard failed to provide relevant history or perform a proper evaluation. For a third patient, who Dr. Blissard treated for chronic pain, he failed to perform a complete evaluation and his treatment of the patient's headaches also did not meet the standard of care. For a fourth patient, Dr. Blissard did not appropriately evaluate and treat the patient's hypernatremia and elevated creatine levels. Dr. Blissard also inappropriately prescribed Nubain to his ex-wife and failed to maintain proper medical records regarding the prescriptions.

Brown, Forrest Carroll, M.D., Lic. No. D3169, Dallas
On August 28, 2015, the Board and Forrest Carroll Brown, M.D., entered into an Agreed Order Granting Termination of Suspension Order, terminating Dr. Brown's 2014 Suspension Order, and subjecting him to the following terms: shall not engage in the practice of Mohs surgery and shall not engage in the practice of dermato-pathology. The Board found Dr. Brown passed the Medical Jurisprudence Exam and is in compliance with the terms of the 2013 Order, as modified by the 2014 Order, but that Dr. Brown be subject to the additional restrictions that he not perform Mohs surgery and he not practice dermato-pathology. All other terms of Dr. Brown's prior active orders remain in full force and effect.

Byrne, Michael Edward, M.D., Lic. No. E2495, Houston
On August 28, 2015, the Board and Michael Edward Byrne, M.D., entered into an Agreed Order requiring Dr. Byrne to within one year complete at least 12 hours of CME, divided as follows: eight hours in risk management and four hours in identifying and managing diabetes; and within 60 days pay an administrative penalty of $2,000. The Board found Dr. Byrne missed the diagnosis of a patient's new onset type 2 diabetes, which he should have recognized given the patient's symptoms. Dr. Byrne should have called the patient for an immediate follow-up and treatment after receiving the patient's lab results but Dr. Byrne's office staff failed to contact the patient until the following day after the patient had already been admitted to the hospital for treatment.

Cahill, Jeffrey Paul, M.D., Lic. No. E9047, Henderson
On August 28, 2015, the Board and Jeffrey Paul Cahill, M.D., entered into an Agreed Order requiring Dr. Cahill to have his practice monitored by another physician for four consecutive monitoring cycles; prohibiting Dr. Cahill from treating patients for chronic pain as defined by Board rules or engaging in the practice of pain management; within 30 days refer any and all current chronic pain patients to an appropriate specialist; abide by the terms and conditions of the Memorandum of Agreement between him and the Drug Enforcement Administration (DEA); within a year complete at least 12 hours of CME, divided as follows: eight hours in medical recordkeeping and four hours in drug abuse/drug seeking behavior. The Board found Dr. Cahill prescribed large quantities of hydrocodone, Xanax, and Soma to 15 patients without adequate clinical indications to do so and failed to document or evaluate the effectiveness of his treatments of the patients, their compliance, or discuss alternative treatments.

Calle, Cristo Antonio, M.D., Lic. No. G4540, San Antonio
On August 28, 2015, the Board and Cristo Antonio Calle, M.D., entered into an Agreed Order requiring Dr. Calle to within one year complete at least eight hours of CME in office-based orthopedics; and within 60 days pay an administrative penalty of $3,000. The Board found Dr. Calle failed to timely obtain an x-ray, which caused delay in diagnosis of a fractured ankle and delay in the patient's receipt of optimal treatment.

Driscoll, Peter Vail, M.D., Lic. No. M0059, Austin
On August 28, 2015, the Board and Peter Vail Driscoll, M.D., entered into an Agreed Order requiring Dr. Driscoll to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year and three attempts pass the Medical Jurisprudence Exam; within 30 days provide the Board documentation demonstrating that personnel who are involved with surgical procedures have proper ACLS/BLS certification and copies of protocols and orders related to his supervision and delegation to midlevel providers and other office staff, which at a minimum must address the management of outpatient anesthesia and management of complications and emergencies; within one year complete at least 44 hours of in-person CME, divided as follows: eight hours in office-based anesthesia, eight hours in medical recordkeeping, eight hours in medical ethics, four hours in risk management, four hours in anesthetic monitoring, four

hours in intravenous anesthetic agents, four hours in providing informed consent, and four hours in completing breast augmentations; and within 60 days pay an administrative penalty of $3,000. The Board found Dr. Driscoll failed to meet the standard of care, failed to follow Board rules for office-based anesthesia and failed to keep adequate medical records in his treatment of three patients. Specifically, Dr. Driscoll failed to meet the standard of care performing an abdominoplasty on one patient, failed to obtain informed consent from a patient for use of transcutaneous sutures during the first revision surgery following a breast augmentation, and performed a trans-umbilical breast augmentation on the third patient, which was contra-indicated and required revision surgeries which were unsuccessful.

Gay, Charles Christophe, M.D., Lic. No. F9472, Bellville
On August 28, 2015, the Board and Charles Christophe Gay, M.D., entered into an Agreed Order requiring Dr. Gay to within 30 days schedule an assessment with and complete any and all training recommendations of the Texas A&M Health Science Center Knowledge, Skills, Training, Assessment, and Research (KSTAR) program, and refrain from prescribing any controlled substances to new patients until he does so; shall not administer, dispense, or prescribe any controlled substances or dangerous drugs with addictive potential or potential for abuse to any patient with the exception of those residing in Austin County, Texas; shall maintain a logbook of all prescriptions for controlled substances or dangerous drugs; shall become familiar with and comply with all State and Federal legal authority pertaining to prescribing, administering, dispensing, supplying, storing, and disposal of dangerous drugs and controlled substances; have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 40 hours of CME, divided as follows: eight hours in medical recordkeeping, 16 hours in chronic pain management, and 16 hours in treating psychiatric disorders; and within 60 days pay an administrative penalty of $1,500. The Board found Dr. Gay failed to meet the standard of care in treating a patient for chronic pain, failed to monitor the patient for abuse or diversion, and failed to follow up on the patient's status after referral to specialists.

Mizer, Glen Lavel, M.D., Lic. No. F6046, Denton
On August 28, 2015, the Board and Glen Lavel Mizer, M.D., entered into an Agreed Order on Formal Filing in which Dr. Mizer agreed to limit his practice of medicine solely to voluntary, charity medicine for a period of no less than three years. Following this period, Dr. Mizer may seek a change of the voluntary/charity care licensure status which would be evaluated according to applicable Board rules. Dr. Mizer further agreed to sign any necessary paperwork with the Board to effectuate this restriction within 30 days from the date of entry of the Order. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Myones, Barry lee, M.D., Lic. No. J2702, Sugar Land
On August 28, 2015, the Board and Barry Lee Myones, M.D., entered into an Agreed Order requiring Dr. Myones to within 30 days contact the Texas A&M Health Science Center Knowledge, Skills, Training, Assessment, and Research (KSTAR) program to schedule an assessment and complete any and all training recommendations within one year. The Board found Dr. Myones failed to meet the standard of care for treating patients with Kawasaki Disease due to a lack of documentation and prolonged and excessive therapy, especially off-label therapy, without documentation of need.

Narayan, Satish Dharmapuri, M.D., Lic. No. M9527, Greenville
On August 28, 2015, the Board and Satish Dharmapuri Narayan, M.D., entered into an Agreed Order requiring Dr. Narayan to within one year complete at least 16 hours of CME, divided as follows: eight hours in risk management, four hours in medical recordkeeping and four hours in diagnosing and treating substances abuse disorders. The Board found Dr. Narayan did not assess or diagnose ADHD at the initial visit but prescribed Adderall at an excessive dose, failed to adequately document his rationale for prescribing medications to the patient and terminated the patient without first providing an adequate referral to another provider.

Niemi, Heli Maarit, M.D., Lic. No. M2424, Plano
On August 28, 2015, the Board and Heli Maarit Niemi, M.D., entered into an Agreed Order requiring Dr. Niemi to within one year complete at least eight hours of CME in interpretation of lab and/or blood results. The Board found Dr. Niemi breached the standard of care in failing to identify a patient's neutropenia and failed to timely refer the patient to a hematologist as required for a patient with moderate to severe neutropenia and failed to monitor the patient's condition.

Rosenthal, Jon Evan, M.D., Lic. No. M4489, Midland
On August 28, 2015, the Board and Jon Evan Rosenthal, M.D., entered into an Agreed Order requiring Dr. Rosenthal to within one year complete at least 12 hours of CME, divided as follows: eight hours, two which must be in-person and six of which may be completed online, in recognition, assessment and treatment of sepsis and four hours in risk management, which may be completed online. The Board found Dr. Rosenthal inappropriately discharged a patient after the patient had met two systemic inflammatory response syndrome (SIRS) criteria at another facility. Dr. Rosenthal's reliance on the patient's subjective improvement during a stay at the emergency department was inappropriate, as that improvement was likely related to the administration of fluids, fever reducing medications and pain medications. The patient's subjective improvement altered the SIRS evaluation. Consequently, while the patient no longer clearly met the SIRS criteria at the time of discharge, the patient should not have been discharged at that time in light of the fact the patient had previously met two of the SIRS criteria earlier that day.

Ruggiero, Michael F., D.O., Lic. No. H9144, Bryan
On August 28, 2015, the Board and Michael F. Ruggiero, D.O., entered into an Agreed Order requiring Dr. Ruggiero to have his practice monitored by another physician for 12 monitoring cycles; within one year complete the prescribing course for controlled substances offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; utilize a controlled substance contract with all patients over 18, requiring random drug screens as appropriate; within one year complete at least 16 hours of CME; and pay an administrative penalty of $3,000. The Board found Dr. Ruggiero failed to meet the standard of care as he failed to document adequate histories or collect/use other sources of objective information that would support his diagnosis of Attention Deficit Disorder made for patients, failed to document specific criteria in measuring progress, and failed to adequately address required random drug testing for those patients who reported a history of or present abuse of other substances or document a review of the Texas Department of Public Safety's (DPS) Prescription Access in Texas (PAT) system.

Silverman, Eric Scott, M.D., Lic. No. L3831, Southlake
On August 28, 2015, the Board and Eric Scott Silverman, M.D., entered into an Agreed Order requiring Dr. Silverman to within one year complete at least 16 hours of CME, divided as follows: eight hours in performing risk assessments and eight hours in preoperative assessment of patients. The Board found Dr. Silverman did not properly assess the patient prior to administering anesthesia, which led to the patient receiving anesthesia with a post-operative ileus and full stomach, which contributed to the patient's aspiration during surgery and subsequent death.

Strong, Steven Michael, M.D., Lic. No. K3019, The Woodlands
On August 28, 2015, the Board and Steven Michael Strong, M.D., entered into an Agreed Order requiring Dr. Strong to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 24 hours of CME, divided as follows: eight hours in managing high risk pregnancies, eight hours in medical recordkeeping and eight hours in risk management; and within 60 days pay an administrative penalty of $3,000. The Board found Dr. Strong did not obtain specific informed consent for the use of a vacuum device to assist delivery and that Dr. Strong's documentation did not address the need for, and discussion of risks and benefits of, assisted delivery.

Templin, David Brian, M.D., Lic. No. M4964, New Braunfels
On August 28, 2015, the Board and David Brian Templin, M.D., entered into an Agreed Order requiring Dr. Templin to within one year complete at least 12 hours of CME, divided as follows: four hours in risk management, four hours in medical recordkeeping and four hours in physician-patient communication. The Board found Dr. Templin failed to obtain an adequate patient history for the patient regarding the patient's overall health and issues that were noted on the patient intake form, and that the patient's complaints were not entered into the Electronic Medical Record for review. As a result Dr. Templin failed to diagnose the patient's deep vein thrombosis.

UNPROFESSIONAL CONDUCT

Fontenot, James Thomas, M.D., Lic. No. E5518, Houston

On August 28, 2015, the Board and James Thomas Fontenot, M.D., entered into an Agreed Order publicly reprimanding Dr. Fontenot and requiring Dr. Fontenot to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 24 hours of CME, divided as follows: eight hours in drug seeking behavior, eight hours in ethics and eight hours in risk management; and within 60 days pay an administrative penalty of $3,000. The Board found Dr. Fontenot acknowledged that he did not keep medical records for patients he evaluated, did not obtain an adequate history, did not perform or document a physical examination or the medical rationale supporting the prescriptions that he authorized, and failed to order proper laboratory tests before prescribing to the patients sent to him by a pharmacist.

Garcia, Charisma, M.D., Lic. No. Q0441, Houston

On August 28, 2015, the Board and Charisma Garcia, M.D., entered into an Agreed Order publicly reprimanding Dr. Garcia and requiring Dr. Garcia to within 60 days provide proof to the Board that she has entered into an agreement with the loan servicing agent for the Texas Guarantee Student Loan Corporation (TGSLC) and/or proof that the default has been cured. The Board found Dr. Garcia is in default on her guaranteed student loan with TGSLC.

Lowery, Bryan Michael, M.D., Lic. No. L3383, Frisco

On August 28, 2015, the Board and Bryan Michael Lowery, M.D., entered into an Agreed Order requiring Dr. Lowery to within 60 days complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Lowery had an improper relationship with a former patient who he treated once, prior to beginning the relationship. The patient was typically treated by Dr. Lowery's practice partner. Subsequently, Dr. Lowery re-filled a prescription for the patient when covering for his practice partner.

Miller, Wilfred Dean, D.O., Lic. No. H3915, Fort Worth

On August 28, 2015, the Board and Wilfred Dean Miller, D.O., entered into an Agreed Order on Formal Filing requiring Dr. Miller to within one year complete at least 12 hours of CME, divided as follows: eight hours in risk management and four hours in performing sports physical examinations; and within 60 days pay an administrative penalty of $500. The Board found Dr. Miller's filing of a lawsuit against a complainant was a violation of the Board's rules regarding intimidation of a complainant. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Pearce, Randy, D.O., Lic. No. BP10046976, Austin

On August 28, 2015, the Board and Randy Pearce, D.O., entered into an Agreed Order publicly reprimanding Dr. Pearce. The Board found Dr. Pearce failed to participate in the Texas Physician Health Program as directed by his residency program and was subsequently suspended from his program for failing to participate. Dr. Pearce also prescribed Xanax to his wife without her knowledge and then took it for his own use.

Rodriguez, Dirk I., M.D., Lic. No. H5735, Dallas

On August 28, 2015, the Board and Dirk L. Rodriguez, M.D., entered into an Agreed Order requiring Dr. Rodriguez to within one year and three attempts pass the Medical Jurisprudence Exam; within in one year complete at least 12 hours of CME, divided as follows: four hours in risk management, four hours in medical recordkeeping and four hours in professionalism and communication; and within 60 days pay an administrative penalty of $2,500. The Board found Dr. Rodriguez made unprofessional and offensive remarks to a colleague and that Dr. Rodriguez failed to properly document post-operative visits.

Steele, Darryl Newell, M.D., Lic. No. F2945, Euless

On August 28, 2015, the Board and Darryl Newell Steele, M.D., entered into an Agreed Order requiring Dr. Steele to within one year complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and within one year complete at least eight hours of CME in ethics. The Board found Dr. Steele engaged in inappropriate conduct with a patient, who was an employee. Specifically, Dr.

Steele's continued invitations to a patient/employee to participate in social activities, including lunch and movies, was inappropriate and a violation of physician patient boundaries.

REVOCATION

Ajim, Ayo Ayodeji, M.D., Lic. No. L2081, Houston
On August 28, 2015, the Board entered a Final Order against Dr. Ayo Ayodeji Ajim, M.D., which revoked his Texas medical license. The Board found Dr. Ajim nontherapeutically prescribed controlled substances to multiple chronic pain patients, failed to properly supervise midlevel providers and improper operation of a pain management clinic. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Ajim has 20 days from the service of the order to file a motion for rehearing.

Barson, Dennis Bernard, Jr., D.O., Lic. No. N0634, Hutto
On August 28, 2015, the Board and Dennis Bernard Barson, Jr., D.O., entered into an Agreed Order of Revocation in which Dr. Barson agreed to the revocation of his Texas medical license in lieu of further disciplinary proceedings. The Board found that on July 27, 2015, Dr. Barson was sentenced to 120 months in prison and ordered to pay approximately $1.2 million in restitution for one count of Conspiracy to Commit Health Care Fraud, and 19 counts of Health Care Fraud, aiding and abetting.

DeBenedetto, Richard, M.D., Lic. No. J9579, South Padre Island
On August 28, 2015, the Board and Richard Bruce DeBenedetto, M.D., entered into an Agreed Order of Revocation in which Dr. DeBenedetto agreed to the revocation of his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. DeBenedetto was sentenced to six years' incarceration in the Texas Department of Criminal Justice by the 216th Judicial District Court in Kerr County, Texas for felony convictions of prescription fraud.

Jones, Andrew P., M.D., Lic. No. H1972, Beaverton, OR
On August 28, 2015, the Board entered a Final Order against Andrew P. Jones, M.D., which revoked his Texas medical license. The Board found Dr. Jones maintained websites that contained advertising and testimonials that are false and misleading. Dr. Jones advertises products over the internet that he professes will treat and cure diseases such as depression, Alzheimer's, cancer, and fibromyalgia, among others. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Jones has 20 days from the service of the order to file a motion for rehearing.

Malhotra, Rajesh, M.D., Lic. No. L5448, Southfield, MI
On August 28, 2015, the Board and Rajesh Malhotra, M.D., entered into an Agreed Order of Voluntary Revocation in which Dr. Malhotra agreed to the revocation of his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Malhotra entered a plea of guilty to a Class D felony for Distribution of a Controlled Substance after he was found to be prescribing without proper registrations. Dr. Malhotra was sentenced to five years of probation. Dr. Malhotra also pled guilty to assault in the third degree, a Class A misdemeanor, and was sentenced to two years probation.

Peringol, Abraham K., M.D., Lic. No. N3989, Sugar Land
On August 28, 2015, the Board and Abraham K. Peringol, M.D., entered into an Agreed Order of Revocation in which Dr. Peringol agreed to the revocation of his Texas medical license in lieu of further disciplinary proceedings. Dr. Peringol was the subject of a formal complaint at the State Office of Administrative Hearings for allegations of violating sexual boundaries with numerous patients, behaving in an abusive manner and providing false information to the Board. This order resolves a formal complaint filed at the State Office of Administrative Hearings

Wiseman, Benjamin E., M.D., Lic. No. F4701, Houston
On August 28, 2015, the Board and Benjamin E. Wiseman, M.D., entered into an Agreed Order of Revocation in which Dr. Wiseman agreed to the revocation of his Texas medical license in lieu of further disciplinary proceedings. Dr.

Wiseman was the subject of a formal complaint at the State Office of Administrative Hearings involving allegations of improper supervision of midlevels, nontherapeutic prescribing and improper involvement with unregistered pain management clinics. This order resolves a formal complaint filed at the State Office of Administrative Hearings

VOLUNTARY SURRENDER

Crast, Frank W., M.D., Lic. No. J3451, McKinney

On August 28, 2015, the Board and Frank W. Crast, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Crast agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Crast is unable to practice medicine with reasonable skill and safety to patients because of illness or as a result of a mental or physical condition.

Cruz, Suzanna Ontiveros, M.D., Lic. No. J8502, Houston

On August 28, 2015, the Board and Suzanna Ontiveros Cruz, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Cruz agreed to voluntarily surrender her Texas medical license in lieu of further disciplinary proceedings. Dr. Cruz was the subject of a formal complaint at the State Office of Administrative Hearings for allegations of non-therapeutic prescribing and improper supervision of mid-level providers. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Hughes, Dennis Patrick Meehan, M.D., Lic. No. M3267, Houston

On August 28, 2015, the Board and Dennis Patrick Meehan Hughes, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Hughes agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Hughes was under investigation by the Board for admitting to possessing and viewing child pornography.

Kracke, William I., M.D., Lic. No. D3303, Amarillo

On August 28, 2015, the Board and William I. Kracke, M.D., entered into an Agreed Order of Voluntary and Permanent Surrender in which Dr. Kracke agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Kracke was under investigation by the Board regarding allegations of unprofessional conduct by engaging in an inappropriate relationship with a patient. Dr. Kracke indicated to the Board that he is disabled and is not able to practice medicine or return to the practice of medicine and that he no longer resides in Texas.

Rocha, Ricardo A., M.D., Lic. No. D3385, Dallas

On August 28, 2015, the Board and Ricardo A. Rocha, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Rocha agreed to voluntarily surrender his Texas medical license within 90 days in lieu of further disciplinary proceedings. The Board found Dr. Rocha had failed to complete required continuing medical education hours as required by his previous Agreed Order. Dr. Rocha indicated to the Board that he wishes to retire from practice to care for his ailing spouse.

Sauceda, Francisco Basil, M.D., Lic. No. H8375, Falfurrias

On August 28, 2015, the Board and Francisco Basil Sauceda, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Sauceda agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Sauceda was under investigation for allegations of violations of the provisions of previous Board orders. Dr. Sauceda indicated that he wishes to cease practicing due to a medical condition which makes it difficult to practice medicine. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Smith, Barlow, M.D., Lic. No. F9026, Marble Falls

On August 28, 2015, the Board and Barlow Smith, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Smith agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Smith was the subject of a formal complaint at the State Office of Administrative Hearings involving allegations that he: incurred disciplinary action in another state; failed to comply with Board subpoenas; prescribed controlled substances in

a nontherapeutic manner to 10 patients; and was indicted on three felony counts of fraudulent delivery of a controlled substance prescription. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Stigler, Del Barker, M.D., Lic. No. E4703, Caldwell
On August 28, 2015, the Board and Del Barker Stigler, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Stigler agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Stigler was under investigation by the Board for authorizing prescriptions for controlled substances while his DPS Controlled Substances Registration number was expired.

Suarez, Laura A., M.D., Lic. No. H2819, San Antonio
On August 28, 2015, the Board and Laura A. Suarez, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Suarez agreed to voluntarily surrender her Texas medical license in lieu of further disciplinary proceedings. Dr. Suarez was under investigation by the Board for violating terms of her 2015 Order. Dr. Suarez wishes to cease the practice of medicine due to a medical condition that makes it difficult to practice.

Yentis, Richard David, M.D., Lic. No. D5333, Fort Worth
On August 28, 2015, the Board and Richard David Yentis, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Yentis agreed to the voluntary surrender of his Texas medical license in lieu of further disciplinary proceedings. Dr. Yentis was under investigation by the Board for allegations related to failure to comply with his June 2014 Order. The Board found Dr. Yentis surrendered his DEA/DPS controlled substances certifications on June 19, 2015, in connection to his prescribing practices. Dr. Yentis indicated to the Board that he has a medical condition that prevents him from safely practicing medicine and would like to retire.

OTHER STATES' ACTIONS

Alexander, Larry L., M.D., Lic. No. J1835, Sanford, FL
On August 28, 2015, the Board and Larry L. Alexander, M.D., entered into an Agreed Order requiring Dr. Alexander to comply with the Order and any terms and conditions imposed by the Settlement Agreement entered by the Florida Board of Medicine, and provide the Board proof of completion of the requirements. The Board found Dr. Alexander was disciplined by the Florida Board of Medicine following allegations that he violated the standard of care by failing to appropriately admit a patient to the hospital or repeat tests, resulting in the patient's death.

Hegwood, Teki Susan, M.D., Lic. No. K2036, Dothan, AL
On August 28, 2015, the Board and Teki Susan Hegwood, M.D., entered into an Agreed Order requiring Dr. Hegwood to comply with the California Medical Board Order and provide proof of compliance within 30 days of completion of the requirements of the order. The Board found Dr. Hegwood was the subject of disciplinary action by the California Medical Board.

Sani, Shahram Norouzi, M.D., Lic. No. P6074, Cleburne
On August 28, 2015, the Board and Shahram Norouzi Sani, M.D., entered into an Agreed Order requiring Dr. Sani to within 60 days pay an administrative penalty of $1,000. The Board found Dr. Sani was the subject of disciplinary action by the Maryland State Board of Physicians for allowing an unlicensed person to position patients and use the x-ray equipment.

NONTHERAPEUTIC PRESCRIBING

Hill, Welton Ellis, M.D., Lic. No. F6746, Bellville
On August 28, 2015, the Board and Welton Ellis Hill, M.D., entered into an Agreed Order requiring Dr. Hill to have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete the physician prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in risk management; and within

60 days pay an administrative penalty of $5,000. The Board found Dr. Hill prescribed benzodiazepines to an elderly patient but failed to appropriately monitor the patient's use of the medications, failed to use other safer medications, and did not justify the treatment in his documentation.

VIOLATION OF BOARD RULE

Legall, Michelle Evette, M.D., Lic. No. M6723, Humble

On August 28, 2015, the Board and Michelle Evette Legall, M.D., entered into an Agreed Order requiring Dr. Legall to within six months perform 16 hours of community service for a nonprofit charitable organization approved by the Board; and within 90 days pay an administrative penalty of $1,000. The Board found Dr. Legall violated her Remedial Plan by failing to complete the requisite CME, failing to pay the Remedial Plan fee, and failing to cooperate with Board staff.

Narang, Harcharan Singh, M.D., Lic. No. L5481, Houston

On August 28, 2015, the Board and Harcharan Singh Narang, M.D., entered into a Mediated Agreed Order requiring Dr. Narang to within 60 days provide the Board a copy of the informed consent form he utilizes regarding the alternative and complementary nature of his practice for review and approval; and within one year complete the board certification review course for the subspecialty of endocrinology. The Board found Dr. Narang failed to comply with the Board rules related to the practice guidelines for the provision of complementary and alternative medicine because Dr. Narang failed to review and discuss all conventional medical treatment options during the assessment of a patient. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Patel, Ranjitkumar, M.D., Lic. No. K3384, Webster

On August 28, 2015, the Board and Ranjitkumar Patel, M.D., entered into an Agreed Order prohibiting Dr. Patel from engaging in the treatment of any chronic pain patients; requiring Dr. Patel to within seven days surrender his DEA/DPS controlled substances registration certificates; prohibiting him from supervising any midlevel provider, including physician assistants and advanced practice registered nurses; and surrender any and all pain management clinic certificates and withdraw any pending applications. The Board found Dr. Patel failed to adequately treat at least four chronic pain patients and was operating a pain management clinic without the proper certification.

Smith, Jack Coldwell, III, M.D., Lic. No. L3131, Amarillo

On August 28, 2015, the Board and Jack Coldwell Smith, III, M.D., entered into an Agreed Order publicly reprimanding Dr. Smith, and prohibiting Dr. Smith from practicing medicine until such a time as he requests in writing to resume practice, appears before the Board and provides clear and convincing evidence that he is physically, mentally, and otherwise competent to safely practice medicine. The Board found Dr. Smith failed to comply with terms of his August 2014 Order by failing to comply with multiple drug tests.

FAILURE TO PROPERLY SUPERVISE OR DELEGATE

Nasser, George Alan, M.D., Lic. No. J7601, The Woodlands

On August 28, 2015, the Board and George Alan Nasser, M.D., entered into a Mediated Agreed Order publicly reprimanding Dr. Nasser and prohibiting him from prescribing any controlled substances in Schedules II except as medically necessary to treat patients in a hospital setting, a surgery center or free-standing catheterization laboratory. Dr. Nasser shall not prescribe any controlled substances or refills for any controlled substances in Schedules II or IV, except as medically necessary to treat patients in a hospital setting, a surgery center or free-standing catheterization laboratory or to treat patients in his cardiology practice for a time period for the expected duration of an acute medical condition, or 72 hours, whichever is shorter. Dr. Nasser shall not be permitted to supervise or delegate prescriptive authority to physician assistants or advanced practice nurses; within one year and three attempts Dr. Nasser must take and pass the Medical Jurisprudence Exam; and within one year pay an administrative penalty of $20,000. The Board found Dr. Nasser failed to adequately supervise an advanced practice nurse who was engaged in nontherapeutic prescribing of controlled substance pain medications and who was operating a clinic as a pain management clinic without a valid certification. Dr. Nasser failed to exercise due diligence when he learned that the APN was treating a large portion of patients for pain and immediately severed his relationship with the APN when he discovered that the

nurse had engaged in subterfuge about the nature of the clinic. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Stout, Keith B., M.D., Lic. No. E9428, Beaumont
On August 28, 2015, the Board and Keith B. Stout, M.D., entered into an Agreed Order requiring Dr. Stout to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 24 hours of in-person CME, divided as follows: eight hours in the supervision of midlevel providers, eight hours in medical recordkeeping and eight hours in ethics; within 30 days provide copies of the prescriptive authority agreements, including standing delegation orders, and other protocols that are used for his supervision of delegates and other staff; and within 60 days pay an administrative penalty of $5,000. The Board found Dr. Stout failed to examine a patient during the first five days the patient was at the hospice facility and failed to supervise his advanced practice nurse who did not properly examine the patient and independently falsified entries in the medical records indicating she had seen the patient.

IMPAIRMENT

Phillips, Cynthia Brooks, D.O., Lic. No. L0510, League City
On August 28, 2015, the Board and Cynthia Brooks Phillips, D.O., entered into an Agreed Order in which Dr. Phillips voluntarily agreed to restrict her Texas medical license to non-clinical practice until such a time as she requests in writing to resume clinical practice, appears before the Board and provides clear and convincing evidence that she can safely practice medicine. Upon notification that Dr. Phillips wishes to resume clinical practice, she shall undergo an independent medical evaluation and follow all recommendations for care and treatment. The Board found Dr. Phillips has been unable to actively practice clinical medicine due to a medical condition and has voluntarily restricted her practice for the last two years.

Stenger, Earl M., M.D., Lic. No. D7315, San Antonio
On August 28, 2015, the Board and Earl M. Stenger, M.D., entered into a Modified Agreed Order, modifying his November 2013 Order. The modification requires Dr. Stenger to within 120 days enroll in the residency program as recommended by KSTAR; within 120 days enroll in and start working towards completion of all required CME courses recommended by KSTAR; and within 120 days complete the physical examination as required by KSTAR. The Board found that KSTAR recommended that if Dr. Stenger's neuropsychological testing and physical evaluation do not find any problems that would be contributing to Dr. Stenger's performance, then Dr. Stenger will need significant remediation. All other terms of the order remain in full effect.

Vasquez, Robert Eloy, M.D., Lic. No. G5730, San Antonio
On August 28, 2015, the Board and Robert Eloy Vasquez, M.D., entered into an Agreed Order requiring Dr. Vasquez for a period of seven years to be subject to the following terms and conditions: shall abstain from the consumption of prohibited substances as defined in the Order, participate in the Board's drug testing program, participate in Alcoholics Anonymous no less than five times per week, and continue his care and treatment with his psychiatrist on at least a bi-monthly basis. The Board found Dr. Vasquez admitted that he had relapsed and drank alcohol. At the request of Texas Physician Health Program, Dr. Vasquez suspended his practice and enrolled in inpatient recovery. Subsequently, Dr. Vasquez tried Antabuse therapy, but it resulted in adverse health issues and he discontinued its use. Dr. Vasquez has had unique personal stressors around the time of his relapse including the murder of a young family member.

VIOLATION OF PRIOR BOARD ORDER

Cammack, James Thomas, M.D., Lic. No. H5696, Lubbock
On August 28, 2015, the Board and James Thomas Cammack, M.D., entered into a Modified Agreed Order, requiring Dr. Cammack to pay an administrative penalty of $1,000 within 60 days and modifying the 2010 Order. The modification removes the university setting requirement for his prescribing authority. The Board found Dr. Cammack violated the drug testing provision of his 2010 Order by calling/logging in late on several occasions. Dr. Cammack was in compliance with the other terms of the 2010 Order. The Board found Dr. Cammack's request to prescribe outside of the university setting was reasonable since he would be prescribing with three other physicians from Texas Tech University and in

order to provide services to an underserved community in his area of practice. All other terms of the 2010 Order remain in full force.

Hugg, Terry Wayne, M.D., Lic. No. F7677, Houston
On August 28, 2015, the Board and Terry Wayne Hugg, M.D., entered into an Agreed Order Modifying Prior Order, modifying Dr. Hugg's 2013 Agreed Order. The modification extends the term of the order for 90 days to complete the outstanding CME requirements and requires Dr. Hugg to pay an additional $250 penalty. The Board found Dr. Hugg violated his 2013 Order by failing to timely complete his CME hours.

ADVERTISING VIOLATIONS

Kaufman, James Kevin, M.D., Lic. No. L0318, Fort Worth
On August 28, 2014, the Board and James Kevin Kaufman, M.D., entered into an Agreed Order requiring Dr. Kaufman to correct the advertisement and representations in all websites, including those websites for which he controls the content, regarding his board certification(s); and within one year complete eight hours of CME in ethics or risk management. The Board found Dr. Kaufman failed to remove website entries stating he was board certified in neurosurgery for eight months after his neurosurgery specialty certification had expired.

INADEQUATE MEDICAL RECORDS

Kasden, Scott E., M.D., Lic. No. J3827, Southlake
On August 28, 2015, the Board and Scott E. Kasden, M.D., entered into a Mediated Agreed Order requiring Dr. Kasden to within one year complete an Advanced Cardiovascular Life Support (ACLS) certification course offered by the American Heart Association (AHA); within one year complete at least four hours of CME in office surgical procedures and office based anesthesia; and within one year complete the medical recordkeeping course and the physician-patient communication course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Kasden failed to obtain the required consent forms for the patient who underwent an in-office procedure, failed to adequately document what was done in his procedure note, and failed to document all the discussions he had with the patient regarding the patient's concerns and goals for the procedure. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

CEASE AND DESIST

Sacks, Damon G., No License, Dallas
On August 28, 2015, the Board and Damon G. Sacks entered into an Agreed Cease and Desist Order, prohibiting Mr. Sacks from practicing medicine in Texas without a license, and from acting as, holding himself out to be, a licensed physician; within 30 days Mr. Sacks shall update all advertising materials in which he is depicted in any way to include a disclaimer indicating that he is not licensed to practice medicine in the state of Texas and shall submit evidence that such revisions have been made. The Board found Mr. Sacks identified himself as "Dr. Sacks" or "Damon Sacks, M.D." on various webpages and that these websites did not include any disclaimer that he is not licensed to practice medicine in Texas.

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

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