Texas Medical Board Press Release

FOR IMMEDIATE RELEASE

June 25, 2015

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TMB disciplines 40 physicians at June meeting, adopts rule changes

At its June 12, 2015 meeting, the Texas Medical Board disciplined 40 licensed physicians and issued two cease and desist orders. The disciplinary actions included four orders related to quality of care violations, four orders related to unprofessional conduct, four revocations, two voluntary surrenders, one order related to criminal activity, two orders related to peer review actions, two orders related to other states' actions, one order related to nontherapeutic prescribing, four orders related to improper prescribing, two orders related to violation of Board rules, two orders related to Texas Physician Health Program violations, ten orders related to violation of prior Board order, and two orders related to inadequate medical records. The Board also took disciplinary action against a surgical assistant.

The Board issued 168 physician licenses at the June meeting, bringing the total number of physician licenses issued in FY15 to 3,177.

RULE CHANGES ADOPTED

CHAPTER 163. LICENSURE

§163.6, Examinations Accepted for Licensure

The Amendment to §163.6, relating to <u>Examinations Accepted for Licensure</u>, revises the language in section 163.6(b)(3)(A) through (D) to clarify exemptions relating to Examination Attempt Limit as is relates to licenses held in other states. The purpose of the amendment is to have clear and more precise rules for applicants.

CHAPTER 166. PHYSICIAN REGISTRATION

§166.2, Continuing Medical Education

The Amendments to §166.2, relating to <u>Continuing Medical Education</u>, amends 166.2(e) by adding the word "physician" to subsections (1)-(4) in order to clarify that the exemption reasons must be those of the "physician" and not anyone else, such as a family member. The rule is further amended in that all references to "licensee" are changed to "physician" in order to be consistent throughout the rule. The purpose of the amendment is to have clear rules that are consistent and unambiguous.

CHAPTER 170. PAIN MANAGEMENT

§170.1, Purpose

The Amendments to §170.1, concerning <u>Purpose</u>, clarify the requirements related to a physician's treatment of pain. Throughout the section, amendments modify language so that the provisions are more clearly delineated as minimum requirements that a physician must do in every case when treating pain. Terms such as "policy" and "guideline(s)" have been changed to read as "rule(s)" and "minimum requirements", and the term "should" has been changed in certain cases to "must."

§170.2, Definitions

The Amendments to §170.2, concerning <u>Definitions</u>, delete definitions for "improper pain treatment" and "non-therapeutic" found in paragraphs (8) and (9) respectively, as such terms are encompassed in the concept of the standard

of care that will be determined and applied by the board in reviewing a physician's treatment of pain. Other amendments reflect renumbering to account for the deleted provisions.

§170.3, Guidelines

The Amendments to §170.3, concerning <u>Guidelines</u>, change the title of the section to "Minimum Requirements for the Treatment of Pain." The amendments further clarify the requirements related to a physician's treatment of pain. Throughout the section, amendments modify language so that the provisions are more clearly delineated as minimum requirements that a physician must do in every case when treating pain. Terms such as "policy" and "guideline(s)" have been changed to read as "rule(s)" and "minimum requirements", and the term "should" has been changed to "must."

CHAPTER 180. TEXAS PHYSICIAN HEALTH PROGRAM AND REHABILITATION ORDERS

§180.4, Operation of Program

The Amendments to §180.4, concerning <u>Operation of Program</u>, eliminate the prohibitions on eligibility for referrals made regarding individuals that have violated the standard of care as a result of the use or abuse of drugs or alcohol, committed a boundary violation with a patient or patient's family member(s), or been convicted of, or placed on deferred adjudication community supervision or deferred disposition for a felony. Further amendments add language providing that the Medical Board may refer such individuals publicly through the entry of an order that addresses the standard of care, boundary, and/or criminal law related violations. In the event of such a referral, the Medical Board retains the authority to discipline the individuals for the standard of care, boundary, and criminal law related violations.

CHAPTER 183. ACUPUNCTURE

§183.4, Licensure

The Amendment to §183.4, concerning <u>Licensure</u>, pertains to the addition of subsection (a)(10), Alternative License Procedure for Military Spouse. The amendment is made to allow alternative demonstration of competency for certain licensing requirements for military spouses as required by Texas Occupations Code, §55.004.

§183.6, Denial of License; Discipline of Licensee

The Amendment to §183.6, concerning <u>Denial of License</u>; <u>Discipline of Licensee</u>, adds subsection (e), relating to Informal Board Proceedings Relating to Licensure Eligibility. The amendment is made to clarify the Acupuncture Board's authority to impose non-disciplinary remedial plans as a condition of licensure.

CHAPTER 184. SURGICAL ASSISTANTS

§184.4, Qualifications for Licensure

The Amendments to §184.4, relating to <u>Qualifications for Licensure</u>, amends the section 184.4(a)(13)(A) and (B)(iii) by adding language that clarifies the surgical assistant program or substantially equivalent program must be accredited for the entire duration of applicant's attendance. The purpose of the amendment is to have clear requirements relating to acceptable education programs for those applying for surgical assistant licensure.

CHAPTER 187. PROCEDURAL RULES

§187.13, Informal Board Proceedings Relating to Licensure Eligibility

The Amendment to §187.13, relating to Informal Board Proceedings Relating to Licensure Eligibility, amends subsection (c)(1), (4)(A) and (B) by making a case change in the word "Board". The rule is further amended in subsection (c)(3)(B)(ii) by adding a 20 day deadline for accepting offers of the committee and changing the word "determined" to "deemed". The rule is also amended in subsection (c)(4)(A) by adding the words "deemed ineligibility" to further clarify what qualifies as "ineligible" and further describe the possible situations to which the subsection applies. Subsection (c)(4)(B) is further amended to change the word "will" to "shall" in order to be consistent with the remainder of the rules. Subsection (c)(4)(E) is amended by eliminating the words "submitted to the board for ratification" and adding language that the committee's determination of ineligibility shall be deemed accepted by the applicant without the need for resubmitting such deemed acceptance to the full board for ratification. The purpose of the amendment is to have

consistent wording throughout the rules in order to improve the clarity of the rules and ensure that the rules relating to licensure comport with the procedures.

§187.24, Pleadings

The Amendments to §187.24, relating to <u>Pleadings</u>, amends subsection (b)(1) by making a case change in the word "Board". The rule is further amended in subsection (b)(5) by eliminating the words "submitted to the board for ratification" and adding language that provides that the committee's determination of ineligibility shall be deemed accepted by the applicant without the need for resubmitting such deemed acceptance to the full board for ratification. The purpose of the amendment is to have consistent wording throughout the rules in order to improve the clarity of the rules and ensure that the rules relating to licensure comport with the procedures.

§187.43, Proceedings for the Modification/Termination of Agreed Orders and Disciplinary Orders

The Amendments to §187.43, concerning <u>Proceedings for the Modification/Termination of Agreed Orders and</u> <u>Disciplinary Orders</u>, clarify the requirements related to a probationer's eligibility for submitting a petition to the board requesting modification or termination of an order.

§187.61, Ancillary Proceeding

The Amendments to §187.61, concerning <u>Ancillary Proceeding</u>, reorganizes language under subsection (b) so that certain language under subsection (b)(2) is moved to new subsection (c) and further modified to clarify that in cases of suspension based upon arrest for certain offenses listed under §164.1595 of the Texas Occupations Code and §187.57(d) of this title (relating to Charge of the Disciplinary Panel), final dispositions of criminal cases may include a deferred adjudication, acquittal, dismissal of the criminal case, or plea agreement, in addition to a court order of guilt and sentence.

§187.70, Purposes and Construction

The Amendments to §187.70, concerning <u>Purposes and Construction</u>, add language clarifying that an adjudication of guilt of the offense charged includes but is not limited to a finding of guilt by a judge or jury. For purposes of §187.70, the Board interprets the term initial conviction, under Chapter 167 of the Occupations Code, to mean an adjudication of guilt, and the suspension of the medical license is mandated upon an initial conviction of certain criminal offenses listed in §164.057.

§187.72, Decision of the Panel

The amendments to §187.72, concerning <u>Decision of the Panel</u>, delete language in subsection (a) providing that an order of suspension by operation of law represents an imminent peril to the public health, safety, or welfare and requires immediate effect and is considered administratively final for purposes of appealing the decision to district court. Further amendments to subsection (a) insert citations to the applicable sections of §164.057, which mandate suspension upon an initial conviction.

§187.73, Termination of Suspension

Repeal of §187.73, concerning <u>Termination of Suspension</u>, is repealed, as the section is redundant, in that termination of the suspension would be governed by the terms of the agreed order probating the suspension under 187.72. The Board also believes that the rule cited is an incorrect standard for determining if a suspension should be terminated, specifically, physical and mental competence to practice medicine. This standard is not relevant to the underlying basis of the suspension, which is criminal conduct that the legislature determined poses a risk to a physician's patients, requiring suspension of the physician's medical license. Physical and mental competence do not mitigate such a risk.

CHAPTER 189. COMPLIANCE PROGRAM

§189.7, Modification/Termination Hearings

The Amendments to §189.7, concerning <u>Modification/Termination Hearings</u>, clarify the requirements related to a probationer's eligibility for submitting a petition to the board requesting modification or termination of an order.

DISCIPLINARY ACTIONS

QUALITY OF CARE

Pauza, Kevin Joseph, M.D., Lic. No. J7127, Tyler

On June 12, 2015, the Board and Kevin Joseph Pauza, M.D., entered into a Modified Agreed Order, modifying Dr. Pauza's 2013 Order. The modification extends the order to include two additional consecutive monitoring cycles, for a total of six consecutive cycles; and within one year complete at least four hours of CME in sleep medicine. The Board found Dr. Pauza's medical records for the patient at issue were inadequate and that Dr. Pauza's stated rationale for prescribing a medication as a sleep aid and for treating the patient with corticosteroid injections after a five-year treatment hiatus were inadequate. All other terms of the order remain in full effect.

Pomonis, Nick Spero, D.O., Lic. No. H0730, Orange

On June 12, 2015, the Board and Nick Spero Pomonis, D.O., entered into an Agreed Order requiring Dr. Pomonis to within one year complete at least 16 hours of CME, divided as follows: eight hours in prescribing controlled substances and eight hours in treating chronic pain. The Board found Dr. Pomonis failed to meet the standard of care for a patient or to sufficiently monitor the patient's side effects, progress or compliance with treatment for chronic pain and depression. Dr. Pomonis ignored red flags of possible abuse warranting a better assessment of the patient's risk for substance abuse and termination if the patient continued to refuse to provide test samples. Dr. Pomonis' medical records were inadequate and lacked documentation supporting diagnosis and treatment.

Ravichandran, Guruswami K., M.D., Lic. No. F3588, Houston

On June 12, 2015, the Board and Guruswami K. Ravichandran, M.D., entered into a Mediated Agreed Order requiring Dr. Ravichandran to within one year complete the physician prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and within 90 days of completing PACE prescribing course, submit to the Board a copy of office protocols for the collaboration with other providers for his patients. The Board found Dr. Ravichandran did not obtain full diagnostic assessments to support measurable treatment plans and failed to obtain and monitor vital signs for drug-specific side effects. Additionally, Dr. Ravichandran's use of benzodiazepines in children was not support by the documentation in the records. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Sullivan, Julie Marie, M.D., Lic. No. N6696, Austin

On June 12, 2015, the Board and Julie Marie Sullivan, M.D., entered into an Agreed Order requiring Dr. Sullivan to complete at least 12 hours of CME, divided as follows: four hours in risk management, four hours in medical recordkeeping and four hours in treatment of headaches. The Board found Dr. Sullivan examined a patient who was being seen for a headache but did not perform a fundoscopic exam despite the patient's complaints. Patient's records lacked detailed information about the patient's complaints of photophobia, prior similar symptoms and family history of headaches, migraines and aneurysms.

UNPROFESSIONAL CONDUCT

Aviles, Fernando Jose, M.D., Lic. No. N7210, El Paso

On June 12, 2015, the Board and Fernando Jose Aviles, M.D., entered into an Agreed Order publicly reprimanding Dr. Aviles and requiring him to have a female chaperone present when he examines a female patient; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 12 hours of CME, divided as follows: four hours in ethics, four hours in prescribing, to include antibiotic prescribing, and four hours in medical recordkeeping; within one year complete the professional boundaries course offered by University of California San Diego Physician Assessment and Clinical Education (PACE) program; and within 60 days pay an administrative penalty of \$2,500. The Board found Dr. Aviles engaged in sexually inappropriate behavior towards patients who were also coworkers and was terminated from his position with a clinic due to his behavior. Dr. Aviles also breached the standard of care with one patient by prescribing without documented clinical justification and failed to keep adequate medical records.

Campbell, Michael G., M.D., Lic. No. L0767, Fredericksburg

On June 12, 2015, the Board and Michael G. Campbell, M.D., entered into an Agreed Order requiring Dr. Campbell to within 60 days enter into a repayment plan to cure the Texas Higher Education Coordinating Board (THECB) default and provide documentation to the Board that he is in good standing with the THECB. The Board found Dr. Campbell defaulted on a student loan with the THECB.

Carrillo, Eduardo, M.D., Lic. No. L2172, Mission

On June 12, 2015, the Board and Eduardo Carrillo, M.D., entered into an Agreed Order requiring Dr. Carrillo to within one year and three attempts pass the Medical Jurisprudence Exam; within 60 days submit a written protocol for ensuring timely completion of death certificates through the Texas Electronic Death Registry (TEDR) system; within one year complete 12 hours of CME, divided as follows: eight hours in risk management and four hours in ethics; and within 60 days pay an administrative penalty of \$2,000. The Board found Dr. Carrillo failed to timely utilize the TEDR system to certify or sign the death certificates of two patients.

Porto, Boris Joseph, M.D., Lic. No. H4621, Lubbock

On June 12, 2015, the Board and Boris Joseph Porto, M.D., entered into an Agreed Order requiring Dr. Porto to have his practice monitored by another physician for eight consecutive monitoring cycles; comply with the terms of his pre-trial diversion agreement with Texas Health and Human Services (HHSC) and provide evidence to the Board upon completion of the agreement; and within one year complete at least eight hours of CME in proper billing. The Board found Dr. Porto was subject to a pre-trial diversion agreement, entered in March 2014, with HHSC related to billing Medicaid for services "not rendered as billed" for patients in a group home.

REVOCATION

Glidden, Weldon, D.O., Lic. No. G3397, Chillicothe

On June 12, 2015, the Board and Weldon Glidden, D.O., entered into an Agreed Order of Revocation in which Dr. Glidden agreed to the revocation of his Texas medical license in lieu of further disciplinary proceedings. Dr. Glidden had been under investigation by the Board for allegations of violation of a Board Order and substance abuse issues.

Kellett, Richard A., S.A., Lic. No. SA00126, Burleson

On June 12, 2015, the Board and Richard A. Kellett, S.A., entered into an Agreed Order of Revocation in which Mr. Kellett agreed to the revocation of his Texas surgical assistant license in lieu of further disciplinary proceedings. Mr. Kellett has reported to the Board that he no longer wishes to maintain his license to practice as a surgical assistant.

Shelton, Douglas Ray, M.D., Lic. No. J2325, Amarillo

On June 12, 2015, the Board entered a Final Order against Douglas Ray Shelton, M.D., which revoked Dr. Shelton's Texas medical license. The Board found Dr. Shelton engaged in violations of patient-physician boundaries with multiple patients, failed to meet the standard of care with respect to two patients' surgical procedures and their follow up care, failed to maintain adequate medical records, and was the subject of adverse peer review during which Dr. Shelton resigned his hospital privileges in lieu of disciplinary action. The action was based on the findings of two administrative law judges at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Shelton has 20 days from the service of the order to file a motion for rehearing.

Osibamowo, Abiodun Oyewale, M.D., Lic. No. K7366, DeSoto

On June 12, 2015, the Board and Abiodun Oyewale Osibamowo, M.D., entered into an Agreed Order of Revocation in which Dr. Osibamowo agreed to the revocation of his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Osibamowo voluntarily surrendered his controlled substances privileges with the DEA for failure to comply with the Federal requirements pertaining to controlled substances and that Dr. Osibamowo departed the United States for Nigeria after a warrant of Removal/Deportation was issued by the United States Department of Homeland Security.

VOLUNTARY SURRENDER

Granville, Robert Richey, Jr., M.D., Lic. No. K9550, Albany, GA

On June 12, 2015, the Board and Robert Richey Granville, Jr., M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Granville agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Granville reported issues concerning impairment and his struggle with alcohol and substance abuse and related arrests.

Sanjar, Mansour R., M.D., Lic. No. G3069, Baytown

On June 12, 2015, the Board and Mansour R. Sanjar, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Sanjar agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found that on January 12, 2015, Dr. Sanjar was sentenced to 120 months in prison and ordered to pay approximately \$8.1 million in restitution for health care fraud.

CRIMINAL ACTIVITY

Ruiz, Roberto, Jr., M.D., Lic. No. P7199, Odessa

On June 12, 2015, the Board and Roberto Ruiz, Jr., M.D., entered into an Agreed Order publicly reprimanding Dr. Ruiz. The Board found Dr. Ruiz engaged in unprofessional conduct by being placed on deferred adjudication community supervision for a felony.

PEER REVIEW ACTIONS

Glover, David John, M.D., Lic. No. E8511, St. Helens, Merseyside, United Kingdom

On June 12, 2015, the Board and David John Glover, M.D., entered into an Agreed Order publicly reprimanding Dr. Glover and prohibiting Dr. Glover from practicing in Texas until he appears before the Board and provides sufficient evidence and information that indicates he is physically, mentally, and otherwise competent to safely practice. The Board found Dr. Glover was disciplined by the General Medical Council in the United Kingdom. The disciplinary actions taken by Dr. Glover's peers were based on unprofessional conduct or professional incompetence that was likely to harm the public.

Stasikowski, J. John, M.D., Lic. No. E5623, Fort Worth

On June 12, 2015, the Board and J. John Stasikowski, M.D., entered into an Agreed Order requiring Dr. Stasikowski to refrain from performing any surgery on patients and may not be present for the performance of surgery on any patient; within one year complete at least eight hours of CME, divided as follows: four hours in effective communication and four hours in risk management; and shall not be permitted to supervise or delegate prescriptive authority to a physician assistant or advanced practice nurse or supervise a surgical assistant. The Board found Dr. Stasikowski surrendered his privileges at Baylor All Saints Hospital while a peer review investigation was pending regarding changes in his behavior and patient care.

OTHER STATES' ACTIONS

Gonzales, Cathryn Jean, M.D., Lic. No. K0479, Magnolia, AR

On June 12, 2015, the Board and Cathryn Jean Gonzales, M.D., entered into an Agreed Order requiring Dr. Gonzales to within 30 days submit to an evaluation by the Physician Health Program and comply with any and all recommendations; Dr. Gonzales shall not practice in Texas until she personally appears before the board and provides sufficient evidence that indicates that she is physically, mentally, and otherwise competent to safely practice medicine; surrender her DPS controlled substances certificate; shall not treat or otherwise serve as a physician for her immediate family and shall not prescribe, dispense, administer or authorize controlled substances or dangerous drugs with addictive potential or potential for abuse to herself or her immediate family; within 60 days of completion of the CPEP evaluation ordered by the Arkansas Medical Board Order, submit a copy of the CPEP report to the Texas Medical Board; within 30 days of completion of the prescribing course required by the Arkansas Medical Board Order, submit to the Texas Medical Board Order, submit or the texas Medical Board Order, submit a copy of the CPEP report to the Texas Medical Board; within 30 days of completion of the prescribing course required by the Arkansas Medical Board Order, submit proof of completion to the

Texas Medical Board; and Dr. Gonzales shall not be permitted to supervise or delegate prescriptive authority to physician assistants, advanced practice nurses, or surgical assistants in the state of Texas. The Board found Dr. Gonzales was temporarily suspended on an emergency basis by the Arkansas State Medical Board. The Board subsequently entered an Order lifting the suspension but restricting Dr. Gonzales from prescribing Schedule II medications and requiring her to take prescribing and boundaries courses and pay a penalty. The action taken by the Arkansas Board was based on Dr. Gonzales' prescribing to several patients and subsequent discovery of her own use of pain medications.

Karsh, Richard Bruce, M.D., Lic. No. N8112, Colorado Springs, CO

On June 12, 2015, the Board and Richard Bruce Karsh, M.D., entered into an Agreed Order prohibiting Dr. Karsh from practicing in Texas until he appears before the Board and provides sufficient evidence and information that indicates he is physically, mentally, and otherwise competent to safely practice. The Board found Dr. Karsh was disciplined by the Colorado Medical Board and other state boards took action based on the Colorado action and/or Dr. Karsh's failure to report the action.

NONTHERAPEUTIC PRESCRIBING

Messer, Dale Leonard, M.D., Lic. No. D2740, Alvin

On June 12, 2015, the Board and Dale Leonard Messer, M.D., entered into an Agreed Order on Formal Filing prohibiting Dr. Messer from treating any chronic pain in an office setting; requiring Dr. Messer to have his practice monitored by another physician for 12 consecutive monitoring cycles; and within one year complete at least 24 hours of CME, divided as follows: eight hours in detecting drug-seeking behavior, eight hours in medical recordkeeping and eight hours in risk management. The Board found Dr. Messer nontherapeutically prescribed to six patients and failed to maintain adequate medical records. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

IMPROPER PRESCRIBING

Cross, Alisa, M.D., Lic. No. P2109, Killeen

On June 12, 2015, the Board and Alisa Cross, M.D., entered into an Agreed Order publicly reprimanding Dr. Cross and requiring Dr. Cross to not treat or otherwise serve as a physician for her immediate family and not prescribe, dispense, administer, or authorize nay medications, including but not limited to controlled substances or dangerous drugs with addictive potential or potential for abuse, to herself or her immediate family; within one year and three attempts pass the Medical Jurisprudence Exam; within 180 days complete the physician prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within 180 days complete the medical recordkeeping course offered by the PACE program; within one year complete at least 16 hours of CME, divided as follows: eight hours in risk management and eight hours in ethics; and within 60 days pay an administrative penalty of \$3,000. The Board found Dr. Cross admitted to prescribing controlled substances to a person with whom she has a close personal relationship from 2009 until 2014 who is a resident of Oregon. Dr. Cross obtained a Texas license in 2012, and between 2012 and 2014, while residing in Texas, Dr. Cross continued to prescribe controlled substances as well as other medication to this person without a demonstrated or documented immediate need.

Gonzalez-Weaver, Rose Marie, D.O., Lic. No. J3484, Uvalde

On June 12, 2015, the Board and Rose Marie Gonzalez-Weaver, D.O., entered into an Agreed Order requiring Dr. Gonzalez-Weaver to within 30 days undergo an independent medical evaluation and follow all recommendations for care and treatment; within 30 days schedule an assessment with the Texas A&M Health Science Center Knowledge, Skills, Training, Assessment, and Research (KSTAR) program and reappear before the board to address the assessment; Dr. Gonzalez-Weaver shall not possess, administer, dispense, or prescribe any controlled substance and shall not authorize refills of controlled substances; shall not treat or otherwise serve as a physician for her immediate family or friends, and shall not prescribe, dispense, administer or authorize controlled substances or dangerous drugs with addictive potential or potential for abuse to herself or her immediate family or friends. The Board found Dr. Gonzalez-Weaver failed to meet the standard of care when she prescribed controlled substances to a family member for a period of time extending beyond the 72 hours of immediate need, failed to document that she provided appropriate follow up care for the issues diagnosed and treated and admitted to taking prescribed narcotics without being under the current care and monitoring of a physician.

Hansen, Mireya, M.D., Lic. No. M9655, Houston

On June 12, 2015, the Board and Mireya Hansen, M.D., entered into an Agreed Order prohibiting Dr. Hansen from treating or otherwise serving as a physician for her immediate family, and shall not prescribe, dispense, administer or authorize controlled substances or dangerous drugs with addictive potential or potential for abuse to herself or her immediate family; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 32 hours of CME, divided as follows: eight hours in ethics, eight hours in appropriate prescribing of controlled substances, eight hours in risk management and eight hours in medical recordkeeping. The Board found Dr. Hansen inappropriately prescribed controlled substances to three family members over several years.

Sax, Steven Lawrence, M.D., Lic. No. G1530, Houston

On June 12, 2015, the Board and Steven Lawrence Sax, M.D., entered into an Agreed Order prohibiting Dr. Sax from administering, dispensing, or prescribing any controlled substances or dangerous drugs with addictive potential or potential for abuse, except as is medically necessary, for treatment of patients in a hospital setting where Dr. Sax has privileges or practices medicine; within one year and three attempts pass the Medical Jurisprudence Exam; and within one year complete at least 12 hours of CME, divided as follows: four hours in medical recordkeeping, four hours in prescribing controlled substances, and four hours in ethics. The Board found Dr. Sax prescribed controlled substances to a close family member numerous times between 2008 and 2014, admitted to prescribing doses that exceeded a 72-hour supply, failed to maintain a medical record for the family member and without documenting his evaluation and treatment of the family member to support the prescribing.

VIOLATION OF BOARD RULE

Cohn, Peter David, M.D., Lic. No. E9584, Dallas

On June 12, 2015, the Board and Peter David Cohn, M.D., entered into an Agreed Order requiring Dr. Cohn to within 30 days release the patient's medical records and provide the Board with proof of their delivery; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least eight hours of CME, divided as follows: four hours in risk management and four hours in ethics; and within 90 days pay an administrative penalty of \$1,000. The Board found Dr. Cohn failed to release a patient's medical records to a requesting insurance company despite the patient's valid authorization and repeated requests by the patient and insurance company to release the records.

Roberts, Michalle, M.D., Lic. No. J4483, Houston

On June 23, 2015, the Board and Michalle Roberts, M.D., entered into a Mediated Agreed Order publicly reprimanding Dr. Roberts and prohibiting Dr. Roberts from engaging in the treatment of chronic pain; 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 medical ethics, eight hours in practice management and eight hours in risk management; and pay an administrative penalty of \$20,000. The Board found Dr. Roberts was improperly involved with a pain management clinic that was not owned, operated or registered in compliance with statutes and rules and that the unlicensed owner was prescribing and dispensing dangerous drugs and controlled substances under Dr. Roberts' name. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

TEXAS PHYSICIAN HEALTH PROGRAM VIOLATION

Gosuico, Amelia De La Cruz, M.D., Lic. No. F8746, Houston

On June 12, 2015, the Board and Amelia De La Cruz Gosuico, M.D., entered into an Agreed Order requiring Dr. Gosuico to within 30 days obtain an independent medical evaluation and follow all recommendations for care and treatment; limit her practice to a group or institutional setting; and shall not be permitted to supervise and delegate prescriptive authority to physician assistants and advanced practice nurses or to supervise surgical assistants. The Board found Dr. Gosuico entered into a three year agreement with the Texas Physician Health Program (TXPHP) due to a mental or

physical impairment. As part of the TXPHP agreement, Dr. Gosuico was to provide monitoring reports from her treating physician but she failed to supply the reports and was referred back to the Board for noncompliance.

Ortiz, Waleska Del Carmen, M.D., Lic. No. M8890, Edinburg

On June 12, 2015, the Board and Waleska Del Carmen Ortiz, M.D., entered into an Agreed Order requiring Dr. Ortiz to within 30 days obtain an independent medical evaluation and follow all recommendations for care and treatment. The Board found Dr. Ortiz signed a five-year agreement with the Texas Physician Health Program (TXPHP) as a result of allegations brought by Board staff regarding her inability to practice due to Lupus, ADHD, anxiety and depression. Dr. Ortiz was referred to the Board from TXPHP for several late drug tests and late submission of psychiatrist and rheumatologist reports.

VIOLATION OF PRIOR BOARD ORDER

Anderson, Timothy W., M.D., Lic. No. F5819, Houston

On June 12, 2015, the Board and Timothy W. Anderson, M.D., entered into a Modified Agreed Order, modifying Dr. Anderson's 2010 Order, as modified by the 2014 Order. The modification allows Dr. Anderson to complete the remaining 3.5 hours of CME in ethics online no later than September 10, 2015. The Board found Dr. Anderson failed to obtain four hours of in-person CME by the deadline set forth in the order. All other terms of the order remain in full effect.

Bangale, Anil, M.D., Lic. No. E7370, Fort Worth

On June 12, 2015, the Board and Anil Bangale, M.D., entered into an Agreed Order requiring Dr. Bangale to within 30 days schedule an assessment with the Texas A&M Health Science Center Knowledge, Skills, Training, Assessment, and Research (KSTAR) program; upon completion of KSTAR, personally appear before the Board to address any issues related to the final KSTAR assessment; and shall not prescribe any Schedule II-IV controlled substances in Texas before appearing before the Board. The Board found Dr. Bangale violated his 2011 Order by failing to follow his chart monitor recommendations and continued to inadequately document whether appropriate care was provided to the patients or whether the plan of care for patients was followed up on.

Ferrell, John Carl, M.D., Lic. No. G8835, Frisco

On June 12, 2015, the Board and John Carl Ferrell, M.D., entered into an Agreed Order Modifying Prior Order, modifying Dr. Ferrell's April 2011 order, as modified by the 2014 Order. The modification publicly reprimands Dr. Ferrell, suspends Dr. Ferrell's license for 30 days, however the suspension is stayed and Dr. Ferrell is placed on probation under the following terms: within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least four hours of CME in medical ethics; have his practice monitored by another physician for an additional four consecutive monitoring cycles; within 120 days submit to an Independent Medical Evaluation; and within 60 days pay an administrative penalty of \$4,000. The Board found Dr. Ferrell is not in compliance with several terms of his 2011 order. Specifically, Dr. Ferrell has failed to submit patient charts in a timely manner and failed to submit a timely response describing his plans to implement chart monitor recommendations. All other terms of the 2011 Order, as modified, remain in full force.

Hamoudi, Walid Hamad, M.D., Lic. No. K7027, Pearland

On June 12, 2015, the Board and Walid Hamad Hamoudi, M.D., entered into a Modified Agreed Order, modifying Dr. Hamoudi's 2010 Order, as previously modified by the 2014 Order. The modification replaces the quarterly peer review reports with eight consecutive chart monitoring cycles. The Board found Dr. Hamoudi violated his 2010 Order by failing to obtain preapproval for his employment at a group practice setting. All other terms of the 2010 Order, as modified, remain in full force.

Hooda, Barkat Sadruddin, M.D., Lic. No. P5993, Galveston

On June 12, 2015, the Board and Barkat Sadruddin Hooda, M.D., entered into an Agreed Order requiring Dr. Hooda to within six months complete at least 8 hours of CME, divided as follows: one hour in professional communication and seven hours in risk management. The Board found Dr. Hooda made good faith efforts to complete the CME hours required in his 2013 remedial plan but failed to obtain pre-approval for the courses.

Maat, Owen Surgent, M.D., Lic. No. J5609, Bellaire

On June 12, 2015, the Board and Owen Surgent Maat, M.D., entered into an Agreed Order requiring Dr. Maat to within one year complete at least four hours of CME in ethics and/or risk management. The Board found Dr. Maat violated his 2013 Order by failing to timely pay his administrative penalty.

Rhodes, Ernesto Philip, M.D., Lic. No. J3886, Midland

On June 12, 2015, the Board and Ernesto Philip Rhodes, M.D., entered into an Agreed Order publicly reprimanding Dr. Rhodes, suspending Dr. Rhodes' Texas medical license for 60 days, and placing Dr. Rhodes on probation for the duration of his license under the following terms: shall abstain from the consumption of prohibited substances as defined in the Order; participate in the Board's drug testing program; participate in AA at least five times per week; participate in Sex and Love Addicts Anonymous at least once per week; participate in local county physician health and rehabilitation group at least once per week; and pay an administrative penalty of \$5,000. The Board found Dr. Rhodes violated his February 2009 Order by failing to abstain from prohibited substances, including illegal drugs and alcohol. Specifically, Dr. Rhodes tested positive for methamphetamines.

Smith, Jody Leeann, M.D., Lic. No. BP10037778, El Paso

On June 12, 2015, the Board and Jody Leeann Smith, M.D., entered into an Agreed Order requiring Dr. Smith to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least eight hours of CME in medical ethics; and within 60 days pay an administrative penalty of \$1,000. The Board found Dr. Smith violated her 2013 Order by continuing to participate in clinical rotations in her residency program without following the proper procedures for having the suspension of her permit lifted. Dr. Smith failed to confirm with the Board whether the issues regarding the Order were resolved and failed to timely update her address of record with the Board.

Stone, John Samuel, M.D., Lic. No. C7501, Houston

On June 12, 2015, the Board and John Samuel Stone, M.D., entered into an Agreed Order requiring Dr. Stone to within 90 days complete at least two hours of CME in ethics as required by the 2013 Remedial Plan; and within 60 days pay an administrative penalty of \$500. The Board found Dr. Stone failed comply with the terms of his 2013 remedial plan by failing to obtain pre-approval for, and to complete two of the required hours of CME in ethics before the required deadline.

Villarreal, Gustavo Enrique, M.D., Lic. No. G6038, Laredo

On June 12, 2015, the Board and Gustavo Enrique Villarreal, M.D., entered into an Agreed Order requiring Dr. Villarreal to immediately cease operating a pharmacy and shall not distribute, provide, or dispense medications for a fee as part of his practice; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 20 hours of CME, divided as follows: eight hours in medical recordkeeping, eight hours in risk management and four hours in ethics; and within 60 days pay an administrative penalty of \$2,000. The Board found Dr. Villarreal operated an unlicensed pharmacy. Specifically, Dr. Villarreal ordered and stocked medications in his office, and dispensed those medications to his patients for a fee and beyond the patients' immediate needs.

INADEQUATE MEDICAL RECORDS

Eni, Ikedinobi Ugochukwu, M.D., Lic. No. K6843, The Woodlands

On June 12, 2015, the Board and Ikedinobi Ugochukwu Eni, M.D., entered into an Agreed Order requiring Dr. Eni to within one year complete at least eight hours of CME in geriatric medicine. The Board found Dr. Eni did not examine the rash/groin area of an elderly patient due to the premature ending of the examination. Dr. Eni failed to document the interactions with the patient and the disruptive individuals accompanying the patient which led to the termination of the examination.

Motley, Jennifer Lee, M.D., Lic. No. L7491, Fort Worth

On June 12, 2015, the Board and Jennifer Lee Motley, M.D., entered into an Agreed Order requiring Dr. Motley to within one year complete at least 12 hours of CME, divided as follows: eight hours in medical recordkeeping and four hours in

risk management; and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Motley failed to document the completion of a sonogram on a patient.

SURGICAL ASSISTANTS

Scott, Christopher James, S.A., Lic. No. SA00375, Houston

On June 12, 2015, the Board entered a Default Order against Christopher James Scott, S.A., which revoked his Texas surgical assistant license. On January 5, 2015, the Board filed a Complaint with the State Office of Administrative Hearings (SOAH) in Docket No. 503-15-1837.SA, alleging that Mr. Scott violated the Act and was subject to disciplinary action by the Board. Mr. Scott was served notice of the Complaint. No answer or responsive pleading was ever filed by Mr. Scott, nor did Mr. Scott appear at the SOAH hearing on April 15, 2015. The Board granted a Determination of Default and Mr. Scott's Texas surgical assistant license was revoked by Default Order. This order resolves a formal complaint filed at SOAH. Mr. Scott has 20 days from the service of the order to file a motion for rehearing.

CEASE AND DESIST

Chavez-Rodriguez, Omar, No License, Galena Park

On June 12, 2015, the Board and Omar Chavez-Rodriguez entered into an Agreed Cease and Desist Order, prohibiting Mr. Chavez-Rodriguez from acting as, or holding himself out to be, a licensed physician in the state of Texas. The Board found Mr. Chavez-Rodriguez was employed at the Women's Hospital of Texas as a surgical technician in the Labor and Delivery Unit of the hospital. On August 4, 2014, Mr. Chavez-Rodriguez surgically removed a tattoo from a coworker and then sutured the wound. Mr. Chavez-Rodriguez acted without a physician's order or without the physician's supervision, using sutures and supplies from the Labor and Delivery unit of the hospital.

Jawhari, Kaled "Karl", D.C., No License, Dallas

On June 12, 2015, the Board and Kaled "Karl" Jawhari, D.C., entered into an Agreed Cease and Desist Order, prohibiting Mr. Jawhari from engaging in the practice of medicine in the state of Texas. Mr. Jawhari shall cease and desist from making offers to treat conditions outside of the scope of chiropractic in the state of Texas. The Board found Mr. Jawhari engaged in the unlicensed practice of medicine by making offers on his website for treatments that exceed the scope of chiropractic.

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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.