Texas Medical Board

News Release

FOR IMMEDIATE RELEASE

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Media contact: Public Information Officer Jill Wiggins at jill.wiggins@tmb.state.tx.us or (512) 305-7018.

Non-media contact: (512) 305-7030 or (800) 248-4062.

Medical Board Disciplines 34 Doctors

At its April 12-13 meeting, the Texas Medical Board took disciplinary action against 34 licensed physicians.

Actions included 13 violations based on quality of care; five actions based on unprofessional conduct; three actions based on inadequate supervision; three actions based on violation of probation or prior board orders; five advertising violations; one action based on a criminal conviction; two voluntary surrenders; and two minimal statutory violations. Administrative penalties totaling \$54,000 were assessed.

New Licenses Issued

The board issued 494 licenses at the April 12-13 meeting.

Proposed Rule Changes

The following rule changes will be published in the Texas Register for comment:

Chapter 161, General Provisions, proposed amendments to §161.3, <u>Organization and Structure</u>, regarding guidelines for conduct of board members.

Chapter 163, Licensure, proposed amendments to §163.1, <u>Definitions</u>, and 163.2, §<u>Full Texas Medical License</u>, regarding recognition of Texas Higher Education Coordinating Board authority to determine a school to be Fraudulent or Substandard and to clarify that any foreign medical school must meet the Board's substantial equivalence requirements; §163.4, <u>Procedural Rules for Licensure Applicants</u>, regarding processing of applications determined to be ineligible to allow appeal to Licensure Committee on one issue, without spending staff time to process the rest of the application; §163.6, <u>Examinations Accepted for Licensure</u>, to delete subparagraph (e) (10-Year Rule) and make it a new §163.7; §163.6, <u>Examinations Accepted for Licensure</u>, adding a new §163.6(e)(4) eliminating requirements to retake the jurisprudence examination; adding a new §163.7, <u>Ten Year Rule</u>, to include the provision previously included in §163.6(e); adding a new §163.8, <u>Authorization to Take Professional Licensing Examination</u>, to set forth in rule the provisions for applicants to take an examination, invoking the exemption from Chapter 61, Subchapter G, Texas Education Code, as provided in §61.303, Texas Education Code; and adding a new §163.9, <u>Only One License</u>, to provide that any outstanding license or permit is canceled upon issuance of another license.

Chapter 164, Physician Advertising, proposed amendments to §164.4, <u>Board Certification</u>, to set forth requirements for advertising a medical specialty.

Chapter 166, Physician Registration, proposed amendments to §166.5, <u>Relicensure Following</u> <u>Cancellation for Nonpayment of Registration Fee</u>, to refer to provisions of Chapter 196 for cancellation upon non-payment, relinquishment, or surrender.

Chapter 172, Temporary and Limited Licenses, proposed amendments to §172.5, <u>Visiting Physician</u> <u>Temporary Permit</u>, to remove the requirement of a license in another state, and adding a new §172.14, <u>Limited License for Administrative Medicine</u>, to establish a new limited license for administrative medicine, as authorized by SB 419.

Chapter 173, Physician Profiles, to include amendments to §173.3, <u>Physician Initiated Updates</u>, requiring updates regarding address changes, conviction, or incarceration within 30 days.

Chapter 182, Use of Experts, proposed amendments to §182.5, <u>Expert Panel</u>, to add the American Board of Oral and Maxillofacial Surgery to subparagraph (2)(B) and to provide for removal from the Expert Panel if a panelist repeatedly provides unreliable reports.

Chapter 184, Surgical Assistants, proposed amendments to §184.4, <u>Qualifications for Licensure</u>, to delete outdated provisions; amendments to §184.8, <u>License Renewal</u>, to provide for cancellation upon

expiration of a permit; and a new §184.26, <u>Voluntary Relinquishment or Surrender of a License</u>, to refer to Chapter 196, regarding Relinquishment or Surrender of a license.

Chapter 187, Procedural Rules, to add a new Subchapter G., <u>Suspension by Operation of Law</u>, to provide a procedure for mandatory suspension or revocation of license upon incarceration under §164.058 of the Medical Practice Act.

Chapter 190, Disciplinary Guidelines, proposed amendments to §190.8, <u>Violation Guidelines</u>, to set standards for making "medical necessity" decisions, providing on-call back-up by person who is not licensed or does not have training or experience, and prohibition against physician subject to an investigation from contacting a complainant or witness for purpose of intimidation.

Chapter 196, Voluntary Surrender of Medical License, to change the title of the chapter and include amendments to §196.1 and §196.4, to change the term for voluntary surrender that is not involved in disciplinary action or impairment to "Relinquishment."

Chapter 198, Unlicensed Practice, proposed amendments to §§198.1 - 198.7, to establish a procedure for cease and desist orders.

Disciplinary Actions

The following are summaries of the Board actions and were taken based on the types of violations listed. The full text of the Board orders will be available on the Board's web site at <u>www.tmb.state.tx.us</u> about 10 days after the Board meeting. The orders provide all information that is public regarding the facts of the case and violations of the law.

Open records requests for orders may be made to <u>openrecords@tmb.state.tx.us</u>. **Media** contact Jill Wiggins at (512) 305-7018 or <u>jill.wiggins@tmb.state.tx.us</u>.

QUALITY OF CARE VIOLATIONS

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

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

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

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

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

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

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

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

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

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

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

On April 13, 2007, the Board and Dr. Mahaffey entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Mahaffey prescribed Dostinex therapy at seven times the usual starting dose. Mitigating factors were that Dr. Mahaffey admitted his mistake to the patient and has taken steps to avoid future similar incidents, including completing additional continuing medical education, and that there was no patient harm.

• **PURYEAR, BILLY HOUSTON, D.O., FORT WORTH, TX, Lic. #D6314** On April 13, 2007, the Board and Dr. Puryear entered into a Mediated Agreed Order restricting his license for five years under terms and conditions requiring that he have his controlled substances certificates modified to eliminate Schedules II and III; limiting his prescribing of benzodiazepines and requiring reevaluation before prescribing or refilling certain benzodiazepines and narcotics; prohibiting him from prescribing, administering or possessing any anorectic or amphetamine-like action drugs; requiring that his practice be monitored by another physician; that he pass the Medical Jurisprudence Examination within one year; that he complete courses in risk management, record keeping, treatment of hypertension and/or pediatrics each year of the order; and that the Board is to determine prior to the end of the order whether Dr. Puryear is competent to safely practice medicine without restriction. The action was based on allegations that Dr. Puryear failed to meet the standard of care in 11 patients for one or more of the following reasons: inadequate histories and physical examinations, lack of ancillary tests, inadequate assessments, inadequate treatment plans, inconsistent use of chronic pain management drug contracts, inappropriate use of controlled substances to treat pain and anxiety and lack of attention to other health problems, and violation of his September 7, 2001, Board Order by failing to document the therapeutic necessity for prescribing pain medication to three patients.

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

On April 13, 2007, the Board and Dr. Rogler-Brown entered into a five-year Mediated Agreed Order requiring that his practice be monitored by another physician; that his billing practice be monitored by a billing auditor; that he complete courses in the areas of risk management, including medical records and practice management, including billing practices and, each year, courses in family medicine; that he pass the Medical Jurisprudence Examination within one year; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Rogler-Brown, in treating eight patients, failed to meet the standard of care for each patient for one or more of the following reasons: his documentation lacked support for the charges that were submitted, he consistently over-coded claims, he failed to appropriately treat some of the patients' health problems, he performed excessive procedures that were not medically justified and he failed to document appropriately as to patient care.

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

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

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

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

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

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

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

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

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

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

UNPROFESSIONAL CONDUCT VIOLATIONS

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

On April 13, 2007, the Board and Dr. Simmons entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of ethics and risk management and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Simmons did not maintain adequate documentation of controlled substances, based on an unannounced inspection that found several controlled substance violations.

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

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

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

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

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

On April 13, 2007, the Board and Dr. Werner entered into an Agreed Order requiring that he successfully complete the professional boundaries course offered by the Vanderbilt Medical Center for Professional Health or an approved equivalent program, complete additional courses in the area of ethics, and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Werner used offensive, inappropriate language and gestures directed toward doctors, nursing staff and, at times, in front of non-staff, including patients and patients' family members.

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

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

VIOLATIONS BASED ON FAILURE TO PROPERLY SUPERVISE OR DELEGATE

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

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

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

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

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

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

VIOLATION OF PROBATION OR PRIOR ORDER

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

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

• LORENTZ, RICK GENE, M.D., SWEENY, TX, Lic. #J2169

On April 13, 2007, the Board and Dr. Lorentz entered into an Agreed Order Modifying Prior Order extending the Agreed Order entered on February 3, 2006, by an additional two years and modifying some of the terms of that order. The action was based on allegations that Dr. Lorentz failed to complete on a timely basis all of the requirements of the prior order.

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

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

ADVERTISING VIOLATIONS

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

On April 13, 2007, the Board and Dr. Burns entered into an Administrative Agreed Order

assessing an administrative penalty of \$500. The action was based on allegations that Dr. Burns used the term "board certified" in his advertising materials after his certification had lapsed and was invalid.

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

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

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

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

• PILISZEK, THEODORES., M.D., HOUSTON, TX, Lic. #G1149

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

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

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

ACTION BASED ON CRIMINAL CONVICTION

• ROUNTREE, RANDOLPH WINSLER, M.D., SAN ANGELO, TX, Lic. #F7123 On April 13, 2007, the Board and Dr. Rountree entered into an Agreed Order revoking Dr. Rountree's medical license. The action was based on Dr. Rountree's arrest and conviction for sexually assaulting a patient.

VOLUNTARY SURRENDERS

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

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

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

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

MINIMAL STATUTORY VIOLATIONS

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

Malone, Mark Thomas, M.D., Austin, TX, Lic. #G3580

Martin, Reg Christopher, M.D., Austin, TX, Lic. #L4053

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The Texas Medical Board, the state agency that regulates physicians, physician assistants, surgical assistants and acupuncturists, provides consumer protection through licensure, investigation and disciplinary action. The Board, under President Roberta M. Kalafut, D.O., and Executive Director Donald W. Patrick, M.D., J.D., and mandated by Senate Bill 104 of the 78th Legislature and S.B. 419 of the 79th Legislature, is strengthening and accelerating the disciplinary process for licensees who fail to meet the required standards of professional proficiency and behavior. Information on filing a complaint is on the agency web site at www.tmb.state.tx.us or by calling (800) 201-9353.