Texas Medical Board
Press Release
FOR IMMEDIATE RELEASE
Thursday, April 13, 2006

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

59 Doctors Disciplined
Since its last Board meeting in February, the Texas Medical Board has taken disciplinary action against 59 licensed physicians. Actions included 14 violations based on quality of care; 10 actions based on unprofessional conduct; one action based on nontherapeutic prescribing; three actions based on inappropriate conduct involving physician-patient relationships; seven actions based on inadequate medical records; five actions based on impairment due to alcohol or drugs; three actions based on impairment due to physical or mental conditions; three actions based on violations of probation or prior orders; three actions based on other state board actions; three actions based on criminal convictions; two actions based on peer review actions; and five minimal statutory violations. Administrative penalties totaling $65,000 were assessed.

New Licenses Issued
During its April 6-7 Board meeting, the Board approved the licensure applications of 324 physicians.

Rule Changes
The Board adopted the following proposed rule changes that were published in the *Texas Register:*
Proposed amendments to *Chapter 175,* ***Fees, Penalties, and Applications*** to include amendments to §175.2 Renewal Fees regarding increase in Physician Assistant renewal fee.

Chapter 183, ***Acupuncture****,* relating to changes mandated by SB419.

Proposed Rule Changes
The following rule changes will be published in the *Texas Register* for comment:

Chapter 163, **Licensure**, amended to include a limit on Texas medical jurisprudence examination attempts, delegated authority to staff to issue licenses, alternative requirements for graduates of unapproved medical schools, and general rule cleanup.

Re-proposed amendments to Chapter 165, **Medical Records**, to include amendments to 165.1 Medical Records and the addition of 165.6, Medical Records Regarding an Abortion on an Unemancipated Minor.

Chapter 166, **Physician Registration**, amended to include the addition of continuing medical education in forensic evidence collection, modifications to voluntary charity care practice by retired physicians, and general rule cleanup.

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

New Chapter 170, **Pain Management.**

Chapter 171, **Postgraduate Training Permits**, to include clarification of reporting requirements, modifications to requirements for board-approved postgraduate fellowship training programs, and general rule cleanup.

Chapter 172, **Temporary Licenses**, to include the addition of section 172.13 relating to Conceded Eminence Licenses and general rule cleanup.

Chapter 174, **Telemedicine** to include amendments to §174.2, Definitions and to §174.6 Delegation to and Supervision of Telepresenters regarding delegation of tasks and activities by a physician to a telepresenter.

Chapter 175, **Fees**, to include amendments to §175.2, Registration and Renewal Fees, regarding Texas Online fees for office-based anesthesia, and new §175.5, Payment of Fees or Penalties regarding the form of payment accepted for fees and penalties.

Chapter 178, **Complaints**, to include amendments to §178.8, Appeals regarding the deletion of the deadline for filing an appeal.

Chapter 185, **Physician Assistants**, relating to changes mandated by SB419.

Chapter 199, **Public Information** to include new §199.5, Notice of Ownership Interest in a Niche Hospital regarding requirements of physicians to notify the Department of State Health Services of an ownership interest in a niche hospital.

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 www.tmb.state.tx.us 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 openrecords@tmb.state.tx.us. **Media** contact Jill Wiggins at (512) 305-7018 or jill.wiggins@tmb.state.tx.us.

QUALITY OF CARE VIOLATIONS:

- **AKKANTI, VENKAT REDDY, M.D., BASTROP, TX, Lic. #J8868**
  On April 7, 2006, the Board and Dr. Akkanti entered into an Agreed Order requiring Dr. Akkanti's practice to be monitored by another physician for one year and requiring him to obtain 20 hours of continuing medical education in record-keeping, dealing with difficult patients, or risk management. The action was based on allegations that Dr. Akkanti failed to meet the standard of care in treating one patient in that he did not adequately manage her asthma, failed to maintain an adequate medical record and failed to reasonably evaluate her for diabetes risk.
- **ANDREWS, SARAH ELIZABETH, M.D., KATY, TX, Lic. #H9753**
  On April 7, 2006, the Board and Dr. Andrews entered into an Agreed Order requiring Dr. Andrews' practice to be monitored by another physician for one year; requiring her to obtain 15 hours of risk management courses; and assessing an administrative penalty of $5,000. The action was based on allegations that Dr. Andrews failed to meet the standard of care in her treatment of four patients in 1998 and 1999.
- **CORLEY, RONALD G., M.D., LUFKIN, TX, Lic. #D8519**
  On April 7, 2006, the Board and Dr. Corley entered into an Agreed Order whereby Dr. Corley agreed to cease performing any procedures that require the use of implants without first obtaining permission from the Board. Additionally, Dr. Corley on his own initiative resigned all surgical privileges and, under the Order, may not reapply for surgical privileges without first obtaining permission from the Board, and must complete a course in record-keeping of at least eight hours

and an Internal Medicine Board Review Course of at least 30 hours. The action was based on allegations that Dr. Corley failed to meet the standard of care in his performance of orthopedic surgery on two patients.

- **DELANEY, SUSAN DELPHINE, M.D., PLANO, TX, Lic. #G9447**
  On April 7, 2006, the Board and Dr. Delaney entered into an Agreed Order requiring Dr. Delaney to complete 10 hours of continuing medical education in risk management; to take and pass the Medical Jurisprudence Examination; and assessing an administrative penalty of $2,000. The action was based on allegations that Dr. Delaney prescribed a Schedule II drug to the son of a physician with whom she cross-covered, but from whom she had not taken a history or independently established a diagnosis to support the prescription. Additionally, Dr. Delaney also accepted from one of her patients a supply of the same drug and dispensed it to the patient's mother without making a record or properly labeling the medication.
- **DESHMUKH, AVI TRIMBAK, M.D., STEPHENVILLE, TX, Lic. #H1067**
  On April 7, 2006, the Board and Dr. Deshmukh entered into an Agreed Order requiring Dr. Deshmukh to complete a course in risk management of at least 10 hours and assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Deshmukh prescribed a sulfa drug to a patient with a known allergy to the drug.
- **DUBBERLY, DANNY LEE, M.D., ROCKPORT, TX, Lic. #E8447**
  On April 7, 2006, the Board and Dr. Dubberly entered into an Agreed Order requiring Dr. Dubberly to take and pass the Medical Jurisprudence Examination within one year and to attend at least 15 hours of continuing medical education in risk management and dealing with the difficult patient. The action was based on allegations that Dr. Dubberly failed to meet the standard of care by failing to prescribe testosterone therapy for one patient. As a mitigating factor, the circumstances surrounding the fact that the patient was a prison inmate impeded clear communication between Dr. Dubberly and the patient.
- **FINLEY, KEVIN WAYNE, D.O., MUNDAY, TX, Lic. #K5525**
  On April 7, 2006, the Board and Dr. Finley entered into an Agreed Order requiring Dr. Finley to complete 25 hours of continuing medical education in emergency medicine. The action was based on allegations that Dr. Finley failed to meet the standard of care because of an inadequate evaluation of one patient who presented to the emergency room where he was the on-call physician.
- **MARINO, BARBARA DOYLE, M.D., TOMBALL, TX, Lic. #H7724**
  On April 7, 2006, the Board and Dr. Marino entered into a five-year Agreed Order requiring Dr. Marino's practice to be monitored by another physician; requiring her to complete the National Board of Medical Examiners' Post-Licensure Assessment program at the University of Florida Comprehensive Assessment and Remedial Education Services; and to complete courses of at least 20 hours in gynecological complications. The action was based on allegations that Dr. Marino failed to meet the standard of care with her sequential use of instruments in the delivery of a baby, that she failed to appropriately treat bowel leakage in one patient following surgery, that she failed to document the need for surgery and continued use of hydrocodone in one patient and that she failed to adequately document complications of surgery for another patient.
- **McBATH, J. MARK, M.D., HOUSTON, TX, Lic. #G8265**
  On April 7, 2006, the Board and Dr. McBath entered into an Agreed Order publicly reprimanding Dr. McBath; requiring him to completed at least 20 hours of courses per year for three years in the areas of pre-operative and post-operative complications and medical record-keeping; and assessing an administrative penalty of $15,000. The action was based on allegations that Dr. McBath failed to practice medicine in an acceptable professional manner in his treatment of four surgical patients. As a mitigating factor, the incidents occurred from 1997 through 1999 and Dr. McBath engaged in additional study following these cases.

- **McCRORY, BEAU LAWSON, M.D., COMANCHE, TX, Lic. #K7823**
  On April 7, 2006, the Board and Dr. McCrory entered into an Agreed Order requiring Dr. McCrory to complete 10 hours of continuing medical education in the area of medical record-keeping and prohibiting him from performing non-emergency gynecological surgery until such time as he obtains acceptable additional training or otherwise demonstrates to the Board that he is qualified for such surgery. Dr. McCory may assist other qualified surgeons in emergency surgery with the approval and informed consent of the patient. The action was based on allegations that Dr. McCory failed to meet the standard of care for one patient by not maintaining adequate medical records, by undertaking surgery without giving sufficient time for iron supplements to work, by failing to discuss with the patient other available treatment options, by failing to adequately disclose that he had not been formally trained in obstetrics/gynecology, by failing to perform an endometrial biopsy prior to surgery, by ordering a blood transfusion in an otherwise healthy woman and by continuing surgery once the pelvic adhesions presented a significant problem for the surgeons.
- **ORLOV, ALEXANDER, D.O., LUFKIN, TX, Lic. #J4402**
  On April 7, 2006, the Board and Dr. Orlov entered into an Agreed Order requiring Dr. Orlov to complete a course in risk management/medical records of at least 20 hours and assessing an administrative penalty of $5,000. The action was based on allegations that Dr. Orlov failed to ensure that a patient with lesions determined to be squamous cell carcinoma followed up for treatment. As mitigating factors, Dr. Orlov did make attempts to contact the patient, who had a caregiver because of mental deficiencies, and whose caregiver was aware of the patient's medical condition. However, Dr. Orlov's duty to this patient was higher due to her mental deficiencies and inability to care for herself.
- **ORTIZ, AURELIO ANTONIO, M.D., MIAMI, FL, Lic. #F7870**
  On April 7, 2006, the Board and Dr. Ortiz entered into an Agreed Order publicly reprimanding Dr. Ortiz; suspending his medical license; staying the suspension and placing him on probation for three years; requiring that he obtain 10 hours of ethics courses; pass the Medical Jurisprudence Examination within one year; and assessing an administrative penalty of $3,000. The action was based on allegations that Dr. Ortiz did not examine a patient admitted to the emergency room for which he was the assigned physician.
- **SHIN, HYON-HO, M.D., AUSTIN, TX, Lic. #J6724**
  On April 7, 2006, the Board and Dr. Shin entered into an Agreed Order requiring Dr. Shin to complete a course in risk-management of at least 10 hours and assessing an administrative penalty of $2,000. The action was based on allegations that Dr. Shin performed a right inguinal hernia repair after he had diagnosed a left inguinal hernia. As mitigating factors, the patient did in fact also have a right inguinal hernia, the hospital staff incorrectly identified the site, Dr. Shin immediately notified the patient of the error and offered to perform the left inguinal hernia repair for no charge, did not bill the patient for the right inguinal hernia repair and had changed his procedures to avoid similar incidents.
- **SIEWERT, RICKY ALLEN, D.O., PERRYTON, TX, Lic. #G2576**
  On April 7, 2006, the Board and Dr. Siewert entered into an Agreed Order requiring Dr. Siewert's practice to be monitored by another physician for the time period required by the monitor to complete and submit four quarterly reports; and requiring Dr. Siewert to attend at least 20 additional hours of continuing medical education, at least 10 of which must be in medical record-keeping. The action was based on allegations that Dr. Siewert failed to practice medicine in an acceptable professional manner in his treatment of one patient who was later admitted to the hospital for sepsis and an incarcerated hernia.

UNPROFESSIONAL CONDUCT:

- **ADAIR, MAUREEN LENORE, M.D., AUSTIN, TX, Lic. #F6376**
  On April 7, 2006, the Board and Dr. Adair entered into an Agreed Order requiring Dr. Adair to complete a course in the area of risk management and assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Adair failed to provide properly requested medical records within 15 business days and failed to timely respond to correspondence from the Board.
- **AHMAD, NASIHA, M.D., CARROLLTON, TX, Lic. #G9703**
  On April 7, 2006, the Board and Dr. Ahmad entered into an Agreed Order requiring Dr. Ahmad to complete a course in ethics of at least 10 hours and assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Ahmad failed to adequately disclose to the board her hospital practice history in her Medical Practice Questionnaire.
- **BEAR, RONALD LYNN JR., M.D., SAN ANTONIO, TX, Lic. #BP20020214**
  On April 7, 2006, the Board and Dr. Bear entered into an Agreed Order requiring Dr. Bear to complete 10 hours of ethics courses and assessing an administrative penalty of $500. The action was based on allegations that Dr. Bear failed to disclose his arrest for assault in 2004 on his application for renewal of his physician training permit. As a mitigating factor, the charges were dismissed and Dr. Bear believed the arrest had been expunged.
- **GHELBER, OSCAR, M.D., Lic. #40245**
  On April 7, 2006, the Board and Dr. Ghelber entered into an Agreed Order assessing an administrative penalty of $250. The action was based on allegations that Dr. Ghelber administered Fentanyl as the anesthetic to a child even though his mother objected to the use of Fentanyl, mistakenly believing her child was allergic to it. As a mitigating factor, Dr. Ghelber did discuss the use of Fentanyl with the mother and thought she understood Fentanyl was acceptable for use in the child's surgery.
- **GRUESBECK, CLAY, M.D., SAN ANTONIO, TX, Lic. #H7749**
  On April 7, 2006, the Board and Dr. Gruesbeck entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. Gruesbeck failed to disclose on his annual registration form that he had been arrested for a class C misdemeanor and had paid a $200 fine.
- **LINAN, LUIS ENRIQUE, M.D., EL PASO, TX, Lic. #H8214**
  On April 7, 2006, the Board and Dr. Linan entered into an Agreed Order requiring Dr. Linan to successfully complete the Anger Management for Healthcare Professionals course provided by the University of California, San Diego, School of Medicine Physician Assessment and Clinical Education Program, or substantially similar course approved by the Executive Director. The action was based on allegations that Dr. Linan slapped a surgical assistant on the hand during an emergency cesarean section.
- **PIERCE, DAMON SCOTT, M.D., DALLAS, TX, Lic. #BP30021144**
  On April 7, 2006, the Board and Dr. Pierce entered into an Agreed Order assessing an administrative penalty of $250. The action was based on allegations that Dr. Pierce failed to disclose on his 2004-2005 postgraduate training permit renewal application a 1998 arrest for criminal mischief relating to damage to a restaurant's table and chair. Dr. Pierce erroneously thought the 1998 arrest had been expunged.
- **RODRIGUEZ, PAUL LOPEZ, M.D., WICHITA, KS, Lic. #K9889**
  On April 7, 2006, the Board and Dr. Rodriguez entered into an Agreed Order suspending the Dr. Rodriguez's medical license, staying the suspension and placing him on probation for five years; requiring that he complete 20 additional hours of continuing medical education each year in the area of ethics or risk management; prohibiting him from supervising physician assistants, advanced practice nurses or surgical assistants; and assessing an administrative penalty of $10,000. The action was based on allegations that Dr. Rodriguez failed to notify the Board on his

license renewal form that he had been suspended by the Oklahoma State Board of Medical Licensure and Supervision for six months in 2004 and placed on probation by the Medical Board of California. The action of the Oklahoma Board was based on Dr. Rodriguez allowing an unlicensed individual to prescribe to patients and operate a laser for hair removal owned by Dr. Rodriguez. The California Board action was based on the Oklahoma Board action.

- **TREVINO, ROGELIO, M.D., McALLEN, TX, Lic. #BP20019970**
  On April 7, 2006, the board and Dr. Trevino entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. Trevino failed to provide all required information on his postgraduate resident permit applications.

- **WILLOWS, BARBARA JEAN, D.O., COLUMBUS, OH, Lic. #E8918**
  On April 7, 2006, the Board and Dr. Willows entered into an Agreed Order accepting the voluntary and permanent surrender of Dr. Willows' medical license. The action was based on Dr. Willows' wish to surrender her Texas medical license as she has no intention of returning to Texas to practice, and followed the indefinite suspension of her Ohio medical license for a conviction for operating a motor vehicle while intoxicated and for alcohol abuse.

NONTHERAPEUTIC PRESCRIBING:

- **WOMACK, ROBERT, M.D., AMARILLO, TX, Lic. #G6773**
  On April 7, 2006, the Board entered a Final Order revoking Dr. Womack's medical license. The action was based on findings of the Board that a Complaint was filed with the State Office of Administrative Hearings on August 22, 2005, alleging that Dr. Womack prescribed for himself nontherapeutic prescriptions of hydrocodone, doxycycline/vibramycin, erythromycin, diflucan/fluconazole, neomycin, amoxil/amoxicillin and phentermine and that no adequate medical records or documentation of need were maintained, and that he additionally nontherapeutically prescribed phentermine for his wife. Dr. Womack did not respond to the Complaint or to correspondence from the Board and on February 17, 2006, the Board's Hearings Counsel issued a Determination of Default that was served on Dr. Womack in accordance with law. Dr. Womack did not respond to the Complaint within 20 days and all facts alleged in the Complaint were deemed to have been admitted. Dr. Womack may file a Motion for Rehearing within 20 days of the Order. If a Motion for Rehearing is filed and the Board denies the motion, the Order in final. If a Motion for Rehearing is filed and the Board grants the motion, the Order is not final and a hearing will be scheduled.

INAPPROPRIATE CONDUCT INVOLVING PHYSICIAN-PATIENT RELATIONSHIP:

- **GRUHLKEY, JAY LOYD, M.D., NEW BRAUNFELS, TX, Lic. #K7750**
  On April 7, 2006, the Board and Dr. Gruhlkey entered into a one-year Agreed Order requiring Dr. Gruhlkey to complete "A Continuing Education Course for Physicians Who Cross Sexual Boundaries" presented by the Center for Professional Health at the Vanderbilt Medical Center; to complete 10 hours of continuing medical education in each of the areas of ethics and risk management; to speak to three local county medical society meetings on the topic of maintaining proper boundaries; and assessing an administrative penalty of $10,000. The action was based on allegations that Dr. Gruhlkey was sexually involved with a patient, who was also an employee, while functioning as the physician for her and her two small children

- **KUHNE, ROBERT CHRISTOPHER, M.D., RICHARDSON, TX, Lic. #H2519**
  On April 7, 2006, following a rehearing granted to Dr. Kuhne, the Board issued a Final Order publicly reprimanding Dr. Kuhn and requiring him to write a letter of apology to a patient acknowledging that his conduct was improper and to complete within one year "A Continuing Education Course for Physicians Who Cross Sexual Boundaries" presented by the Center for Professional Health at the Vanderbilt Medical Center and the "Maintaining Professional Boundaries and Managing Difficult and Frustrating Patients" course offered by the Texas

Medical Association's Committee on Physician Health and Rehabilitation. The action was based on a finding by an Administrative Law Judge of the Texas State Office of Administrative Hearings that Dr. Kuhne, while examining a patient seeking treatment of FSD (female sexual dysfunction) made a comment relating to oral sex that was unprofessional and dishonorable.

- **ROUNTREE, RANDOLPH WINSLER, M.D., SAN ANGELO, TX, Lic. #F7123**
  On April 7, 2006, the Board and Dr. Rountree entered into an Agreed Order suspending Dr. Rountree's medical license until such time as he demonstrates to the Board that he is safe and competent to practice medicine. The action was based on allegations that Dr. Rountree sexually assaulted a patient and had inappropriate sexual contact with three other patients.

INADEQUATE MEDICAL RECORDS:

- **DUARTE, LUIS E, M.D., SAN ANGELO, TX, Lic. #K2451**
  On April 7, 2006, the Board and Dr. Duarte entered into an Agreed Order publicly reprimanding Dr. Duarte; requiring him to complete the medical record-keeping course and physician-patient communication course provided by the University of California, San Diego, School of Medicine Physician Assessment and Clinical Education Program; to complete an additional course in record-keeping or risk management of at least 10 hours; and assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Duarte's documentation failed to provide sufficient information of the continued care he provided to two spinal surgery patients.
- **HEINEMANN, JEFFREY JOHN, M.D., HOUSTON, TX, Lic. #L0818**
  On April 7, 2006, the Board and Dr. Heinemann entered into an Agreed Order requiring Dr. Heinemann to obtain 10 hours of continuing medical education in risk management and record-keeping. The action was based on allegations that Dr. Heinemann failed to maintain an adequate anesthesia medical record for one surgery patient.
- **LUECKE, JAMES DAVIS, M.D., FORT DAVIS, TX, Lic. #H4504**
  On April 7, 2006, the Board and Dr. Luecke entered into an Agreed Order requiring Dr. Luecke to complete 20 hours of continuing medical education in the areas of record-keeping and risk management; and assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Luecke's nurse practitioner failed to document vital signs and physical examination for one patient, that Dr. Luecke failed to document home visitations for one patient, and that his medication log did not reflect the administration of all medications.
- **SCHRAPPS, JEROME FRANCIS, M.D., BEAUMONT, TX, Lic. #J2907**
  On April 7, 2006, the Board and Dr. Schrapps entered into an Agreed Order assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Schrapps failed to maintain adequate medical records for two patients.
- **SINGH, HARRYPERSAD, M.D., SILSBEE, TX, Lic. #G1310**
  On April 7, 2006, the Board and Dr. Singh entered into an Agreed Order requiring Dr. Singh's practice to be monitored by another physician for one year and requiring him to complete a course of at least eight hours in medical records. The action was based on allegations that Dr. Singh failed to keep adequate medical records due to illegible handwriting and not providing information necessary for patient continuity.
- **WILLIAMS, GWENEVERE EVETTE, M.D., KINGWOOD, TX, Lic. #H7587**
  On April 7, 2006, the Board and Dr. Williams entered into an Agreed Order requiring Dr. Williams to obtain at least 10 additional hours of continuing medical education in the area of risk management, billing or record-keeping; and assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Williams' medical records lacked sufficient information in relation to the service rendered.

- **LONG, JAMES MICHAEL, M.D., WACO, TX, Lic. #K1753**
  On April 7, 2006, the Board and Dr. Long entered into an Agreed Order requiring that Dr. Long refrain from treating or otherwise serving as a physician for his immediate family, prescribing or refilling by telephone or permitting any individual under his supervision or control to prescribe or refill any prescription for narcotics or employing any family members in his medical practice or office; requiring that he maintain adequate medical records and complete 15 hours of continuing medical education in medical records, ethics and appropriate prescribing practices. The action was based Dr.Long's failure to maintain adequate medical records when prescribing to family members.

IMPAIRMENT DUE TO ALCOHOL OR DRUGS:

- **CONNER, PATRICK TRAVIS, M.D., SPRINGFIELD, MO, Lic. #G3243**
  On April 7, 2006, the Board and Dr. Conner entered into an Agreed Order whereby the Board accepted the voluntary surrender of Dr. Conner's medical license. The action was based on Dr. Connor's disability due to drug addiction and bipolar disorder.
- **DEMBERG, JAMES HAROLD, M.D., TYLER, TX, Lic. #F3096**
  On April 7, 2006, the Board and Dr. Demberg entered into a 10-year Agreed Order requiring Dr. Demberg to abstain from the consumption of prohibited substances, including alcohol; submit to screenings for drugs and alcohol; continue to participate in Alcoholics Anonymous at least five times per week; complete eight hours of continuing medical education in anger management; continue psychotherapy; limit his medical practice to a group or institutional setting approved by the Executive Director; and prohibiting him from supervising a physician assistant, advanced practice nurse or surgical assistant. The action was based on Dr. Demberg's admission that he is an alcoholic and on allegations that he was arrested for driving while intoxicated and that his privileges were suspended by the East Texas Medical Center for inappropriate behavior.
- **DUNCAN, CHRISTOPHER W., M.D., SAN ANTONIO, TX, Lic. #G3314**
  On April 7, 2006, the Board and Dr. Duncan entered into an Agreed Order suspending Dr. Duncan's license for an additional six months, at a minimum, and until he demonstrates to the Board he is safe and competent to practice medicine, and requires him to abstain from the consumption of drugs and alcohol and to submit to screening for drugs and alcohol as requested by the Board for a period of 15 years from the date of staying his suspension, if his suspension is stayed by future Board action. The action was based on Dr. Duncan's positive test for cocaine and his admission of relapse on cocaine during the Christmas 2005 holiday.
- **PATT, RICHARD BERNARD, M.D., HOUSTON, TX, Lic. #J5440**
  On April 6, 2006, a disciplinary panel of the Board temporarily suspended Dr. Patt's medical license following a temporary suspension hearing without notice. The action was based on a finding by the panel that Dr. Patt is a real danger to the health of his patients or to the public due to his impaired status and that there was an imminent peril to the public health, safety, or welfare that required immediate effect of the Order of Temporary Suspension. As findings of fact, the panel also found that Dr. Patt had been suspended from St. Luke's Episcopal Hospital based upon indications that he was impaired in the operating room as reported by nursing staff. A brief physical examination of Dr. Patt revealed what appeared to be needle marks in his antecubital fossae. A drug screen from a urine specimen provided the same day tested positive for amphetamine, methamphetamine, oxazepam and morphine.
- **KESSELER, RANDALL GENE, D.O., SANGER, TX, Lic. #G8212**
  On April 7, 2006, the Board and Dr. Kesseler entered into an Agreed Order in which Dr. Kesseler agreed to the voluntarily suspension of his medical license until such time as he demonstrates to the Board that he is physically, mentally and otherwise competent to practice medicine. The

action was based on Dr. Kesseler's self-reported chemical dependence and his desire to enter a voluntary suspension of his medical license while seeking treatment.

IMPAIRMENT DUE TO PHYSICAL OR MENTAL CONDITIONS:

- **HENSHAW, CLYDE VERNON JR., D.O., FORT WORTH, TX, Lic. #H0446**
  On April 7, 2006, the Board and Dr. Henshaw entered into an Agreed Order whereby the Board accepted Dr. Henshaw's voluntary and permanent surrender of his medical license. The action was based on allegations that Dr. Henshaw failed to meet the standard of care in his treatment of one patient and because Dr. Henshaw has found it difficult to practice medicine with reasonable skill and safety because of illness.
- **TORRES, ARTURO A., M.D., HOUSTON, TX, Lic. #H2085**
  On March 24, 2006, a disciplinary panel of the Texas Medical Board entered an Order of Temporary Suspension that temporarily suspended Dr. Torres' medical license, effective immediately. The action was based on a finding by the panel that Dr. Torres' practice of medicine constitutes a continuing threat to the public welfare because of his impaired status or lack of competence.
- **VON HENNER, CHARLES MASON, M.D., SAN MARCOS, TX, Lic. #C2803**
  On April 7, 2006, the Board and Dr. Von Henner entered into an Agreed Order whereby Dr. Von Henner voluntarily surrendered his medical license. Dr. Von Henner wished to retire and surrender his medical license as a result of his concern regarding age-related physical changes that could possibly impact the future treatment of his patients.

VIOLATION OF PROBATION OR PRIOR ORDER:

- **BROWN, MICHAEL GLYN, M.D., HOUSTON, TX, Lic. #G3190**
  On March 1, 2006, the Board revoked Dr. Brown's license. The action followed an Informal Show Compliance Proceeding/Modification Hearing at which representatives of the Board determined that Dr. Brown had violated the terms of his December 18, 2002, Agreed Order by testing positive for cocaine, and directed the Executive Director to execute an Order of Revocation pursuant to the mandatory revocation provisions of the December 18, 2002, Order.
- **RANELLE, JOHN B., D.O., HARLINGEN, TX, Lic. #E9349**
  On April 5, 2006, the Board, acting through its Executive Director, entered an Order suspending Dr. Rannelle's medical license for at least 60 days, at which time he must personally appear before the Board and provide a practice plan before the suspension may be lifted. The action was based on Dr. Rannelle's admission that he signed another physician's name on patient charts at the request of Wellcare Clinic administrators for purposes of billing the Texas Workers Compensation Commission, thereby violating the terms of his December 1, 2003, Agreed Order. That Agreed Order required Dr. Ranelle to comply with all of the provisions of the Medical Practice Act and other applicable provisions of law.
- **SHARY, JOHN H. III, M.D., PLAINVIEW, TX, Lic. #E8903**
  The Board suspended Dr. Shary's medical license on March 14, 2006. The suspension is effective until Dr. Shary appears before the Board and demonstrates that he is safe and competent to practice medicine and is authorized to do so by subsequent order of the Board. The action was based on Dr. Shary's failure to cooperate with the Board in providing observed specimens for drug testing and for refusing to provide further specimens as required by the Agreed Order entered into by the Board and Dr. Shary on August 28, 1999. The 1999 Order followed two prior suspensions of Dr. Shary, in 1996 and 1998, for cocaine and alcohol use.

OTHER STATES' BOARD ACTIONS:

- **DILSAVER, STEVEN CHARLES, M.D., MERCED, CA, Lic. #J3272**
  On April 7, 2006, the Board and Dr. Dilsaver entered into an Agreed Order suspending Dr. Dilsaver's medical license until such time as he demonstrates that he has a clear and unconditioned license to practice in California and that he is physically, mentally and otherwise competent to practice medicine. The action was based on the action of the Medical Board of California in placing Dr. Dilsaver on probation relating to his informing that Board that he had bipolar disorder, which has since been diagnosed as being in remission.
- **JALFON, ISAAC MITRANI, M.D., MEMPHIS, TN, Lic. #H1885**
  On April 7, 2006, the Board and Dr. Jalfon entered into an Agreed Order requiring Dr. Jalfon to appear before the Board before practicing medicine in Texas. The action was based on the action of the Tennessee Board of Medical Examiners placing Dr. Jalfon's license on probation for two years for a self-reported substance abuse problem. Dr. Jalfon practices in Tennessee.
- **MEHARRY, LEROY IRWIN, M.D., UMATILLA, OR, Lic. #F4955**
  On April 7, 2006, the Board and Dr. Meharry entered into an Agreed Order publicly reprimanding Dr. Meharry and requiring him to comply with all terms and conditions imposed by an Order of the Oregon Board of Medical Examiners. The action was based on the action of the Oregon Board in disciplining Dr. Meharry for issues relating to prescribing and dispensing of controlled substances to staff and family members without proper documentation and controls.

ACTIONS BASED ON CRIMINAL CONVICTIONS:

- **HARRIS, PAUL P., M.D., SUGARLAND, TX, Lic. #J9776**
  On April 7, 2006, the Board and Dr. Harris entered into an Agreed Order accepting the voluntary surrender of Dr. Harris' medical license and requiring him to cease the practice of medicine as of March 9, 2006. The action was based on Dr. Harris' request that the voluntary surrender of his medical license be accepted by the Board.
- **PLATT, THOMAS CARROLL, M.D., DEXTER, MI, Lic. #K9872**
  On April 7, 2006, the Board and Dr. Platt entered into an Agreed Order accepting the voluntary and permanent surrender of Dr. Platt's medical license. The action was based on Dr. Platt's plea of guilty to a final conviction for a felony, committed in Michigan, involving possession of pornography.
- **WOODS, RONALD ALFRED JR., M.D., SHERMAN, TX, Lic. #H4808**
  On April 7, 2006, the Board and Dr. Woods entered into a five-year Agreed Order publicly reprimanding Dr. Woods and requiring him to be evaluated by a Board-appointed psychiatrist; to follow any continued care recommendations and to have any continued treatment and care monitored by the psychiatrist; to continue counseling as directed by 336th District Court of Grayson County; to keep a log of community service as required by the Court; to comply with all other terms and conditions of his court-ordered probation; to have a chaperone, or parent or legal guardian, present in the examination room any time he examines a patient 18 years of age or younger; to attend at least 25 hours per year of continuing medical education in ethics, risk management and maintaining proper boundaries; and assessing an administrative penalty of $5,000. The action was based on an Order of Deferred Adjudication; Community Supervision from the 336th District Court for the offense of obscenity, a felony. The order resulted from an incident in which Dr. Woods videotaped his 11 year-old daughter and two of her friends playing and dancing in the nude and performing excretory functions at his home.

PEER REVIEW ACTIONS:

- **MAEWAL, HRISHI KESH, M.D., FORT WORTH, TX, Lic. #E7175**
  On April 7, 2006, the Board and Dr. Maewal entered into an Agreed Order restricting Dr. Maewal's license for three years under the following terms and conditions: Dr. Maewal is not to

perform interventional cardiac procedures until he has completed a period of training in interventional cardiology to consist of a minimum of 100 proctored cases with a proctor approved by the Executive Director. The Order also requires Dr. Maewal to obtain at least 50 hours of continuing medical education in the area of invasive cardiology. The action was based on the action of the board of trustees for Plaza Medical Center in Fort Worth in suspending Dr. Maewal's interventional cardiac catheterization privileges based on the care of two patients.

- **NEPPER, LEONARD GAYLON, D.O., BROWNWOOD, TX, Lic. #J9240**
  On April 7, 2006, the Board and Dr. Nepper entered into a Mediated Agreed Order requiring Dr. Nepper to pay an administrative penalty of $3,000 and to complete continuing medical education in the areas of boundaries, ethics, and record-keeping. The action was based on action taken against Dr. Nepper by Brownwood Regional Medical Center for an alleged violation of the Medical Center's personnel policies. Dr. Nepper denies the underlying allegations, but entered into this Order in lieu of litigation.

MINIMAL STATUTORY VIOLATIONS:
The following licensees agreed to enter into orders with the Board for minimal statutory violations such as failure to send medical records within 15 business days or failure to complete required continuing medical education.

Clayton, Gary Randall, M.D., Beaumont, TX, Lic. #H5430
Harris, Cynthia Ellis, M.D., Austin, TX, Lic. #H8934
Polinger, Iris Sandra, M.D., Stafford, TX, Lic. #E8117
Pucek, Mark Douglass, M.D., Dickinson, TX, Lic. #G3707
Saifee, Nafees Fatima, M.D., Fort Worth, TX, Lic. #E3762

-30-

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.