Texas Medical Board

News Release

FOR IMMEDIATE RELEASE

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Medical Board Disciplines 41 Doctors

At its February 15-16 meeting, the Texas Medical Board took disciplinary action against 41 licensed physicians.

Actions included seven violations based on quality of care; three actions based on unprofessional conduct; one action based on inappropriate conduct involving physician-patient relationships; seven actions based on inadequate medical records; one action based on impairment due to alcohol or drugs; two actions based on other states' actions; one action based on inadequate supervision; four actions based on violation of probation or prior board orders; three advertising violations; one action based on peer review action; one action based on a criminal conviction; four voluntary surrenders; and six minimal statutory violations. Administrative penalties totaling \$33,000 were assessed.

New Licenses Issued

The board issued 404 licenses at the February 15-16 meeting.

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 <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

- BERTSCH, NANCY MARIE, M.D., COLLEGE STATION, TX, Lic. #J6334
 On February 16, 2007, the Board and Dr. Bertsch entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Bertsch failed to meet the standard of care because she did not recognize fetal intolerance of labor and nonreassuring fetal status and allowed labor to continue despite a markedly abnormal fetal monitor strip. Mitigating factors were that Dr. Bertsch subsequently completed additional continuing medical education in fetal monitoring, has reviewed the case with her peers at Scott and White, and that the Scott and White setting provides a controlled environment which allows for easy and encouraged consultation of peers.
- FORD, RYAN DEAN, M.D., ALBANY, TX, Lic. #L5335
 On February 16, 2007, the Board and Dr. Ford entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of administration of antibiotics and the treatment of infectious diseases and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Ford failed to meet the standard of care in treating one patient with Gentamicin by not monitoring the patient's serum levels of Gentamicin while she was receiving the medication.
- INGRAM, ALICE, M.D., SRPING, TX, Lic #K9085

 On February 16, 2007, the Board and Dr. Ingram entered into an Agreed Order requiring that she not return to practice until passing the Special Purpose Examination; that, for a period of three years after returning to practice, she not resume an obstetrics practice without completing an obstetrics/gynecology mini-residency and complying with additional terms and conditions. The Agreed Order also required that Dr. Ingram complete additional continuing medical education in the area of risk management, and assessed an administrative penalty of \$3,000. The action was based on allegations that Dr. Ingram incorrectly calculated a delivery date for one patient, resulting in an elective C-section, and administered an incorrect dose of methotrexate for a possible ectopic pregnancy in a second patient, who became ill but recovered.
- MACK, SUZANNE EILEEN, M.D., DENTON, TX, Lic. #J3540

 On February 16, 2007, the Board and Dr. Mack entered into a five-year Agreed Order limiting her controlled substance prescribing authority to non-narcotic medications in schedules III, IV and V; requiring that her practice be monitored by another physician; and requiring that she complete additional continuing medical education in the areas of ethics and medical records. Additionally, the Agreed Order prohibits Dr. Mack from practicing pain management or treating chronic pain patients indefinitely, unless and until she appears before the Board and demonstrates she is qualified and safe to practice in this area. The action was based on allegations that Dr. Mack failed to meet the standard of care in treating five patients for pain management.
- MASSEY, WARNER BARRON, M.D., GRAND SALINE, TX, Lic. #D6084
 On February 16, 2007, the Board and Dr. Massey entered into a three-year Agreed Order requiring that he have an office management audit and implement recommended changes; that his practice be monitored by another physician; that he maintain adequate medical records using a dictation/transcription procedure and maintain a logbook of all prescriptions; that he not prescribe, dispense or administer to his family; that he prescribe, dispense or administer parenteral pain medications only to hospital patients; and that he complete in each year of the order additional continuing medical education in treatment of medical complaints seen in family practice. The action was based on allegations that, for one patient, Dr. Massey failed to document basic information, including a history and physical, and treated the patient with in excess of 50 narcotic pain medication injections for headaches.

• SANCHEZ, DAVID WAYNE, M.D., ALPINE, TX, Lic. #J1567

On February 16, 2007, the Board and Dr. Sanchez entered into an Agreed Order requiring that he complete additional continuing medical education in the area of risk management. The action was based on allegations that Dr. Sanchez failed to meet the standard of care when he did not order a chest x-ray for a patient complaining of shortness of breath, assuming, incorrectly, that one had been done in the emergency room.

• TRESE, SUSAN COHEN, M.D., GARLAND, TX, Lic#J9480

On February 9, 2007, the Board and Dr. Trese entered into an Agreed Order requiring that she pass the Medical Jurisprudence Examination and complete additional continuing medical education in risk management, prohibiting her from treating or otherwise serving as a physician for her immediate family and assessing an administrative penalty in the amount of \$2,000. The action was based on allegations that Dr. Trese prescribed Adderall or its generic counterpart for a member of her family, and gave a member of her family unused Adderall given to her by another physician, in the absence of immediate need and without documentation.

UNPROFESSIONAL CONDUCT VIOLATIONS

• CANTU, DENNIS DAVID, M.D., LAREDO, TX, Lic. #F1430

On February 16, 2007, the Board and Dr. Cantu entered into an Agreed Order requiring that he either obtain eight hours of continuing medical education in office management and/or risk management or provide documentary evidence of a Texas Medical Association review of his office management practices and his compliance with any recommendations, and assessing an administrative penalty of \$500. The action was based on allegations that Dr. Cantu failed to provide properly requested medical records within 15 business days and did not timely respond to a Board investigator's request for records.

• SPENCER, EDWARD E., M.D., KILLEEN, TX, Lic. #H0837

On February 16, 2007, the Board and Dr. Spencer entered into a five-year Agreed Order requiring that he obtain 10 hours of ethics education and that he perform 100 hours of community service to a low-income or under-served population in the first year of the order and 20 hours each succeeding year, and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Spencer was the registered agent and sole proprietor of a professional association doing business as the Family Practice Clinic, and in that capacity he entered a plea of guilty to charges that the clinic made false statements relating to health care matters and submitted false claims to the U.S. Government, and that Dr. Spencer was untruthful in a statement in his correspondence with the Board regarding this matter.

• WASHAK, RONALD VICTOR, M.D., WEST BEND, WI, Lic. #J5052

On February 16, 2007, the Board and Dr. Washak 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 \$2,000. The action was based on allegations that Dr. Washak, in 2003, saw patients one morning when his physical condition was compromised.

INAPPROPRIATE CONDUCT INVOLVING PHYSICIAN-PATIENT RELATIONSHIP

• LOFTUS, BRIAND., M.D., BELLAIRE, TX, Lic. #H9230

On February 16, 2007, the Board and Dr. Loftus entered into a three-year Agreed Order requiring the following: that he obtain an independent forensic evaluation from a Board-appointed psychiatrist and undergo any continuing psychiatric care recommended by the evaluating psychiatrist; successfully complete either the professional boundaries course offered by the Vanderbilt Medical Center for Professional Health or the similar course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; have a chaperone when examining female patients; develop a policy for e-mail management to ensure all e-mail is placed in the patient's medical record; complete 10 hours of ethics courses each year;

and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Loftus developed over time through e-mail correspondence a romantic relationship with a patient.

INADEQUATE MEDICAL RECORDS VIOLATIONS

- FRAZEE, LEWIS JACOB, M.D., PLANO, TX, Lic. #G1289
 - On February 16, 2007, the Board and Dr. Frazee entered into an Agreed Consent Order requiring that he complete additional continuing medical education in risk management and assessing an administrative penalty of \$2,000. The action was based on allegations that Dr. Frazee violated Board rule 165.1(a), relating to the contents of a medical record.
- LADD, DANIEL JOSEPH, D.O., AUSTIN, TX, Lic. #L1102
 On February 16, 2007, the Board and Dr. Ladd entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Ladd failed to obtain written informed consent for a surgical procedure for one patient.
- LAHIJI, HOSEIN, M.D., McALLEN, TX, Lic. #J9145

 On February 16, 2007, the Board and Dr. Lahiji entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of risk management and ethics and assessing an administrative penalty of \$2,500. The action was based on allegations that Dr. Lahiji failed to document adequate medical treatment prior to placement of a percutaneous test stimulator and a permanent Interstim, and that he failed to obtain informed consent from the patient for the placement of the stimulator and the permanent Interstim.
- PALMER, WESLEY DEAN, D.O., BRIDGE CITY, TX, Lic. #G5457
 On February 16, 2007, the Board and Dr. Palmer entered into an Agreed Order requiring that he complete additional continuing medical education in the area of medical records and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Palmer failed to maintain adequate medical records documenting his treatment of two patients for chronic pain and anxiety.
- REDDY, TARAKUMARB., M.D., HURST, TX, Lic. #J0644
 On February 16, 2007, the Board and Dr. Reddy entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of medical records and risk management and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Reddy failed to provide properly requested medical records within 15 business days and that he failed to appropriately document medical records of one patient.
- SEIF, FAYEZ GAMIL, M.D., GREENVILLE, TX, Lic. #K1055
 On February 16, 2007, the Board and Dr. Seif entered into an Administrative Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Seif's medical records for one patient revealed no specific physical documentation communicating and discussing the patient's abnormal bilirubin of 1.9.
- SOROKOLIT, WALTER THEODORE, M.D., FORT WORTH, TX, Lic. #F2456
 On February 16, 2007, the Board and Dr. Sorokolit entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of medical records and risk management. The action was based on allegations that Dr. Sorokolit failed to keep adequate medical records for one patient on whom he performed surgery.

IMPAIRMENT DUE TO ALCOHOL OR DRUGS

• POOLE, REX DARREL, M.D., AUSTIN, TX, Lic. #K0543

On February 16, 2007, the Board and Dr. Poole 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 Dr. Poole's self-report of impairment due to intemperate drug use.

OTHER STATES' BOARD ACTIONS

- McCrea, ROBERT STANLEY, M.D., CARROLLTON, TX, Lic. #E2712
 On February 16, 2007, the Board and Dr. McCrea entered into an Agreed Order publicly reprimanding Dr. McCrea and assessing an administrative penalty of \$3,000. The action was based on allegations that a Decree of Censure was issued to Dr. McCrea by the Arizona Medical Board for falling below the standard of care by failing to treat vigorously a patient's pregnancy-induced hypertension, and that Dr. McCrea failed to report this to the Board on his medical license renewal form.
- ENGSTROM, PAUL FORREST, M.D., ROSWELL, NM, Lic. #G1384
 On February 16, 2007, the Board and Dr. Engstrom entered into an Agreed Administrative Order subjecting Dr. Engstrom to all terms and conditions of an order of the New Mexico Board of Medicine. The action was based on the action of the New Mexico Medical Board in placing Dr. Engstrom on probation for three years based on his failure to maintain medical records and his failure to be able to produce them on proper request.

VIOLATIONS BASED ON FAILURE TO PROPERLY SUPERVISE OR DELEGATE

• VLAHAKOS, M.D., VICTOR, AUSTIN, TX, Lic. #E2915
On February 16, 2007, the Board and Dr. Vlahakos entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of prescribing practices, supervision of medical personnel, medical records and ethics; prohibiting him from re-applying for his DEA or DPS registrations until completion of the additional continuing medical education; and assessing an administrative penalty of \$500. The action was based on allegations, that

and assessing an administrative penalty of \$500. The action was based on allegations that members of Dr. Vlahakos' office staff ordered large amount of alprazolam, hydrocodone, diazepam and propoxyphene for their family members and for patients who could not afford the medications.

VIOLATION OF PROBATION OR PRIOR ORDER

- BARTLEY, MICHAEL ALAN, M.D., IRVING, TX., Lic. #H6033
 On February 15, 2007, the Board, acting through its executive director, revoked Dr. Bartley's license. The action was based on a finding that Dr. Bartley had violated the terms of his order by ingesting cocaine.
- BURROWS, WILLIAMS BRADLEY, D.O., MOUNT PLEASANT, TX, Lic. #J9637 On February 16, 2007, the Board and Dr. Burrows entered into an Administrative Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Burrows failed to provide a urine sample on the required day in violation of his order.
- HAJI, ASHA KARIM, M.D., BRYAN, TX, Lic. #E2220

 On February 16, 2007, the Board and Dr. Haji entered into a Modified Agreed Order extending her Agreed Order by six months, requiring her to complete the medical record keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, or an approved equivalent program, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Haji had not completed all of the continuing medical education required by the prior order by the deadline.
- NICHOLS, DWIGHT JAMES, M.D., BRECKENRIDGE, TX, Lic. #D0985
 On February 16, 2007, the Board and Dr. Nichols entered into an Agreed Modification Order extending his existing order for one year, requiring him to have executive director approval to change his practice setting, and deleting the provision of the order relating to the Special Purpose Examination. The action was based on allegations that Dr. Nichols had not met all of the requirements of his order.

ADVERTISING VIOLATIONS

• LOWN, IRA GENE, M.D., AUSTIN, TX, Lic. #M4308

On February 16, 2007, the Board and Dr. Lown entered into an Administrative Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Lown used the term "board certified" in advertisements in a manner that created a false and confusing impression to the public that he was board certified in orthopedic medicine when he was instead board certified only in surgery.

• MIESCH, MARY GAIL, M.D., PARIS, TX, Lic. #H7081

On February 16, 2007, the Board and Dr. Miesch entered into an Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Miesch placed an advertisement in her local paper that created an unjustified expectation about the results of using a particular antioxidant to reverse aging.

• REYES, JOSE, M.D., SAN ANTONIO, TX, Lic. #H6540

On February 16, 2007, the Board and Dr. Reyes entered into an Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that, in his web-based advertising, Dr. Reyes stated he was board certified in bariatric medicine, notwithstanding that a physician may use the term "board certified" only if the certifying board meets certain qualifications, which the Board of Bariatric Medicine does not meet.

ACTION BASED ON PEER REVIEW ACTIONS

• CAMPBELL, ODETTE L., M.D., DALLAS, TX, Lic. #H9609

On February 16, 2007, the Board and Dr. Campbell entered into a two-year Agreed Order requiring that her practice be monitored by another physician; that she complete additional continuing medical education in the areas of medical records, and assessing an administrative penalty of \$2,500. The action was based on allegations that Dr. Campbell resigned from her place of practice while under review due to documentation concerns.

ACTION BASED ON CRIMINAL CONVICTION

• GILLILAND, MARK DOUGLAS, M.D., HOUSTON, TX, Lic. #G2088

On February 16, 2007, the Board and Dr. Gilliland entered into an Agreed Order of Revocation by which Dr. Gilliland's medical license was revoked. The action was based on Dr. Gilliland's conviction of a third degree felony, intoxicated assault with a motor vehicle, and his subsequent sentencing to two years confinement in a Texas Department of Criminal Justice facility.

VOLUNTARY SURRENDERS

• EVANS, DAVID RONALD, D.O., PLANO, TX, Lic. #D9131

On February 16, 2007, the Board and Dr. Evans entered into an Agreed Order accepting the voluntary and permanent surrender of Dr. Evans' medical license. The action was based on allegations that Dr. Evans has suffered from a long history of alcohol and opioid abuse and is also disabled due to a stroke and a heart ailment.

• HUGHES, KEITH PATRICK, M.D., LINCOLN, NE, Lic. #K3246

On February 16, 2007, the Board and Dr. Hughes entered into an Agreed Order accepting the voluntary surrender of Dr. Hughes' medical license. The action was based on the revocation of Dr. Hughes' Nebraska medical license by the Nebraska Department of Health and Human Services for failing to abstain from alcohol and ingesting a prescription drug in violation of the terms and conditions of his probation.

• KILPATRICK, HAMILTON WRIGHT, M.D., UVALDE, TX, Lic. #C3109

On February 16, 2007, the Board and Dr. Kilpatrick entered into an Agreed Order accepting the voluntary surrender of Dr. Kilpatrick's medical license. The Board's representatives discussed

with Dr. Kilpatrick allegations pertaining to Dr. Kilpatrick's prescribing of narcotics without adequate documentation for patients he treated as an independent medical contractor for a Houston physician between 2002 and 2005.

• RUSSOL, FREDERICK JOSEPH, M.D., ODESSA, TX, Lic. #E8876
On February 16, 2007, the Board and Dr. Russol entered into an Agreed Order accepting the voluntary surrender of Dr. Russol's medical license. Concerns regarding Dr. Russol's physical illness gave rise to his determination that he should retire from the practice of medicine and should voluntarily surrender his medical license.

MINIMAL STATUTORY VIOLATIONS

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

Harris, Brian Eugene, M.D., Matawan, NJ, Lic. #L8068

Messenger, Dennis Dwight, M.D., San Antonio, TX, Lic. #F4282

Redman, Paul Clark, M.D., Dayton, TX, Lic. #D7266

Salinas, Fulgencio P., M.D., Edinburg, TX, Lic. #G7325

Wald, Donald Marvin, M.D., Morgantown, WV, Lic. #C3277

Yalavarthi, Ranganayaki, M.D., Odessa, TX, Lic. #G2626

CORRECTION

The summary of the disciplinary actions taken by the Board against Dr. Robert Cassella appearing in the August 31, 2006, press release included language indicating that Dr. Cassella's license would be suspended for 90 days, following which the suspension would be stayed and Dr. Cassella placed on probation for 10 years. However, the agreement between the Board and Dr. Cassella was that the suspension would be automatically stayed as of the effective date of the order.

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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.