Texas Medical Board

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Medical Board issues 672 physician licenses while reducing licensure processing time; disciplines 50 physicians

At its February 7-8 meeting, the Texas Medical Board issued 672 physician licenses. While continuing to issue a large number of licenses, the board is moving towards meeting its legislative mandate to reduce the time it takes to issue a license; the average time for processing is down to 67.5 days, from a high of more than 90 before last year's legislative action to increase agency staff and resources to improve licensure processing times.

Also at its February 7-8 meeting, the Texas Medical Board took disciplinary action against 50 licensed physicians.

Actions included 15 violations based on quality of care; five actions based on unprofessional conduct; one action based on violation of probation or prior board order; one action based on inadequate medical records violations; four actions based on impairment due to alcohol or drugs; one action based on nontherapeutic prescribing; two actions based on inadequate supervision; five voluntary surrenders; two action based on criminal convictions; one action based on peer review actions; and 13 minimal statutory violations.

Proposed Rules and Rule Changes from the February 7-8 board meeting will be issued in a separate release next week.

DISCIPLINARY ACTIONS

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**

• CHERICO, FELIX, JR., M.D., LIC. #E9153, AUSTIN, TX

On February 8, 2008, the Board and Dr. Cherico entered into an Agreed Order requiring Dr. Cherico to write a letter of apology to a patient, complete 10 hours of continuing medical education in patient communications and risk management, and pay an administrative penalty of \$5,000. The action was based on Dr. Cherico's failure to appropriately test for a patient's breast cancer and failure to communicate with the patient.

• DOTSON, RODNEY N., M.D., LIC. #D9988, HEREFORD, TX On February 8, 2008, the Board and Dr. Dotson entered into a seven-year Mediated

Agreed Order publicly reprimanding Dr. Dotson and requiring that he complete the Health Science Rural and Community Health Institute peer evaluation program; have a licensed medical assistant with education, training, or experience in medical terminology to assist him with documentation; pass the Special Purpose Examination; and have his practice monitored by another physician. The action was based on standard of care violations found by the physician authorized to monitor his practice under Dr. Dotson's 2004 Order.

• FARBER, STEVEN H., M.D., LIC. #F8102, THE WOODLANDS, TX

On February 8, 2008, the Board and Dr. Farber entered into an Agreed Order publicly reprimanding Dr. Farber and assessing a \$2,500 administrative penalty. The action was based on Dr. Farber inappropriately prescribing medication without first establishing a proper professional relationship with a patient.

• GARTON, SUSAN M., D.O., LIC. #H8061, SAN ANTONIO, TX On February 8, 2008, the Board and Dr. Garton entered into an Agreed Order requiring Dr. Garton to complete 10 hours of continuing medical education in medical record keeping and pay an administrative penalty of \$500. The action was based on Dr. Garton's failure to maintain an adequate medical record and disclose potential risks involved with estrogen therapy applied to transgender reassignment.

• HERNANDEZ, RAMIRO, M.D., LIC. #E6093, EL PASO, TX

On February 8, 2008, the Board and Dr. Hernandez entered into a Mediated Agreed Order publicly reprimanding Dr. Hernandez and requiring that Dr. Hernandez request modification of his DEA and DPS controlled substances registrations eliminating his Schedule II-IV prescription authorizations; that his practice be monitored by another physician for five years; that he pass the Medical Jurisprudence Examination; that he perform 100 hours of community service a year for five years; and prohibiting him from supervising or delegating prescriptive authority to a physician assistant or advance practice nurse or supervising a surgical assistant.

• KODALI, SAYOJIRAO, M.D., LIC. #G1691, LONGVIEW, TX

On February 8, 2008, the Board and Dr. Kodali entered into an Agreed Order requiring that Dr. Kodali submit proof of current ACLS certification and complete continuing medical education in recordkeeping (10 hours), risk management (10 hours), and post-operative management of surgical patients (10 hours). The action was based on Dr. Kodali's failure to adequately monitor two patients.

• LEWIS, HAROLD D., D.O., LIC. #E6126, AUSTIN, TX

On February 8, 2008, the Board and Dr. Lewis entered a five-year Agreed Order publicly reprimanding Dr. Lewis, limiting his prescriptive authority of Controlled Substances, and requiring that his practice be monitored by another physician. In addition, the order requires that he not treat any chronic pain patients except for prescribing for immediate needs; not use any PAs or APNs in his practice; not re-open his North Austin clinic; not assume position of medical director of any additional methadone clinics without first notifying the Board; complete continuing medical education in the areas of risk management (10 hours/year) and medical record keeping (10 hours/year); and pay an administrative penalty of \$5,000. The action was based on Dr. Lewis's violation of the Board's rules regarding the treatment of pain and for maintaining inadequate medical records.

• LIGGETT, CHARLES JR., M.D., LIC. #F2324, HOT SPRINGS, AK

On February 8, 2008, the Board and Dr. Liggett entered an Agreed Order suspending his license for 30 days and publicly reprimanding him. The action was based on Dr. Liggett's failure to recognize the development of systemic inflammatory response syndrome and treat his patient for postoperative hypertension and sepsis in a timely and appropriate manner.

• MACKEY, JESSE J., M.D., LIC. #H9677, COPPELL, TX

On February 8, 2008, the Board and Dr. Mackey entered into an Agreed Order requiring that Dr. Mackey write a scholarly paper about Pulmonary Emboli and Other Acute/Life-Threatening Thrombotic Conditions and that he complete continuing medical education in the areas of diagnosis and treatment of patients presenting with acute/life-threatening/emergency conditions (20 hours), diagnosis and treatment of pulmonary emboli (10 hours), and medical record keeping (10 hours). The action was based on his failure to adequately test for the diagnosis and treatment of a patient who was at risk for pulmonary embolus.

• MARQUIS, ALEJANDRO F., LIC. #K1248, KELLER, TX

On February 8, 2008, the Board and Dr. Marquis entered into an Agreed Order requiring that Dr. Marquis complete continuing medical education in risk management (20 hours) and in medical record keeping (15 hours) and that he pay an administrative penalty of \$1,000. The action was based on Dr. Marquis' failure to examine a nursing home patient during the patient's nine-day stay who suffered from several severe medical conditions including congestive heart failure and pneumonia.

• MILLER, DUANE C., M.D., LIC. #D6498, ABILENE, TX

On February 8, 2008, the Board and Dr. Miller entered into an Agreed Order requiring that Dr. Miller complete 10 hours of continuing medical education in medical management of psychiatric patients or management of medical problems of psychiatric patients. The action was based on Dr. Miller's failure, along with another treating physician, to timely order enough lab tests and coordinate the monitoring of a patient's lithium levels, which resulted in the failure to diagnose lithium toxicity.

• PHILLIPS, DANA, M.D., LIC. #H4720, LUBBOCK, TX

On February 8, 2008, the Board and Dr. Phillips entered into an Agreed Order requiring that Dr. Phillips complete 10 hours of continuing medical education in physician/patient communications and 30 hours of continuing medical education in risk management. The action was based on Dr. Phillips' failure to disclose reasonably foreseeable risks of a breech presentation in a multiparous patient who was over 38 weeks gestation and failure to document that the patient was given adequate information about the high risk nature of her pregnancy.

• TAKASE, KOUJI, M.D., LIC. #G1839, HOUSTON, TX

On February 8, 2008, the Board and Dr. Takase entered into an Agreed Order requiring that Dr. Takase surrender his controlled substances registration certificates to the DPS and DEA and that he not possess, administer or prescribe controlled substances. The action was based on his prescriptions of controlled substances to a patient without proper documentation and without a treatment plan.

• TRAYNHAM, JULIE A., D.O., LIC. #L6244, JUSTIN, TX

On February 8, 2008, the Board and Dr. Traynham entered into a three-year Agreed Order requiring that Dr. Traynham's practice be monitored by another physician, that she

complete a medical record keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, and that she maintain adequate medical records on all patient office visits, consultations, surgeries performed, drugs provided, and treatment rendered. The action was based on Dr. Traynham's delivery of inappropriate care to a chronic pain patient who was subsequently hospitalized for drug overdoses.

• UDELL, KIMBERLY, D.O., LIC. #L1225, ARLINGTON, TX On February 8, 2008, the Board and Dr. Udell entered into an Agreed Order assessing an administrative penalty of \$250. The action was based on Dr. Udell's termination of patient care without providing reasonable notice.

UNPROFESSIONAL CONDUCT VIOLATIONS

• BRUCE, LENA R., M.D., LIC. #H6081 TEXAS CITY, TX

- On February 8, 2008, the Board and Dr. Bruce entered into an Agreed Order publicly reprimanding Dr. Bruce and requiring her to obtain an independent medical evaluation and follow recommendations, complete a professional boundary course, and pay an administrative penalty of \$5,000. The action was based on Dr. Bruce's personal relationship with a patient who was also the spouse of another patient under her care.
- COLLINS, DIANA M., M.D., LIC. #J4534, SUGARLAND, TX On February 8, 2008, the Board and Dr. Collins entered into an Agreed Order publicly reprimanding Dr. Collins and requiring that she take and pass the Medical Jurisprudence Examination, complete 15 hours of continuing medical education in ethics, and pay an administrative penalty of \$2,000. The action was based on Dr. Collin's failure to respond

physician. HELMER III, RICHARD E., M.D., LIC. #D8265, AUSTIN, TX

On February 8, 2008, the Board and Dr. Helmer entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on Dr. Helmer's physical examination of a female patient, during which he was not sufficiently sensitive to her privacy concerns, and did not discuss with her in advance what his intentions were in regard to components of the examination, when a chaperone was not present during the examination.

to a Board subpoena request for medical records relating to the investigation of another

• McCLELLAN, DAVID M., M.D., LIC. #G0476, CROSBY, TX

On February 8, 2008, the Board an Dr. McClellan entered into an Agreed Order reprimanding Dr. McClellan, prohibiting him from engaging in any practice of medicine that involves direct or indirect contact with female patients, prohibiting him from supervising or delegating prescriptive authority to a physician assistant or advanced practice nurse or supervise a surgical assistant, and assessing a \$5,000 administrative penalty. The action was based on his violation of a prior order and making inappropriate remarks of a sexual nature to a patient.

• SCHOTTSTAEDT, MARGARET, M.D., LIC. # F3324, GILMER, TX

On February 8, 2008, the Board and Dr. Schottstaedt entered into an Agreed Order requiring that Dr. Schottstaedt pay an administrative penalty of \$750 and that she complete 10 hours of continuing medical education in the area of pain management. The

action was based on her ordering of medication including morphine for non-specific patient emergency kits at a hospice facility.

VIOLATION OF PROBATION OR PRIOR ORDER

• MAYS, JEFFRY P., M.D., LIC. #J7815, BRADY, TX

On February 8, 2008, the Board and Dr. Mays entered into an Agreed Order assessing an administrative penalty of \$500. The action was based on Dr. Mays' violation of his 2006 Order with Board by failing to timely call the Board's substance abuse screening program on two occasions.

INADEQUATE MEDICAL RECORDS

• TYE, CHRISTOPHER, M.D., LIC. #J2388, SOUTHLAKE, TX

On February 8, 2008, the Board and Dr. Tye entered into an Agreed Order requiring that Dr. Tye's practice be monitored by another physician for one year and that he complete 10 hours of continuing medical education in medical recordkeeping. The action was based on Dr. Tye's failure to document a patient's pre-surgery work-up exam and ensure that adequate post-op status documentation was completed.

IMPAIRMENT DUE TO ALCOHOL OR DRUGS

• ARROYO, CARLOS, M.D., LIC. #F9148, CHANNELVIEW, TX

On February 8, 2008, the Board and Dr. Arroyo entered into an Agreed Order requiring that Dr. Arroyo's license be suspended; he abstain from consuming prohibited substances, including alcohol and drugs not prescribed for him; participate in the Board's program for testing for drugs and alcohol. In addition, he may not supervise or delegate prescriptive authority to a physician assistant or advanced practice nurse or supervise a surgical assistant. The action was based on his abuse of cocaine and the previous temporary suspension of his license.

• DAVIS, BRIAN R., M.D., LIC. #M3514, LOUISVILLE, KY

On February 8, 2008, the Board and Dr. Davis entered into a 10-year Agreed Order requiring that he abstain from consuming prohibited substances, including alcohol and drugs not prescribed for him; participate in the Board's program for testing for drugs and alcohol; participate in the activities of Alcoholics Anonymous at least five times per week; meet with a psychiatrist monthly; and have his physician supervisor submit reports to the Board every six months for the first two years under the Order regarding issues of work performance and impairment. The action was based on the suspension of his hospital privileges at a hospital in New York and the surrender of his medical license in New York due to alcohol impairment issues.

• HALL, JOHN, D.O., LIC. #J4179, SAN ANTONIO, TX

On February 8, 2008, the Board entered into an Agreed Order suspending Dr. Hall's license and requiring that he abstain from consuming prohibited substances, including alcohol and drugs not prescribed for him, and that he participate in the Board's program for testing for drugs and alcohol. The action was based on his testing positive for cocaine in violation of his November 30, 2007 order.

• HANCOCK, TODD W., M.D., LIC. #L5758, ALLEN, TX

On February 8, 2008, the Board and Dr. Hancock entered into a 10-year Agreed Order requiring that Dr. Hancock abstain from consuming prohibited substances, including alcohol and drugs not prescribed for him; participate in the Board's program for testing for drugs and alcohol; undergo an independent medical evaluation; receive weekly psychotherapy and monthly psychiatric treatment; not engage in the practice of anesthesia; limiting his practice to no more than 20 hours per week for the first 30 days of the Order, and 40 hours per week thereafter, in a group or institutional setting with two onsite monitors; not prescribe to himself or family members; not prescribe Class II Schedule drugs outside a hospital setting; and participate in the activities of Alcoholics Anonymous at least five times per week. The action was based on Dr. Hancock's intemperate use of Fentanyl and Vicodin.

NONTHERAPEUTIC PRESCRIBING

• STEWART, EWA K., M.D., LIC. #K9430, GARLAND TX

On February 8, 2008, the Board and Dr. Stewart entered into an Agreed Order requiring that Dr. Stewart complete at least 15 hours of continuing medical education in the treatment of pediatric dehydration, pediatric pharmacology, and risk management and that he pay an administrative penalty of \$1,000. The action was based on her prescription of Phenergan that was contraindicated for a patient less than two years of age.

INADEQUATE SUPERVISION OR DELEGATION

• ARMSTRONG, DAVILL, M.D., LIC. #F3025, HOUSTON, TX

On February 8, 2008, the Board and Dr. Armstrong entered into an Agreed Order requiring Dr. Armstrong to pay a \$2,000 administrative penalty. The action was based on the employment of his wife as a medical technician and allowing her to prescribe medication to a patient when there was no physician onsite and while Dr. Armstrong's license was suspended by the Board.

• GIRALDI, RODOLFO G., M.D., LIC. #J0503, HOUSTON, TX

On February 8, 2008, the Board and Dr. Giraldi entered into an Agreed Order requiring Dr. Giraldi to surrender his DEA and DPS registration certificates and remain inactive from the practice of medicine until he elects to return to the practice of medicine at which time he may not practice pain management; that he limit his practice to internal/family medicine, and that he has his practice monitored by another physician for five years. The action was based on Dr. Giraldi's violation of the Board's rules relating to treatment of pain and supervision of delegates.

VOLUNTARY SURRENDERS

• ANDERSON, RONALD R., D.O., LIC. #D4462 DALLAS, TX On February 8, 2008, the Board and Dr. Anderson entered into an Agreed Order whereby Dr. Anderson voluntarily and permanently surrendered his license due his inability to comply with his order and his desire to reside outside of Texas and retire.

• BROWNING, JAMES M., M.D., LIC. #E4225, FT. WORTH, TX

On February 8, 2008, the Board and Dr. Browning entered into an Agreed Order whereby Dr. Browning voluntarily and permanently surrendered his license in lieu of further disciplinary proceedings.

• FADHLI, WAMEETH, M.D., PERMIT NO. 514476 On February 8, 2008, the Board and Dr. Fadhli entered into an Agreed Order of

Voluntary Surrender whereby the Dr. Fadhli voluntarily surrendered his PIT license. The action was based on his conviction of a felony conviction for aggravated assault.

• FONTENOT, JAMES N., M.D., LIC. #G7206, WICHITA FALLS, TX On February 8, 2008, the Board and Dr. Fontenot entered into an Agreed Order whereby Dr. Fontenot voluntarily and permanently surrendered his license. The action was based on his inability to practice medicine safely due to a physical or mental condition.

• WACHENDORFER, RUTH, M.D., LIC. #J4592, DALLAS, TX On February 8, 2008, the Board and Dr. Wachendorfer entered into an Agreed Order of Voluntary Surrender whereby Dr. Wachendorfer voluntarily and permanently surrendered her license in lieu of further disciplinary proceedings

ACTION BASED ON CRIMINAL CONVICTIONS

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

On February 8, 2008, the Board and Dr. Kornell entered into an Agreed Order amending his 2006 Order by placing Dr. Kornell on a stayed revocation rather than a stayed suspension and assessing an administrative penalty of \$500. The action was based on his conviction for a third-degree felony of unlawfully obtaining from a legally registered pharmacist a controlled substance by using a false or forged prescription. The conviction was in relation to his arrest addressed in his 2006 order.

• TATE, HAROLD A., M.D., LIC. #L5921, LAS VEGAS, NV

On February 8, 2008, the Board entered into a five-year Agreed Order revoking Dr. Tate's license and probating the revocation and requiring Dr. Tate to complete his criminal probation with the state of California and complete his probation imposed by the Medical Board of California. The action was based on his felony conviction for failure to file an income tax return and for disciplinary action taken by another state medical board.

ACTIONS BASED ON PEER REVIEW ACTIONS

• BAILEY, CHARLES F., JR., M.D., LIC. #C6859, GRAND PRAIRIE, TX

On February 8, 2008, the Board and Dr. Bailey entered into an Agreed Order requiring that Dr. Bailey limit his medical practice to his current position as the Medical Director of the Price Daniel Prison Unit in Snyder in Texas or at a setting approved by the Board's executive director and that he obtain 10 hours of continuing medical education in neurology. The action was based on a peer review action taken due to his failure to provide adequate treatment of a patient with an acute stroke and failure to recognize the immediate need for hospitalization.

MINIMAL STATUTORY VIOLATIONS

Thirteen licensees agreed to enter into orders with the Board for minimal statutory violations.

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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.