

Medical Board Bulletin Fall 2006

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Texas Medical Board Bulletin

The newsletter of the Texas Medical Board

Fall 2006

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Governor Names Drs. McNeese, Zeitler to Board

Governor Rick Perry has appointed two new members to the Texas Medical Board. They are Margaret Carter McNeese, M.D., and Irvin E. Zeitler Jr., D.O.

Dr. McNeese, of Houston, is the associate dean for admissions and student affairs and professor of pediatrics at the University of Texas Health Science Center Medical School in Houston. She is an expert on child abuse and has authored numerous articles on the subject. She is a member of the American Academy of Pediatrics and is a member of and former alternate delegate to the Texas Medical Association, where she previously served on the Child and Adolescent Health Subcommittee and the Child Health Committee. Dr. McNeese is also a member of the Southern Medical Association, the American Medical Association and the Houston Pediatric Society. She previously served on the Harris County Child Welfare Medical Committee, the Mental Health Mental Retardation Advisory Committee and the National Committee to Prevent Child Abuse. A graduate of Mary Baldwin College in Virginia, Dr. McNeese received her medical degree from the University of Texas Medical Branch in Galveston. She replaces Christine L. Canterbury, M.D., who resigned from the board.

Dr. Zeitler, of San Angelo, is a board certified family practice physician at Shannon Medical Center, where he serves as Vice President of Medical Affairs. He graduated from the University of Texas at Austin with a B.S. in pharmacy and earned his medical degree from the University of North Texas Health Science Center at Fort Worth. He completed his family practice residency at Texas Tech. Dr. Zeitler is a member of the Texas Medical Association, a Fellow of the American Academy of Family Practice, and a member and former board member of the Texas Osteopathic Medical Association. He previously practiced in Stamford, Texas, and served as Medical Director of Shannon Clinic. Dr. Zeitler has served on one of the Medical Board's District Review Committees since 1988, having been appointed by three different governors.

Dr. Zeitler replaces David Garza, D.O., who had served on the board since 1999. At its June meeting, the board expressed gratitude for Dr. Garza's spirit, compassion and professionalism while ensuring quality healthcare for the citizens of Texas. During his time on the board, Dr. Garza served in the following capacities: chairman of the Licensure Committee, Disciplinary Process Review Committee and Standing Orders Committee and as a member of the Executive Committee, Credentials Verification Study

Committee, Search Committee, Finance Committee, Ad Hoc Committee to Study Integrative and Complementary Medicine, Ad Hoc Committee for Optometric Issues, Ad Hoc Committee to Study Office-Based Anesthesia, and the Non-Profit Health Organizations Committee.

The board is also grateful to Dr. Canterbury for her service since September 15, 2003. During her time on the board, Dr. Canterbury served on the Disciplinary Process Review Committee and on the Standing Orders Committee, which she also chaired.

From the Board President

Board Recognizes the Value of Stakeholder and Focus Groups

by Roberta A. Kalafut, D.O.

During the 79th legislative session in 2005, the Texas Medical Board came under Sunset Review. This process is done every 12 years to re-evaluate the Texas Medical Board's statute, rules, policies and basic operations. The result was S.B. 419, which redefined and updated the Medical Practice Act in the Texas Occupations Code. Of the many initiatives and recommendations that came out of that bill, I would like to address one specifically: Sec. 153.0015 of the Texas Occupations Code: Guidelines For Input In Rulemaking. (a) *The board shall adopt guidelines to establish procedures for receiving input during the rulemaking process from individuals and groups that have an interest in matters under the board's jurisdiction. The guidelines must provide an opportunity for those individuals and groups to provide input before the board provides notice of the proposed rule.* In implementing this guideline, TMB has had several opportunities to work with our stakeholders and develop focus, resource and stakeholder groups from a wide array of interested parties. Below are several examples of ongoing collaborative efforts.

Pain Medicine Resource Group

There is no better example of success in working together than the recent work done in updating and essentially rewriting Board Rule 170: Authority of Physician to Prescribe for the Treatment of Pain. A resource group was formed after initial attempts at drafting a document were met with numerous and diverse opinions from the public and physicians. The group consisted of representatives of the Texas Medical Association, the Texas Osteopathic Medical Association, the Texas Pain Society, the National Foundation for Treatment of Pain, the Texas Academy of Family Physicians, and advanced nurse practitioners. My participation in this group was unique in that, in addition to representing TMB, I am a practicing board certified pain medicine physician dealing with these issues and rules on a daily basis in my private practice. During an intensive but collegial work session, the group reviewed the proposed draft line by line, making edits, changes, and additions that were acceptable to all. The finished work product can be seen on our web site at <http://www.tmb.state.tx.us/rules/proprules.php>. It comes before the full board for final approval at the December 7-8 meeting.

Licensure Stakeholder Group

The stakeholder group to discuss licensure rulemaking issues consisted of representatives of TMB, the Texas Medical Association, the Texas Osteopathic Medical Association, the Texas Hospital Association,

the Texas Health Policy Institute (representing consumers), a defense attorney who represents applicants before the Licensure Committee, and a director of residency education at a Texas medical school. Through a collaborative effort from this stakeholder group, TMB recommended and adopted licensure rules, edits, and changes. These board-approved rules are on the web site at http://www.tmb.state.tx.us/rules/rules/bdrules_toc.php and included Chapter 163, Licensure; Chapter 166, Physician Registration; Chapter 171, Postgraduate Training Permits; and Chapter 172, Temporary Licenses.

Enforcement Stakeholder Group

Another stakeholder group was formed to address rulemaking for enforcement and disciplinary issues. Stakeholder members included representatives of TMB, TMA, TOMA, THA, a defense attorney who represents physicians in disciplinary proceedings before TMB, an associate dean for graduate medical education from a Texas medical school and, representing consumers, the publisher of a well-known magazine. As with the licensure group, their collaborative efforts resulted in disciplinary rules recommended and adopted by TMB. These rules are also on our web site and included changes to Chapter 178, Complaints; Chapter 180, Rehabilitation Orders; and Chapter 182, Use of Experts.

As Henry Ford said,

Coming together is a beginning

Staying together is progress

Working together is success.

These words reflect the sentiment of the relationship the Texas Medical Board developed over the last two years and continues to develop with our stakeholders, resource and focus groups in developing board rules affecting our licensees and our patients.

Public Board Member Tells Why He Serves

by Eddie J. Miles Jr.

In 1997, I was asked by then-Governor George W. Bush's Appointments Office to sit on the Texas Medical Board. I believe I was appointed to this board because of the balance between my vast work experience and my extensive community involvement. As a board member for the past nine years I believe it is more important than ever that the Medical Board continue to have general public representation and provide a voice for the people.

I have been given an invaluable opportunity to serve the general public throughout Texas and do not take this appointment lightly. The duties we are tasked with are demanding and challenging. The decisions we make are extremely thought-provoking as they quite literally affect people's lives across the spectrum. On my drive to Austin for each meeting, I take time to ponder and remind myself that I must make just and fair decisions while not losing sight of whom I represent: the people of Texas.

In 2003, I had the honor of being reappointed to this essential board by Governor Rick Perry. I sincerely believe that every time the board meets, we take steps forward in the overall best interest of each and every Texan. As positive changes continue to occur, we will all reap the benefits of the Medical Board's mission: "to protect and enhance the public's health, safety and welfare ." I am quickly reminded that my family, loved ones and myself are part of that public. It behooves me to remain a committed board member, and on that you have my full pledge.

TDSHS Announces Electronic Death Registration System

The Texas Department of State Health Services is implementing an Internet-based death registration system, providing an alternative to the traditional paper death certificates. The online system, Texas Electronic Registrar, is a user-friendly, secure, efficient way for all critical parties in death registration, such as physicians, funeral directors and local registrars, to complete their respective portions of the death registration process online. For a physician, this new registration system means that certification of cause-of-death is only a few clicks away on any computer with Internet access. Here are some of the benefits of the new system:

For physicians:

- Saves time and effort by enabling electronic completion of the death certificate

- Provides for paperless filing of a death record

- Reduces errors and subsequent rejection of death certificates

- An automatic request for Social Security Number verification is initiated to check if the correct SSN is on the record, eliminating SSN-related amendments.

For public health:

- Improves cause-of-death data provided to electronic disease surveillance systems and researchers

For bereaved families:

- Timely certification of death eliminates delays in estate settlement and other necessary business

The electronic death registration system is available at no charge. The system allows a physician to delegate death certificate completion to office or clinic staff and only requires the physician to enter a personal identification number to complete the actual electronic signature and certification. More information on the electronic death registration system is available online at www.dshs.state.tx.us/vs/edeath.

Governor Appoints Four to Physician Assistant Board

Governor Rick Perry has made four appointments to the Texas Physician Assistant Board: Ron Bryce, M.D., of Red Oak; Anna Arredondo Chapman, of Del Rio; Michael A. Mitchell, D.O., of Henrietta; and Pamela Welch, PA-C, of Mount Vernon.

Dr. Bryce is the mayor of Red Oak and an emergency and a family practice physician. He received a bachelor's degree and medical degree from Oral Roberts University in Tulsa, Oklahoma. He is a medical director at Family Medical Care, P.A., and at Family Medical and Urgent Care. He is a diplomate of the American Board of Family Practice. He is also a member of the American Medical Association, the Texas Medical Association and the Christian Medical Association. Dr. Bryce serves as a board member of the Abundant Life Missions.

Ms. Chapman is the acting city secretary for the city of Del Rio. She received a bachelor's degree in business administration from Sul Ross State University in Alpine and a master's in business administration from Regis University in Denver. She retired from the federal government in 2004 after 32 years of contracting and public administration experience. She is a member of Alpha Sigma Nu Honor Society of the Jesuit Institution of Higher Education, a board member of the State Bar of Texas District 15 Grievance Committee, and she is involved with Catholic Daughters of the Americas, Pan American Round Table, Texas Municipal Clerks' Association and other community organizations.

Dr. Mitchell is a family practice physician at Clinics of North Texas in Wichita Falls. He is a member of the American Osteopathic Association and the Texas Osteopathic Medical Association. He has also served as a member of the American Osteopathic College of Family Physicians and the American Military Surgeons of the United States. He serves on the Wichita County Diabetes Advisory Board and on the Texas Academy of Physician Assistants Board of Directors as physician liaison. Dr. Mitchell received a bachelor's degree from the University of Central Oklahoma and he graduated from the Oklahoma State University College of Osteopathic Medicine.

Ms. Welch works in Emory, Texas, as the provider of a family practice clinic owned by Primary Care Associates in Greenville. She is a fellow member of the American Academy of Physician Assistants, is a member of the board of directors of the Texas Academy of Physician Assistants as the chairman of the Regional Affairs Committee and serves as the Northeast Texas Regional Representative. She is a founder and organizer of Belgard Memorial, a graduate of Leadership Longview and was selected by her peers to receive the Outstanding Physician Assistant of the Year award for 2005. She also serves as an advocate for underinsured and uninsured children of Texas. She is a survivor and participant in Race for the Cure. She is a graduate of Wichita State University and holds an MBA from LeTourneau University.

In addition to these new appointments, Governor Perry reappointed Dwight Deter, PA-C, of El Paso, Timothy Webb, of Houston, and Margaret Bentley, of DeSoto, to the P.A. Board.

Governor Appoints Raymond Graham to Acupuncture Board

Governor Rick Perry appointed public member Raymond J. Graham to the Texas State Board of Acupuncture Examiners.

Mr. Graham, of El Paso, received a bachelor's degree from Thomas Edison State College in New Jersey. He is president and owner of Frontera Manufacturing Support Services, LLC, and R & J's Construction, LLC. He is a member El Paso Industrial Development Authority, El Paso Workforce Retraining Advisory Committee, El Paso Manufacturing Cabinet, Upper Rio Grande Workforce Development Board, Vice

Chairman Upper Rio Grande College Tech Prep Youth Consortium and president of Showtime El Paso. He served as chairman of the El Paso Civil Service Commission, president of the Society of Plastic Engineers, chairman of the Industry Retention/Expansion Committee for the El Paso Chamber of Commerce and president of the El Paso Community Concerts Association. He was also a member of the El Paso Employer Forum, the El Paso Cluster Team Development, the American Management Association, the Unite El Paso, the El Paso Education Summit, the Employment Services for the Guard and Reserve and the City of El Paso Airport Board.

Complaint Notice Posters

Chapter 178 of the Board Rules requires licensees to post in their offices a notice of complaint procedure in English and Spanish. The signs must be displayed prominently, supplied with all bills for services, and/or placed on all registration forms, applications or contracts. Posters are available for download on the TMB web site at <http://www.tmb.state.tx.us/professionals/hcpres/compost.php>

Rule Changes

The board has adopted the following rules and rule changes since the last issue of the *Medical Board Bulletin*. The rules can be found on the TMB website at http://www.tmb.state.tx.us/rules/rules/bdrules_toc.php.

Chapter 163, Licensure, 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.

Chapter 163, Licensure to include new § 163.14, Interpretation of § 1.51(d), S.B. 419 relating to exam attempt requirements for those applicants in TMB Licensure system as of August 31, 2005, and adopted as an emergency rule.

Chapter 165, Medical Records, amendments to § 165.1 Medical Records and § 165.6 Medical Records Regarding an Abortion on an Unemancipated Minor.

Chapter 166, Physician Registration, 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.

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 and Limited Licenses, to include the addition of § 172.13 relating to Conceded Eminence Licenses and general rule cleanup.

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

Chapter 175, Fees, 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 179, Investigations, amendments to §179.8, Alcohol and Drug Screening During Investigations for Substance Abuse, regarding alcohol and drug screening during an investigation for substance abuse.

Chapter 185, Physician Assistants, relating to changes mandated by S.B. 419.

Chapter 192, Office Based Anesthesia to include amendments to §192.1, to include amendments to the chapter title, §192.1, Definitions, §192.2, Provision of Anesthesia in Outpatient Settings, §192.3, Compliance with Office-Based Anesthesia Rules, §192.4, Registration, §192.5, Inspections, §192.6, Requests for Inspection and Advisory Opinion.

Chapter 193, Standing Orders, to include new §193.12 Immunizations of Elderly.

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.

Abortion Consent

In accordance with S.B. 419 of the 79th Legislature, the Texas Medical Board has adopted amendments to Chapter 165 of the Board Rules regarding parental consent for abortion performed on an unemancipated minor. The rule and the consent form are now available on the TMB web site at <http://www.tmb.state.tx.us/rules/rules/165.php#f>

Formal Complaints

The following Formal Complaints have been filed with the State Office of Administrative Hearings regarding the licensees listed below. The cases were unresolved at the time of publication.

Royal H. Benson III, M.D..... H0175..... 8/30/06..... Failure to practice in an acceptable manner consistent with public health and

welfare; unprofessional conduct; violation of a board rule.

- Dean A. Cabansag, M.D..... L3255..... 8/28/06..... Failure to maintain adequate medical records; violation of Board Rule 170 regarding treatment of pain; failure to practice in an acceptable manner consistent with public health and welfare; unprofessional conduct; dispensing to a known user or person the physician should have known was an abuser of narcotics, controlled substances or dangerous drugs.
- Kevin E. Conner, M.D..... H7715..... 8/30/06..... Failure to practice in an acceptable manner consistent with public health and welfare; unprofessional conduct; nontherapeutic prescribing; failure to meet the standard of care.
- Avi T. Deshmukh, M.D..... H1067..... 8/18/06..... Failure to practice in an acceptable manner consistent with public health and welfare; nontherapeutic prescribing.
- Philip Eichelberger Jr., M.D..... C6308..... 8/29/06..... Failure to practice in an acceptable manner consistent with public health and welfare; unprofessional conduct; nontherapeutic prescribing; violation of board rules.
- Forney W. Fleming III, M.D..... D5989..... 8/18/06..... Failure to practice in an acceptable manner consistent with public health and welfare; unprofessional conduct; nontherapeutic prescribing.
- Kimberly A. B. Finder, M.D..... G9332..... 8/18/06..... Unprofessional conduct; false advertising.
- Bhara R. Gandhi, M.D..... J3477..... 8/18/06..... Failure to practice in an acceptable manner consistent with public health and welfare; unprofessional conduct; delegating to someone not qualified; aiding and abetting the unlicensed practice of medicine.
- Joseph E. Garcia, M.D..... H0368..... 7/3/06..... Failure to meet the standard of care; unprofessional conduct; failure to safeguard against potential complications; nontherapeutic prescribing.
- Volker H. Gressler, M.D..... J5775..... 8/30/06..... Failure to practice in an acceptable manner consistent with public health and welfare; unprofessional conduct; nontherapeutic prescribing; improper delegation and supervision; failure to meet the standard of care; violation of board rules.
- James D. Key Sr., M.D..... E3339..... 8/21/06..... Failure to practice in an acceptable manner consistent with public health and

welfare; failure to meet the standard of care; nontherapeutic prescribing; unprofessional conduct.

Billy H. Puryear, D.O..... D6314..... 8/29/06..... Failure to practice in an acceptable manner consistent with public health and welfare; unprofessional conduct; nontherapeutic prescribing; violation of board rules.

Charles I. Sitomer, M.D..... G7341..... 8/28/06..... Failure to meet the standard of care; failure to obtain informed consent; boundary violations; unprofessional conduct.

William R. Sheldon Jr., M.D..... F1999..... 8/31/06..... Failure to practice in an acceptable manner consistent with public health and welfare; unprofessional conduct; violation of board rules.

Jeffrey S. Smith, M.D..... K3476..... 8/29/06..... Failure to practice in an acceptable manner consistent with public health and welfare; unprofessional conduct; failure to maintain adequate medical records; nontherapeutic prescribing.

Ronald V. Washak, D.O..... J5052..... 9-20-06..... Inability to practice because of illness, drunkenness or excessive use of drugs; action by peers; failure to practice in an acceptable manner consistent with public health and welfare; intemperate use of drugs or alcohol; unprofessional conduct.

Lucia L. Williams, M.D..... G9013..... 8/30/06..... Failure to practice in an acceptable manner consistent with public health and welfare; unprofessional conduct; failure to maintain adequate medical records; nontherapeutic prescribing.

William G. Williams, M.D..... Temp..... 8/28/06..... Unprofessional conduct; failure to practice in an acceptable manner consistent with public health and welfare.

Physician Assistant

David A. Ray, PA-C..... PA02287..... 8/18/06..... Unprofessional conduct; violation of the law by committing an act of moral turpitude; failure to practice in an acceptable manner consistent with public health and welfare.

Disciplinary Actions

Since the Spring 2006 issue of the *Medical Board Bulletin*, the Board has taken disciplinary action on 155 physicians. The Texas Physician Assistant Board took action against one physician assistant. The following is a summary of those actions.

QUALITY OF CARE VIOLATIONS:

ANWAR, SYED IMTIAZ, M.D., BEAUMONT, TX, Lic. #K3671

On August 25, 2006, the Board and Dr. Anwar entered into a five-year Agreed Order requiring that his practice be monitored by another physician; that he take and pass the Special Purpose Examination; that he successfully complete the patient communication course at the University of California San Diego Physician Assessment and Clinical Education (PACE) program, or an approved equivalent program; and that he obtain a total of 10 hours of continuing medical education in the areas of geriatrics, ethics, and the corporate practice of medicine each year of the order, and assessing an administrative penalty of \$3,000. The action was based on allegations that Dr. Anwar failed to meet the standard of care in treating six elderly patients in nursing homes and hospitals because of inadequate documentation, inadequate assessment of patients, lack of aggressive intervention regarding medical conditions, inadequate supervision of a nurse practitioner, failure to monitor nursing home patients with sufficient frequency, failure to ensure proper nutritional status of nursing home residents, failure to prescribe medications and monitor the side effects of the medications prescribed, failure to monitor fluid and electrolyte status of nursing home residents and failure to follow up on abnormal laboratory values.

ARMSTRONG, DAVILL, M.D., HOUSTON, TX, Lic. #F3025

On June 2, 2006, the Board and Dr. Armstrong entered into an Agreed Order of Suspension whereby Dr. Armstrong's license was suspended until such time as he provides information, including a psychological and neuropsychiatric evaluation, to the board demonstrating that he is physically, mentally, and otherwise competent to safely practice medicine. The action was based on allegations that Dr. Armstrong violated the standard of care in treating 15 patients by treating only specific patient complaints at each office appointment without completing a history and physical and without monitoring chronic medical conditions, and on an Assessment Report from the Center for Personalized Education for Physicians that found Dr. Armstrong's judgment and reasoning below acceptable standards, with significant gaps in his medical knowledge.

ARREDONDO, ADAM GALLARDO, M.D., WAXAHACHIE, TX, Lic. #K7648

On June 2, 2006, the Board and Dr. Arredondo entered into an Agreed Order publicly reprimanding Dr. Arredondo and placing him on probation for five years with the following requirements: monitoring of his practice by another physician; modification of his Drug Enforcement Administration Controlled Substances Registration Certificate and his Texas Department of Public Safety Controlled Substances Registration Certificate to eliminate his authority to prescribe Schedules II and III; completing 50 hours per year of continuing medical education in pain management; no supervising or teaching residents or supervising or delegating prescriptive authority to a physician assistant or advanced practice nurse; and assessing an administrative penalty of \$20,000. The action was based on allegations that Dr. Arredondo failed to meet the standard of care in treating 10 patients for the following reasons: failure to review past records; inadequate assessments prior to starting opioid therapy; failure to perform behavior evaluation prior to starting therapy; failure to perform drug screens prior to starting therapy; failure to perform a trial of physical therapy and/or non-opioids; failure to document a treatment plan; inadequate monitoring of

patient responses to therapy; prescribing excessive and nontherapeutic doses of Schedule II drugs; inappropriate follow up; prescribing inappropriate dose escalation; lack of attention to red flags for abuse; and performing procedures that were not indicated.

AURIGNAC, FABIAN, M.D., MCALLEN, TX, Lic. #K3977

On August 25, 2006, the Board and Dr. Aurignac entered into a five-year Agreed Order requiring that his practice be monitored by another physician; that his cardiac catheterization laboratory procedures be monitored by another physician; that in each year of the order he complete 50 hours of continuing medical education in cardiology, 20 hours in medical records and 10 hours in ethics; that he pass the Medical Jurisprudence Examination; and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Aurignac failed to meet the standard of care in his diagnosis and treatment of a cardiac patient; that he was suspended or lost his privileges at three different hospitals in 2005; and that he did not adequately supervise his physician assistant.

BAKER, MERRIMON WALTERS, M.D., CLEVELAND, TX, Lic. #G4807

On October 6, 2006, the Board and Dr. Baker entered into an Agreed Order suspending his medical license, staying the suspension and placing him on probation under the following terms and conditions: Dr. Baker may not perform or be present at any spine surgery; his practice is to be monitored by another physician for three years; he is required to abstain from consuming prohibited substances, including alcohol and drugs not prescribed for him, for one year; he is required to participate in the board's program for testing for drugs and alcohol; and he may not supervise physician assistants or advanced practice nurses. The action was based on allegations of standard-of-care violations in surgical and post-surgical patients and in post-operative care management, and allegations of a lack of documentation in medical records to indicate the basis for medical decision-making, rationales for surgical procedures or to provide for continuity of care.

BENAVIDES, GERMAN, M.D., SAN ANTONIO, TX, Lic #F0877

On August 25, 2006, the Board and Dr. Benavides entered into an Agreed Order requiring that he complete 10 hours of continuing medical education in the areas of orthopedic infections, risk-management, and medical record-keeping; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Benavides failed to meet the standard of care in treating two patients, one in 1997 and one in 1998, and failed to maintain an adequate medical record on one patient in 1999.

BURROUGHS, KAREN, M.D., STEPHENVILLE, TX, Lic. #J1901

On August 25, 2006, the Board and Dr. Burroughs entered into a three-year Agreed Order publicly reprimanding Dr. Burroughs; requiring that her practice be monitored by another physician; and requiring that she complete 10 hours of continuing medical education in the area of risk management and 25 hours per year in the area of assessing, diagnosing, and treating substance abuse. The action was based on allegations that Dr. Burroughs failed to meet the standard of care in the management of pain and appropriate prescription of narcotic pain medications in treating a patient with multiple medical problems, including excessive use of pain medications.

CANTU, PHILIP MARTINEZ, M.D., FORT WORTH, TX, Lic. #K2865

On August 25, 2006, the Board and Dr. Cantu entered into a three-year Agreed Order requiring that his practice be monitored by another physician; that he successfully complete the medical record-keeping

course at the University of California San Diego Physician Assessment and Clinical Education (PACE) program, or an approved equivalent program; and assessing an administrative penalty of \$3,000. The action was based on allegations that Dr. Cantu performed a wrong level percutaneous nucleoplasty on one patient, failed to meet the standard of care in his treatment of a second patient for left neck and parascapular pain, and failed to appropriately manage treatment of a third patient, including failing to keep appropriate medical records.

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

On June 22, 2006, the Board and Dr. Caquias entered into a two-year Agreed Order requiring that his practice be monitored by another physician; that he successfully 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 that he resign from his role of "gatekeeper" with the Cameron County indigent program. The action was based on allegations that the "gatekeeper" role performed by Dr. Caquias does not allow for appropriate patient evaluation and medical record-keeping and that Dr. Caquias failed to maintain adequate medical records.

COLEMAN, WILLIAM PIERCE, M.D., WACO, TX, Lic. #D6910

On August 25, 2006, the Board and Dr. Coleman entered into a one-year Agreed Order requiring that his practice be monitored by another physician, and that he complete eight hours of continuing medical education in each of the areas of risk management and pain management and 16 hours in the area of medical records. The action was based on allegations that Dr. Coleman failed to meet the standard of care in treating one patient for chronic pain and failed to adequately document his treatment of the patient.

COOK, ROBERT LEE, M.D., TOMBALL, TX, Lic. #L0101

On June 2, 2006, the Board and Dr. Cook entered into an Agreed Order assessing an administrative penalty of \$1,000. Dr. Cook was unexpectedly called to assist in the dissection of pelvic lymph nodes when the surgeon scheduled to perform the procedure did not report to the operating room. The action was based on allegations that, after Dr. Cook was consulted intraoperatively, he should have discussed the case with the patient's family members present at the hospital before doing surgery.

DAVE, PRAMESH CHANDRAKANT, M.D., IRVING, TX, Lic. #K0014

On October 6, 2006, the Board and Dr. Dave entered into an Agreed Order requiring that his practice be monitored by another physician for two years, that he attend 50 hours per year of continuing medical education, at least 10 of which shall be in each of the areas of the treatment of infections and medical records, and assessing an administrative penalty of \$2,000. The action was based on allegations that Dr. Dave failed to timely follow up lab results and prescribe antibiotics for a nursing home patient.

DAVIS, JERRY THOMAS, D.O., FORT WORTH, TX, Lic. #F9351

On August 25, 2006, the Board and Dr. Davis entered into a two-year Agreed Order requiring Dr. Davis' practice to be monitored by another physician; requiring him to maintain adequate medical records; and requiring him to complete the following continuing medical education requirements: 15 hours in record-keeping, 10 hours in the treatment of anxiety, and 10 hours in the treatment of depression. The order prohibits Dr. Davis from supervising a physician assistant. The action was based on allegations that Dr. Davis did not meet the standard of care in treating one person for complaints of anxiety and hypertension, and failed to record a proper evaluation.

DECKER, DOUGLAS CAMPBELL, M.D., FORT WORTH, TX, Lic. #F6561

On June 2, 2006, the Board and Dr. Decker entered into an Agreed Order publicly reprimanding Dr. Decker, requiring him to attend at least 16 hours of continuing medical education in each of the areas of risk management and medical records, and assessing an administrative penalty of \$10,000. The action was based on allegations that Dr. Decker failed to meet the standard of care in his treatment of one patient because he failed to order a pregnancy test prior to his performance of a bladder suspension surgery and a hysterectomy. After surgery, the pathology report confirmed an eight week fetus in the uterus.

DICKEY, JOHN COKE, M.D., LUBBOCK, TX, Lic. #C7584

On October 6, 2006, the Board and Dr. Dickey entered into an Agreed Order requiring that his practice be monitored by another physician who will review the records for Dr. Dickey's next 30 surgical cases, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Dickey failed to appropriately assess a patient's condition following gynecological surgery.

DRAKE, CASSIUS MARCELLUS, M.D., ROYAL OAK, MI, Lic. #L0141

On June 2, 2006, the Board and Dr. Drake entered into an Agreed Order requiring Dr. Drake to complete 12 hours of continuing medical education in the area of managing infectious disease. The order was based on allegations that Dr. Drake prescribed the wrong antibiotic for treating a urinary tract infection, in part because he relied on information from the patient that he had been successfully treated with that antibiotic previously.

EDWARDS, LEO KING, M.D., SAN ANTONIO, TX, Lic. #F1524

On August 25, 2006, the Board and Dr. Edwards entered into an Agreed Order requiring that he complete 10 hours of continuing medical education in the treatment of hypertension. The action was based on allegations that Dr. Edwards failed to meet the standard of care because he did not see a patient in person within 24 hours after a consult was made.

FOX, EDWARD JOSEPH, M.D., ROUND ROCK, TX, Lic. #H8048

On August 25, 2006, the Board and Dr. Fox entered into an Agreed Order requiring that he complete 16 hours of continuing medical education in the area of general neurology and testing to exclude multiple sclerosis. The action was based on allegations that Dr. Fox failed to meet the standard of care in treating one patient by not ordering an MRI when he first saw the patient in 1994.

GARCIA, ALFREDO T., M.D., HOUSTON, TX, Lic. #F3468

On June 2, 2006, the Board and Dr. Garcia entered into an Agreed Order requiring Dr. Garcia to complete continuing medical education courses of at least eight hours in each of the areas of medical records and hematology/interpreting laboratory values. The action was based on allegations that Dr. Garcia failed to meet the standard of care by discharging a patient without ordering a blood count following a second transfusion to determine that the patient was not at substantial risk and not documenting the reason for the discharge.

JAROLIMEK, LUBOR JAN, M.D., HOUSTON, TX, Lic. #J6505

On August 25, 2006, the Board and Dr. Jarolimek entered into an Agreed Order assessing an administrative penalty of \$1,500. The action was based on allegations that Dr. Jarolimek did not ensure that the correct knee had been prepped before beginning the procedure. The error was recognized after the arthroscope was inserted, but before any other surgery was performed.

KUHL, PETER VAN DOREN, M.D., SAN ANTONIO, TX, Lic. #E6462

On June 2, 2006, the Board and Dr. Kuhl entered into an Agreed Order requiring Dr. Kuhl's practice to be monitored by another physician for 12 months; requiring that he complete a course of at least 10 hours in the area of the use of laboratory results in treating pregnant patients; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Kuhl failed to obtain a complete blood count upon the admission of a pregnant patient to the hospital. Obtaining a complete blood count on admission may have identified the patient as developing the HELLP Syndrome. Mitigating factors include that the patient's blood pressure readings continued to be within normal limits and, therefore, preeclampsia, a precursor of the HELLP Syndrome, was not readily identifiable.

LONIAN, ROBERT DUKE, M.D., PLANO, TX, Lic. #L4044

On August 25, 2006, the Board and Dr. Lonian entered into an Agreed Order requiring that his practice be monitored by another physician for 18 months, and that he complete 10 hours of continuing medical education in risk management and eight hours in medical records. The action was based on allegations that Dr. Lonian failed to meet the standard of care in performing a breast examination, including failing to discuss the examination with the patient prior to performing the examination, and failing to adequately document the procedure, findings and consent.

MAIN, ELLIS GERARD, D.O., CORPUS CHRISTI, TX, Lic. #J2176

On August 25, 2006, the Board and Dr. Main entered into an Agreed Order requiring that his practice be monitored by another physician for one year and that he obtain 25 hours of continuing education in risk management and/or record-keeping. The action was based on allegations that Dr. Main failed to meet the standard of care for one patient when he failed to have a patient come in when his condition worsened, and Dr. Main only called in medication.

MARKS, ERIC ADAM, M.D., BEAUMONT, TX, Lic. #K3325

On August 25, 2006, the Board and Dr. Marks entered into a three-year Agreed Order requiring that his practice be monitored by another physician; that he complete 10 hours of continuing medical education in record-keeping and 10 hours in cardiovascular disease each year; and assessing an administrative penalty of \$3,000. The action was based on allegations that Dr. Marks failed to meet the standard of care in his evaluation, monitoring and treatment of a patient who presented with complaints of chest pain and shortness of breath.

MCDONNELL, MARK F., M.D., HOUSTON, TX, Lic. #G1476

On August 25, 2006, the Board and Dr. McDonnell entered into a Disposition of Contested Case by Agreed Stipulation pursuant to which Dr. McDonnell agreed to a binding stipulation with the board that he will not resume the practice of medicine in Texas from the date of his signing the document (August 18, 2006) to November 30, 2006, when his license expires, nor will he ever re-apply for a Texas medical license. The action was based on information as set out in the complaint filed with the State Office of Administrative Hearings relating to the standard of care concerning the indications for and performance

of certain back surgeries performed by Dr. McDonnell. Dr. McDonnell denies he has violated any provisions of the Medical Practice Act.

NETSCHER, DAVID T., M.D., HOUSTON, TX, Lic. #H0091

On June 2, 2006, the Board and Dr. Netscher entered into an Agreed Order assessing an administrative penalty of \$2,500. The action was based on allegations that Dr. Netscher operated for degenerative arthritis on a patient's left ring finger, which did have significant osteoarthritis, rather than the left index finger as planned, with such wrong site surgery being a violation of the standard of care

NOVAK, JACOB JOHN, M.D., FLOWER MOUND, TX, Lic. #K2766

On June 2, 2006, the Board and Dr. Novak entered into an Agreed Order requiring Dr. Novak to complete a course in the area of acute care pediatrics of at least 10 hours and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Novak failed to meet the standard of care in treating a patient's ear infection by prescribing the wrong dosage of one of two antibiotics administered/prescribed, not recording the prescribed antibiotics in the patient's medical record, and failing to take a full set of vital signs.

OBUKOFE, CHRISTIE EMUOBO, M.D., HOUSTON, TX, Lic. #J3566

On August 25, 2006, the Board and Dr. Obukofe entered into a three-year Agreed Order requiring that her practice be monitored by another physician; that she complete 15 hours of continuing medical education in the area of management of high-risk obstetrical patients; and that she obtain and maintain board certification from the American College of Obstetrics and Gynecology. The action was based on allegations that Dr. Obukofe failed to meet the standard of care in treating one patient during pregnancy and labor and delivery, and for not more aggressively obtaining urine samples from another patient, which may have provided more timely detection of gestational diabetes.

PERRY, THOMAS CLEMENT, M.D., SOUR LAKE, TX, Lic. #K6233

On August 25, 2006, the Board and Dr. Perry entered into a three-year Agreed Order requiring that his practice be monitored by another physician for one year; that he complete 20 hours of continuing medical education each year in the areas of record-keeping, infectious disease, neurology, and pediatrics; and assessing an administrative penalty of \$3,000. The action was based on allegations that Dr. Perry failed to meet the standard of care in his treatment of three emergency room patients, two in 1999 and one in 2001.

PORTER, CLARENCE MILTON, M.D., SAN ANTONIO, TX, Lic. #F3292

On August 25, 2006, the Board and Dr. Porter entered into a two-year Agreed Order requiring that he complete a total of 20 hours of continuing medical education in emergency medicine, surgical medicine and medical records in each year of the order; and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Porter failed to meet the standard of care because he did not follow through on abnormal laboratory results by contacting the patient's surgeon directly or sending the patient to the surgeon's office.

RANELLE, ROBERT GEORGE, D.O., FORT WORTH, TX, Lic. #H3598

On August 25, 2006, the Board and Dr. Ranelle entered into a three-year Agreed Order requiring Dr. Ranelle to obtain a written consultation from a board certified orthopedic or neurologic surgeon before performing non-emergent spine surgery; requiring that his practice be monitored by another physician; requiring him to complete eight hours of continuing medical education in medical records and 20 hours in spine topics in each year of the order; and assessing an administrative penalty of \$15,000. The action was based on allegations that Dr. Ranelle's notes did not contain adequate information to justify the anterior/posterior fusion from L4 to S1 with decompression that he performed on the patient, and that his post-operative notes do not adequately document the patient's progress.

SERRANO, JUAN HERNAN, M.D., HOUSTON, TX, Lic. #E3766

On June 2, 2006, the Board and Dr. Serrano entered into a three-year Agreed Order publicly reprimanding Dr. Serrano; requiring his practice to be monitored by another physician; requiring that he complete at least 10 hours of courses in each of gynecological surgical complications and medical records; and assessing an administrative penalty of \$3,000. The action was based on allegations that Dr. Serrano failed to meet the standard of care in evaluating and treating two patients, one of whom was determined during surgery to be pregnant, before performing hysterectomies.

SHAHAR, JULIO, M.D., HOUSTON, TX, Lic. #H6954

On June 2, 2006, the Board and Dr. Shahar entered into an Agreed Order requiring Dr. Shahar to complete courses in pulmonology, radiology, and intensive care of at least 20 total hours in duration. The action was based on allegations that Dr. Shahar failed to meet the standard of care because of his delay in diagnosing and correcting a pneumothorax.

SOMMER, RAYMOND L., M.D., BARTONVILLE, TX, Lic. #F2026

On August 25, 2006, the Board and Dr. Sommer entered into an Agreed Order requiring Dr. Sommer to complete 10 hours of continuing medical education in each of the areas of medical records and cardiac care, and assessing an administrative penalty of \$2,500. The action was based on allegations that Dr. Sommer failed to meet the standard of care in treating a patient who presented to the emergency room for chest pain radiating to her left arm.

SPANN, SCOTT WEAVER, M.D., AUSTIN, TX, Lic. #K1685

On June 2, 2006, the Board and Dr. Spann entered into an Agreed Order requiring Dr. Spann to complete 10 hours of continuing medical education in risk management and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Spann performed arthroscopic surgery on the wrong knee, thereby violating the standard of care.

TALMAGE, EDWARD ARTHUR, M.D., HOUSTON, TX, Lic. #D2722

On June 2, 2006, the Board and Dr. Talmage entered into an Agreed Order whereby the board accepted the voluntary and permanent surrender of Dr. Talmage's medical license. During the pendency of two board investigations involving allegations that Dr. Talmage had not met the standard of care in caring for several patients with complaints of chronic pain, Dr. Talmage permanently retired from the practice of medicine and has no desire to contest the board's allegations, preferring to voluntarily surrender his medical license.

VAVRIN, CHARLES RICHARD, M.D., ARLINGTON, TX, Lic. #D1510

On August 25, 2006, the Board and Dr. Vavrin entered into an Agreed Order requiring Dr. Vavrin to complete 10 hours of continuing medical education in wound infection treatment and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Vavrin failed to meet the standard of care by not appropriately evaluating a post-operative wound infection in one patient in 2000.

VICTORES, RUBEN DARIO, M.D., BEAUMONT, TX, Lic. #H9727

On August 25, 2006, the Board and Dr. Victores entered into an Agreed Order requiring Dr. Victores to complete 40 hours of continuing medical education divided among the subject areas of high-risk obstetrics, post-operative management and record-keeping, and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Victores failed to meet the standard of care in his performance of gynecological surgery for two patients and failed to appropriately document an indication for a vacuum procedure for a third.

WADE, DEAN EDWARD, M.D., DALLAS, TX, Lic. #F5789

On June 2, 2006, the Board and Dr. Wade entered into an Agreed Order requiring Dr. Wade to complete a course in interventional anesthetic techniques of at least 15 hours, and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Wade failed to meet the standard of care by failing to confirm preoperatively the placement of a central venous line.

WHITE, ROBERT FRANK, M.D., MOUNT VERNON, TX, Lic. #C7159

On August 25, 2006, the Board and Dr. White entered into an Agreed Order requiring Dr. White to arrange to "shadow" for 10 days in their offices each of the following board certified specialists of his choosing: a rheumatologist, an allergist or otolaryngologist with an allergy practice, and a pain management specialist. The action was based on reports from Dr. White's practice monitor that identified potential continuing problems in his treatment of patients with potential rheumatoid arthritis, with allergy/ear, nose and throat symptoms and/or pain management needs.

WILGERS, KENNETH DOUGLAS, M.D., BEAUMONT, TX, Lic. #K7946

On August 25, 2006, the Board and Dr. Wilgers entered into an Agreed Order requiring that he complete 10 hours of continuing medical education in the areas of treatment of infection, treatment of drug overdose, and medical records/risk management, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Wilgers failed to meet the standard of care in evaluating and treating three emergency room patients, although the board found that all three cases were very complicated and that Dr. Wilgers demonstrated a good knowledge and understanding of emergency room medicine.

ZEID, YASSER FAHMY, M.D., HENDERSON, TX, Lic. #K3545

On August 25, 2006, the Board and Dr. Zeid entered into an Agreed Order requiring him to complete 10 hours of continuing medical education in high risk delivery/difficult delivery, and assessing an administrative penalty of \$2,500. The action was based on allegations that Dr. Zeid failed to meet the standard of care in that he did not recognize the severity of a fetal compromise, which resulted in delay in delivery.

UNPROFESSIONAL OR DISHONORABLE CONDUCT VIOLATIONS:

BARNETT, MARCUS DUANE, M.D., HOUSTON, TX, Lic. #H9773

On August 25, 2006, the Board and Dr. Barnett entered into an Administrative Agreed Order assessing an administrative penalty of \$250. The action was based on allegations that Dr. Barnett failed to report a misdemeanor arrest on his 2005 annual registration.

BEAR, RONALD LYNN, M.D., SAN ANTONIO, TX, Lic. #BP20020214

On August 25, 2006, the Board and Dr. Bear entered into an Agreed Order revoking Dr. Bear's board permit. The action was based on allegations that Dr. Bear was suspended from his residency program and later resigned from the residency program.

BRINK, RONALD H., M.D., MONTGOMERY, TX, Lic. #G2332

On August 25, 2006, the Board and Dr. Brink entered into an Agreed Order restricting his medical license by prohibiting him from supervising or delegating medical acts, medical services or prescriptive authority. The action was based on allegations that Dr. Brink aided and abetted the practice of medicine by a person not licensed to practice medicine, delegated professional medical responsibility or acts to an unqualified person, and failed to adequately supervise those acting under his supervision.

COLTMAN, CHARLES ARTHUR, M.D., SAN ANTONIO, TX, Lic #E9547

On August 25, 2006, the Board and Dr. Coltman entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Coltman self-prescribed various non-narcotic medications without maintaining a medical record.

DESRUISSEAU, PAUL WINTLE, M.D., HOUSTON, TX, Lic. #G1885

On August 25, 2006, the Board and Dr. Desruisseaux entered into an Administrative Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Desruisseaux failed to provide full and correct information in his 2005 online license renewal application because he paid insufficient attention to the application, which was completed by his staff.

EILERS, EMILY ARLENE, M.D., SAN ANTONIO, TX, Lic. #K2897

On August 25, 2006, the Board and Dr. Eilers entered into an Agreed Order requiring that she complete 10 hours of continuing medical education in the area of ethics; that she complete a board-approved course in anger management; and assessing an administrative penalty of \$2,500. The action was based on allegations that Dr. Eilers failed to report on her 2004 annual registration application that she had been arrested in 2003 for assault and driving while intoxicated and had pled guilty to disorderly conduct in relation to that incident.

FABRE, LOUIS FERNAND, M.D., HOUSTON, TX, Lic. #D5986

On October 6, 2006, the Board and Dr. Fabre entered into a Mediated Agreed Order publicly reprimanding Dr. Fabre and requiring that he have an independent protocol supervisor and have all research protocols approved by two institutional review boards; that he complete courses of at least 10 hours in each of medical records and risk management, and assessing an administrative penalty of \$5,000. Dr. Fabre performs medication clinical trials for pharmaceutical companies. The action was based on

allegations of failure to supervise adequately the activities of those acting under his supervision during a clinical trial for the drug Clozaril for which Dr. Fabre enlisted V.Z. (deceased), a forty-seven year old male, to participate.

GOODMAN, JOHN WILLIS, M.D., RUSK, TX, Lic. #D2437

On October 6, 2006, the Board and Dr. Goodman entered into an Agreed Order requiring that he have a chaperone in the room any time he performs a physical examination on any patient and prohibiting him from performing genital or rectal examinations. The action was based on allegations that Dr. Goodman conducted inappropriate genital examinations on several inmates in 1998.

JOHNSON, BILL J., M.D., GRAPEVINE, TX, Lic. #F9623

On June 2, 2006, the Board and Dr. Johnson entered into an Agreed Order assessing an administrative penalty of \$3,000. The order was based on allegations that Dr. Johnson's office manager sent out about 40 letters to other office managers and doctors stating that each person who referred someone to the esthetic practice Dr. Johnson had established in his internal medicine clinic would receive a \$50 discount on a future esthetic treatment. Such an offer constitutes a reward to a person for referring patients to Dr. Johnson's practice, which violates the Medical Practice Act. In mitigation, an advertising firm that works with physicians recommended the use of the letter.

LEON, MILTIADIS N., M.D., SAN ANGELO, TX, Lic. #K0890

On June 2, 2006, the Board and Dr. Leon entered into a two-year Mediated Agreed Order requiring Dr. Leon to continue the practice of having female patients who are unaccompanied in the office examined with another person in attendance, to complete a maintaining proper boundaries course sponsored either by Sante or the Center for Professional Health at Vanderbilt University Medical Center and to obtain 10 hours of ethics courses each year for two years. The action was based on unspecified allegations relating to disruptive behavior toward hospital personnel that may be reasonably expected to adversely impact the quality of care rendered to patients.

LEWIS, HAROLD DAVIS, D.O., AUSTIN, TX, Lic. #E6126

On August 25, 2006, the Board and Dr. Lewis entered into a Mediated Agreed Order requiring that he complete 10 hours of continuing medical education in each of the areas of risk management and medical record-keeping, and assessing an administrative penalty of \$1,000. Additionally, if Dr. Lewis resumes participation in a preceptorship program, the order requires that he notify the board and submit documentation of his protocols and procedures for preceptorship participants, and complete a course in the area of preceptorship programs. The action was based on allegations that Dr. Lewis inadequately supervised a third-year medical student assigned to his clinic.

MAESE, FEDERICO, M.D., DALLAS, TX, Lic. #J4319

On October 6, 2006, the Board and Dr. Maese entered into an Agreed Order requiring that he pass the Medical Jurisprudence Examination within one year, that he complete a course in medical office management of at least 20 hours and assessing an administrative penalty of \$2,500. The action was based on allegations that Dr. Maese failed to timely provide triplicate prescriptions to a pharmacy.

RANDELL, DAVID J., D.O., ABILENE, TX, Lic. #H5795

On August 25, 2006, the Board and Dr. Randell entered into a two-year Agreed Order requiring that his practice be monitored by another physician, that he complete 10 hours of continuing medical education in medical record-keeping and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Randell failed to adequately supervise a nurse practitioner.

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

On June 2, 2006, the Board and Dr. Reyes entered into an Agreed Order assessing a \$1,000 administrative penalty. The action was based on allegations that Dr. Reyes distributed an advertisement that included a photograph of an individual who was not identified as a model or an actual patient and also incorrectly referred to cosmetics as a field of medicine, thereby violating board rules relating to false, misleading or deceptive advertising.

SACCO, CHERYL FORBES, M.D., BAY CITY, TX, Lic. #L3211

On August 25, 2006, the Board and Dr. Sacco entered into an Administrative Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Sacco dispensed prescription products (Tenuate) from her office to at least four patients in violation of board rule 169.4.

SUNIO, FORTUNATO O., M.D., DENTON, TX, Lic. #D5646

On October 6, 2006, the Board and Dr. Sunio entered into a Negotiated Agreed Order requiring that he have a chaperone any time he performs a physical examination on a female patient; that he successfully complete the professional boundaries course offered by the Vanderbilt Medical Center for Professional Health or an approved equivalent program; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Sunio did not follow protocol when conducting physical examinations on two teenage patients at Terrell State Hospital.

TAVEAU, H. SPRAGUE, D.O., AMARILLO, TX, Lic. #J0696

On August 25, 2006, the Board and Dr. Taveau entered into an Agreed Order requiring that he present to the board for approval a revised informed consent specifically addressing the use of intravenous colloidal silver; that he become familiar with and comply with all provisions of the board's rules concerning standards for physicians practicing complementary and alternative medicine; that he provide to the board an internal audit concerning his office billing practices for the period November 1, 2005, to May 1, 2006; and assessing an administrative penalty of \$2,500. The action was based on allegations that Dr. Taveau failed to obtain appropriate informed consent from one patient treated with intravenous colloidal silver.

THOMPSON, CHRISTOPHER PAUL, M.D., AUSTIN, TX, Lic. #J4559

On August 25, 2006, the Board and Dr. Thompson entered into an Agreed Order prohibiting him from treating or prescribing to his extended family; requiring that he complete 10 hours of continuing medical education in ethics and medical records; and requiring that he pass the Medical Jurisprudence Examination. The action was based on allegations that Dr. Thompson prescribed numerous medications for his wife over a long period of time without maintaining any medical records concerning the prescriptions.

VANBIBER, RUSSELL CARL, M.D., HOUSTON, TX, Lic. #G5728

On August 25, 2006, the Board and Dr. Vanbiber entered into an Agreed Order requiring Dr. Vanbiber to complete 10 hours of courses in the area of ethics, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Vanbiber was arrested for the felony offense of intoxicated assault with a motor vehicle following an accident. The charge was reduced to the Class A misdemeanor offense of driving while intoxicated, to which Dr. Vanbiber pleaded no contest. There was no evidence suggesting that Dr. Vanbiber has an alcohol abuse problem or had any on-call or other patient-related duties when the incident took place.

NONTHERAPEUTIC PRESCRIBING VIOLATIONS:

CASSELLA, ROBERT R., M.D., CARROLLTON, TX, Lic. #F4784

On August 25, 2006, the Board and Dr. Cassella entered into a Mediated Agreed Order suspending his medical license for 90 days, following which the suspension will be automatically stayed and Dr. Cassella will be placed on probation for 10 years. The order additionally requires that Dr. Cassella obtain an independent forensic evaluation from a board-appointed psychiatrist and undergo any continuing psychiatric care recommended by the evaluating psychiatrist; that he not apply for or obtain controlled substances registration certificates from the Drug Enforcement Administration or the Department of Public Safety without board approval; that he complete 10 hours of continuing medical education in each of the areas of ethics and medical record-keeping; that he pass the Medical Jurisprudence Examination; that he have his practice monitored by another physician; and assessing an administrative penalty of \$500. The action was based on allegations that Dr. Cassella repeatedly prescribed controlled substances to three patients without being able to produce medical records for these patients for substantial portions of the time periods involved. On March 14, 2004, Dr. Cassella voluntarily surrendered his DEA registration to DEA diversion investigators.

FLETCHER, REX ALBERT, M.D., AMARILLO, TX, Lic. #K3187

On August 25, 2006, the Board and Dr. Fletcher entered into an Agreed Order requiring that he complete eight hours of continuing medical education in risk management and four hours in pain management and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Fletcher prescribed narcotic pain medication for a person he knew professionally who was not his patient and for whom he did not keep a medical record.

HEATH, GARY L., M.D., ABILENE, TX, Lic. #F1632

On June 2, 2006, the Board and Dr. Heath entered into a five-year Agreed Order requiring his practice to be monitored by another physician; requiring Dr. Heath to complete the Medical Review Officer certification; requiring him to maintain a file for all prescriptions written for controlled substances and dangerous drugs with addictive potential or potential for abuse; and assessing an administrative penalty of \$15,000. The action was based on allegations that Dr. Heath engaged in nontherapeutic prescribing of opioids to three patients.

MORENO, KILLEEN MOSS, M.D., BALLINGER, TX, Lic. #H0653

On June 2, 2006, the Board and Dr. Moreno entered into a three-year Agreed Order requiring Dr. Moreno's practice to be monitored by another physician and requiring Dr. Moreno to obtain 10 hours of continuing medical education each year in the area of prescribing narcotics and drug-seeking patient behaviors and 10 hours in medical records. The action was based on allegations that Dr. Moreno violated

the Medical Practice Act through her prescribing practice for hydrocodone cough syrup over a period of one year to one patient she knew or should have known was an abuser of narcotics or was a drug seeker.

OKOSE, PETER CHUKWUEMEKA, M.D., FRIENDSWOOD, TX, Lic. #J2714

On August 25, 2006, the Board and Dr. Okose entered into a 10-year Agreed Order publicly reprimanding Dr. Okose; prohibiting him from practicing chronic pain management; limiting his practice to a group or an institutional setting; limiting him to seeing no more than 20 patients per day and 100 patients per week; requiring that he have Schedule II and III drugs eliminated from his controlled substances registration certificates; requiring that his practice be monitored by another physician; requiring that he complete 10 hours of continuing medical education in ethics each year of the order; prohibiting him from supervising a physician assistant or advanced practice nurse; and assessing an administrative penalty of \$14,000. The action was based on allegations that Dr. Okose failed to meet the standard of care in his treatment of 13 patients for chronic pain. Additional allegations were that Dr. Okose prescribed the exact same regimen of medicines to each patient, used preprinted prescription pads for prescribing Lorcet and Soma, charged each patient the same amount, and reported seeing 300 to 400 patients per week. The order supersedes the Agreed Order of Temporary Suspension entered into by the board and Dr. Okose on July 11, 2006.

INAPPROPRIATE CONDUCT INVOLVING PHYSICIAN-PATIENT RELATIONSHIP VIOLATIONS:

DONOVITZ, GARY STEVEN, M.D., ARLINGTON, TX, Lic. #F6580

On October 6, 2006, the Board and Dr. Donovitz entered into an Agreed Order requiring that he 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, and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Donovitz had an affair with a person who was his patient and employee.

HELLER, CARL STUART, M.D., KINGWOOD, TX, Lic. #F8154

On June 2, the Board and Dr. Heller entered into a 10-year Mediated Agreed Order publicly reprimanding Dr. Heller and requiring that he complete courses of at least 20 hours each in pain management and risk management and 10 hours in medical records; prohibiting him from engaging in the practice of pain management, requiring that he complete the "Maintaining Proper Boundaries" course presented by the Center for Professional Health at the Vanderbilt Medical Center or a similar course approved by the executive director of the board; requiring that he maintain adequate medical records on all patient office visits; requiring that his practice be monitored by another physician for a period of five years; requiring that he take and pass the Medical Jurisprudence Examination; prohibiting him from prescribing to family members or other persons with whom he has a personal relationship outside the physician-patient relationship; and assessing an administrative penalty of \$3,000. Additionally, Dr. Heller's license may be immediately suspended if he fails to comply with the terms of the order. The action was based on allegations that Dr. Heller treated a young man, previously homeless, who came to live with him and for whom he became an informal guardian, for complaints including anxiety, depression and chronic pain due to an accident, but did not meet the standard of care in keeping medical records for this treatment. Additional allegations were that Dr. Heller prescribed medications to the young man, who drank alcohol,

that were dangerous to use concurrently with alcohol, and wrote prescriptions for excessive amounts of habit-forming medications and was refilling them early, even though the young man was a known abuser of medications. Dr. Heller also prescribed Fentanyl for the young man for the treatment of pain following dental surgery. The young man was later found dead in Dr. Heller's home from an overdose of Fentanyl. No criminal charges were filed.

HUGHES, DONALD D., M.D., FORT WORTH, TX, Lic. #E8575

On August 25, 2006, the Board entered an order revoking Dr. Hughes' medical license and assessing an administrative penalty of \$55,000 and transcript cost of \$2,397.50. The action followed a hearing by an administrative law judge of the State Office of Administrative Hearings and was based on findings by the administrative law judge that Dr. Hughes committed unprofessional or dishonorable conduct that injured the public, that he became personally and financially involved with a patient, that he engaged in sexual contact with patients, and that he failed to practice medicine in an acceptable manner consistent with public health and welfare. No motion for rehearing was filed with the board; therefore the order dated August 25, 2006, was effective September 25, 2006.

WILSON, PATRICK HENRY, M.D., SAN ANTONIO, TX, Lic. #F2500

On August 25, 2006, the Board and Dr. Wilson entered into an Agreed Order publicly reprimanding Dr. Wilson and requiring that he complete the "Maintaining Proper Boundaries" course offered by the Vanderbilt Medical Center and 10 hours of continuing medical education in ethics. Additionally, Dr. Wilson must have a chaperone present during any examination of a female patient and must have a written consent from a female patient to perform a physical examination not related to the identified surgical site and anesthesia. The action was based on allegations that Dr. Wilson violated the standard of care by performing a breast examination without a documented chaperone present and without having the consent of the patient to perform the examination.

INADEQUATE MEDICAL RECORDS VIOLATIONS:

BANJO, CHAIM, M.D., DALLAS, TX, Lic. #G4442

On August 25, 2006, the Board and Dr. Banjo entered into an Agreed Order requiring that his practice be monitored by another physician for two independent reviews; requiring that he complete 10 hours of continuing medical education in medical record-keeping; requiring that he implement a plan for improving his medical record documentation; and assessing an administrative penalty of \$3,000. The action was based on allegations that, for one patient, Dr. Banjo's medical records appeared to be superficial.

BASATNEH, LUTFI S., M.D., MESQUITE, TX, Lic. #K3984

On August 25, 2006, the Board and Dr. Basatneh entered into an Agreed Order requiring Dr. Basatneh to complete a course in record-keeping of at least 16 hours and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Basatneh failed to meet the standard of care in his treatment of one patient by not ordering a timely MRI of the cervical spine. Dr. Basatneh testified that he recommended the MRI, which the patient refused, but this was not documented.

BURGESSER, MARY FRANCES, M.D., AMARILLO, TX, Lic. #K4005

On October 6, 2006, the Board and Dr. Burgesser entered into an Agreed Order requiring that her practice be monitored by another physician for two years; that she complete a course in medical records; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Burgesser's medical records for her chronic pain patients did not have full information as required for chronic pain patients.

HARE, H. PHILLIP JR., M.D., SAN ANTONIO, TX, Lic. #B9649

On August 25, 2006, the Board and Dr. Hare entered into an Agreed Order requiring that his practice be monitored by another physician for one year and that he complete 10 hours of continuing medical education in record-keeping. The action was based on allegations that Dr. Hare failed to meet the standard of care in treating one patient because of inadequate documentation of her symptoms, the rationale for stopping certain medications, and her mental status on discharge.

MOLIVER, CLAYTON L., M.D., WEBSTER, TX, Lic. #G8291

On August 25, 2006, the Board and Dr. Moliver entered into an Agreed Order requiring that he specifically note the date and time that each medical record is written or dictated, as well as the date and time of any amendment, supplementation, change or correction, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Moliver made amendments, supplements, changes or corrections in one patient's medical record that were not made contemporaneously with the act or observation and that he failed to indicate the time and date of the amendments, supplementations, changes or corrections.

NIKKO, PHAN ANTHONY, M.D., HOUSTON, TX, Lic. #K5639

On October 6, 2006, the Board and Dr. Nikko entered into an Agreed Order requiring that his medical records for the previous quarter be reviewed by another physician; that he complete a course in record keeping/risk management of at least 10 hours; and assessing an administrative penalty of \$1,000. If the monitor report is unfavorable, Dr. Nikko's practice will continue to be monitored quarterly for a period of one year. If the report is favorable, the order will terminate on completion of the course and payment of the penalty. The action was based on allegations that Dr. Nikko failed to appropriately document patient consent and/or discussion of risks and benefits of laser treatment.

PADILLA, MARLON DAYMOND, M.D., DALLAS, TX, Lic. #K2254

On June 2, 2006, the Board and Dr. Padilla entered into an Agreed Order requiring Dr. Padilla to complete at least 20 hours in ethics courses and assessing an administrative penalty of \$6,000. The action was based on allegations that Dr. Padilla failed to properly document follow-up care he provided to patients referred to him by various health care providers.

PHILLIPS, JIM JASON, M.D., CARTHAGE, TX, Lic. #K5658

On August 25, 2006, the Board and Dr. Phillips entered into a three-year Agreed Order requiring that his practice be monitored by another physician; that he prepare a protocol for treating pain patients; that he attend the two-day 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. Phillips failed to meet the standard of care for treating pain for one patient he treated from January, 2002, to July, 2004,

because his medical records did not adequately document the reasons for his prescriptions or support the prescription of many of the drugs prescribed to the patient.

POLSEN, CHARLES GEORGE, M.D., LEAGUE CITY, TX, Lic. #J2902

On August 25, 2006, the Board and Dr. Polsen entered into a one-year Mediated Agreed Order requiring that a portion of his medical charts be monitored by another physician; that he complete 10 hours of continuing medical education in each of the areas of risk management and record keeping; and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Polsen failed to maintain adequate medical records for two patients.

SAVAGE, CYNTHIA CATHRYN ALMY, M.D. (formerly Cynthia Cathryn Almy Howard), HOUSTON, TX, Lic. #J1444

On October 6, 2006, the Board and Dr. Savage entered into an Agreed Order requiring that she complete a course in medical records of at least 20 hours in duration. The action was based on allegations that Dr. Savage failed to document the reason for the delay in transferring a patient to another hospital.

SHAIKH, MUHAMMAD YAQOOB, M.D., HOUSTON, TX, Lic. #K4240

On June 2, 2006, the Board and Dr. Shaikh entered into a three-year Mediated Agreed Order requiring that Dr. Shaikh's practice be monitored by another physician; requiring that Dr. Shaikh attend 10 hours of additional continuing medical education in each of the areas of medical record-keeping and pain management; and requiring that he maintain a logbook of prescriptions written for Schedule II controlled substances. The action was based on allegations that Dr. Shaikh failed to maintain adequate medical records on five pain management patients.

SRUNGARAM, RAMESH K., M.D., SUGAR LAND, TX, Lic. #H1845

On June 2, 2006, the Board and Dr. Srungaram entered into an Agreed Order whereby Dr. Srungaram voluntarily and permanently surrendered his Texas medical license. The action followed allegations that Dr. Srungaram's documentation of patients' medical records did not support that he met the standard of care in determining whether patients were appropriate candidates for bariatric surgery. Dr. Srungaram no longer resides in the United States and does not intend to return to Texas.

THOMAS, FRED C., M.D., DALLAS, TX, Lic. #G1785

On August 25, 2006, the Board and Dr. Thomas entered into a two-year Agreed Order requiring that his practice be monitored by another physician; that he attend the two-day medical record-keeping course offered by the University of California at San Diego Physician Assessment and Clinical Education (PACE) program, or an approved equivalent program; that he complete 10 hours of continuing medical education in risk management each year; and assessing an administrative penalty of \$3,000. The action was based on allegations that the medical records for three of Dr. Thomas' nursing home patients were sparse and illegible and therefore substandard.

TREAT, STEVEN PAUL, D.O., FRISCO, TX, Lic. #L7903

On October 6, 2006, the Board and Dr. Treat entered into an Agreed Order requiring that he complete a course in medical records of at least 10 hours and assessing an administrative penalty of \$1,000. The

action was based on allegations that Dr. Treat failed to maintain adequate medical records for one patient whom he treated in the emergency room.

WELLS, JOHN ARTHUR, M.D., BROWNSVILLE, TX, Lic. #F7294

On August 25, 2006, the Board and Dr. Wells entered into an Agreed Order publicly reprimanding Dr. Wells and requiring that he complete eight hours of continuing medical education in each of the areas of ethics and medical records and assessing an administrative penalty of \$500. The action was based on allegations that, for one patient, Dr. Wells twice failed to provide necessary medical records to an insurance company; consequently the insurance company closed the patient's disability claim due to lack of medical information.

WRIGHT, MARK LEE, M.D., WACO, TX, Lic. #H4810

On August 25, 2006, the Board and Dr. Wright entered into an Administrative Agreed Order assessing an administrative penalty of \$250. The action was based on allegations that Dr. Wright insufficiently documented the basis for his diagnosis of a patient as being drug-seeking and having a borderline personality.

IMPAIRMENT DUE TO PHYSICAL OR MENTAL CONDITION:

ANDREWS, WILLIAM ALAN, M.D., FRIENDSWOOD, TX, Lic. #F6394

On October 6, 2006, the Board and Dr. Andrews entered into an Agreed Order requiring that he obtain a complete evaluation from a board-appointed psychiatrist to assess his fitness to practice medicine in light of his medical problems; that he 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; and assessing an administrative penalty of \$500. The action was based on allegations that Dr. Andrews committed a boundary violation by inquiring about a female patient's marital status and telling her that he would like to socialize with her in the future, and on allegations that Dr. Andrews' medical problems, including depression, anxiety and severe back pain, and the medications prescribed for him for these conditions, may affect his ability to safely practice medicine.

IMPAIRMENT DUE TO ALCOHOL OR DRUGS VIOLATIONS:

BHATELEY, DILEEP CHANDRA, M.D., MARLIN, TX, Lic. #J0919

On August 25, 2006, the Board and Dr. Bhateley entered into a 10-year Agreed Order requiring Dr. Bhateley to 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; obtain an independent forensic evaluation from a board-appointed psychiatrist and undergo any continuing psychiatric care if recommended by the evaluating psychiatrist; participate in the activities of Alcoholics Anonymous; complete 10 hours of continuing medical education in ethics; and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Bhateley pled guilty to the charge of driving under the influence of alcohol in 2003 and was involved in an accident in 2005 that occurred while he was intoxicated. Additionally, Dr. Bhateley did not report his arrest on his application for license renewal.

DERUSHA, MARTIN ALLYN JR., D.O., ARLINGTON, TX, Lic. #K0454

On October 6, 2006, the Board and Dr. Derusha entered into a 10-year Agreed Order suspending his medical license for 90 days and then 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; continue receiving care from his current treating psychiatrist and continue to be monitored by his evaluating psychiatrist; participate in the activities of Alcoholics Anonymous at least five times per week; continue to participate in the activities of a county or state medical society committee on physician health and rehabilitation; and have a practice mentor to meet with him on a monthly basis. The action was based on allegations that Dr. Derusha violated his previous confidential rehabilitation order by consuming alcohol, after which he was arrested for DWI.

CHO, PAUL HENRY, M.D., FORT WORTH, TX, Lic. #L1292

On June 2, 2006, the Board and Dr. Cho entered into an Agreed Order requiring Dr. Cho to abstain from consuming prohibited substances, including alcohol and drugs not prescribed for him; to participate in the board's program for testing for drugs and alcohol; to continue receiving care from his psychiatrist and psychotherapist; and to participate in the activities of Alcoholics Anonymous and/or Narcotics Anonymous. Additionally, Dr. Cho may not reapply for a controlled substance registration from the Drug Enforcement Administration for at least six months and until he obtains approval to reapply from a panel of board representatives. The action was based on allegations Dr. Cho abused and was addicted to Hycodan/hydrocodone cough syrup and had written fraudulent prescriptions to obtain this drug.

GRIFFITH, KARL EDWARD, M.D., DALLAS, TX, Lic. #G5121

On August 25, 2006, the Board and Dr. Griffith entered into a 10-year Agreed Order prohibiting Dr. Griffith from practicing anesthesiology; requiring him to abstain from consuming prohibited substances, including alcohol and drugs not prescribed for him; to participate in the board's program for testing for drugs and alcohol; requiring him to continue receiving care from his current treating psychiatrist at least once every six weeks; and requiring him to participate in the activities of Alcoholics Anonymous. The action was based on Dr. Griffith's self-report to the board of a long history of battling substance abuse.

KOPECKY, CRAIG TINDALL, M.D., SAN ANTONIO, TX, Lic. #K7177

On June 2, 2006, the Board and Dr. Kopecky entered into an Agreed Order suspending Dr. Kopecky's medical license until such time as he appears before the board and demonstrates he is physically, mentally and otherwise competent to safely practice medicine. The action was based on Dr. Kopecky's admission of prior alcohol and drug abuse, including self-prescribing of hydrocodone, and that while his sobriety date is March 17, 2005, he is still struggling with his recovery.

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

On August 25, 2006, the Board and Dr. Kornell entered into a 10-year Agreed Order requiring Dr. Kornell to abstain from consuming prohibited substances, including alcohol and drugs not prescribed for him; to participate in the board's program for testing for drugs and alcohol; to obtain an independent forensic evaluation from a board-appointed psychiatrist and undergo any continuing psychiatric care if recommended by the evaluating psychiatrist; to continue receiving care from his current treating psychiatrist at least once per month; to continue receiving care from his current treating psychotherapist at least once per week; to participate in the activities of Alcoholics Anonymous; and not reapply for his controlled substances registration certificates. The order further requires that Dr. Kornell's practice be monitored by another physician. The action was based on allegations that Dr. Kornell abused alcohol and

narcotic pain relievers, wrote prescriptions in other persons' names for his own use and possessed large amounts of controlled substances at his office and his home.

RAMIREZ, ARACELI, M.D., BROWNSVILLE, TX, Lic. #L3083

On August 25, 2006, the Board and Dr. Ramirez entered into a seven-year Agreed Order restricting her medical license under the following terms and conditions: Dr. Ramirez is required to abstain from consuming prohibited substances, including alcohol and drugs not prescribed for her; to participate in the board's program for testing for drugs and alcohol; to obtain an independent forensic evaluation from a board-appointed psychiatrist and undergo any continuing psychiatric care if recommended by the evaluating psychiatrist; undergo a complete examination by a board certified urologist approved by the board and follow all recommendations for treatment; eliminate Schedule II and III drugs from her controlled substances registration certificates; participate in Alcoholics Anonymous; not practice medicine beyond 30 hours per week; and limit her practice to a group or an institutional setting. Additionally Dr. Ramirez may not supervise a physician assistant or advanced practice nurse. The action was based on allegations that Dr. Ramirez self-prescribed pain medication and wrote prescriptions in the name of family members for pain medication she then took herself. These actions were subsequent to Dr. Ramirez's diagnosis of interstitial cystitis during her residency.

WOODWARD, DEBRA KENNAMER, M.D., KERRVILLE, TX, Lic. #H2360

On August 25, 2006, the Board and Dr. Woodward entered into a 10-year Agreed Order requiring Dr. Woodward to abstain from consuming prohibited substances, including alcohol and drugs not prescribed for her; to participate in the board's program for testing for drugs and alcohol; to obtain an independent forensic evaluation from a board-appointed psychiatrist and undergo any continuing psychiatric care recommended by the evaluating psychiatrist; see a board-approved psychotherapist at least twice each month and continue to participate in the activities of Alcoholics Anonymous and the activities of her county or state medical society committee on physician health and rehabilitation. The action was based on Dr. Woodward's self-reported substance abuse relapse and a prior history of substance abuse and depression.

VIOLATIONS OF PROBATION OR PRIOR ORDERS:

GULDE, ROBERT E., M.D., AMARILLO, TX, Lic. #D0679

On August 25, 2006, the Board entered a Stipulated Cancellation Order canceling Dr. Gulde's medical license for non-payment of his license renewal fees. Dr. Gulde was the subject of a Mediated Agreed Order, effective August 16, 2002, that required him to complete certain amounts of continuing medical education each year. Dr. Gulde did not complete all of the required amounts of continuing medical education.

HUFF, JOHN DAVID SR., M.D., FAIRFIELD, IA, Lic. #D7993

On June 2, 2006, the Board and Dr. Huff entered into an Agreed Order accepting the voluntary and permanent surrender of his medical license. The action was based on Dr. Huff's inability to comply with a previous final order of the board due to financial hardship because he is not currently practicing medicine. The final order followed a hearing at the State Office of Administrative Hearings and prohibited Dr. Huff from practicing ophthalmology or surgery in any form until certain conditions were met, including the payment of a \$29,000 administrative penalty. The final order was based on allegations that Dr. Huff failed to meet the standard of care in performing cataract surgery on four patients.

JOHNSON, TERRY LEE, M.D., WICHITA FALLS, TX, Lic. #J5795

On August 25, 2006, the Board and Dr. Johnson entered into an Agreed Order extending his June 3, 2005, Agreed Order by one year. The action was based on allegations that Dr. Johnson failed to fully comply with the terms of that order in that he did not request required psychiatric reports.

KING, JOHN Q. T. JR., M.D., KATY, TX, LIC. #E2656

On August 25, 2006, the Board entered an order revoking Dr. King's medical license. The action followed a hearing by an administrative law judge of the State Office of Administrative Hearings and was based on findings by the administrative law judge that Dr. King violated the requirements of a previous agreed order Dr. King entered into with the board, by failing to obtain a monitor and by providing false information about his medical practice to a board compliance officer. No motion for rehearing filed with the board; therefore the order dated August 25, 2006, was effective October 5, 2006.

SMITH, FRANK EDWARD, M.D., HOUSTON, TX, Lic. #D1811

On June 2, 2006, the Board and Dr. Smith entered into an Agreed Order making public Dr. Smith's prior confidential non-public rehabilitation order and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Smith had violated his prior order by ingesting alcohol, as evidenced by a positive test for EtG, a derivative of alcohol.

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

On October 6, 2006, the Board and Dr. Weldon entered into a Modified Agreed Order modifying his current board order by adding one provision assessing an administrative penalty of \$500 and a second provision that would result in a 30-day suspension of Dr. Weldon's medical license if he fails to comply with the continuing medical education requirements of his current order. The action was based on allegations that Dr. Weldon failed to timely complete all of the continuing medical education required by his current order.

WOMACK, JAMES CHANSLOR, M.D., NEW BRAUNFELS, TX., Lic. #G8516

On August 25, 2006, the Board and Dr. Womack entered into an Agreed Order of Revocation. The action was based on allegations that Dr. Womack failed to comply with the terms of his probation for substance abuse by writing and filling prescriptions for himself, taking several bottles of narcotic cough medicine from the clinic where he was employed, and having a positive drug screen for meperidine.

ADVERTISING VIOLATIONS:

CARTER, HARVEY LEE III, M.D., DALLAS, TX, Lic. #H1564

On August 25, 2006, the Board and Dr. Carter entered into an Agreed Order assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Carter ran a radio advertisement that was misleading in that it included a claim that a procedure would result in "perfect vision, or better" without including a disclaimer.

LE CONEY, RICHARD HUCHET, M.D., KEMAH, TX, Lic. #F0243

On August 25, 2006, the Board and Dr. Le Coney entered into an Agreed Order assessing an administrative penalty of \$250. The action was based on allegations that Dr. Le Coney advertised that he is board certified by the American Board of Anti-Aging Medicine, a board not recognized by the American Board of Medical Specialties, in violation of board rule 164.4(e).

MULLETT, CHRISTOPHER THOMAS, D.O., CORPUS CHRISTI, TX, Lic. #J8326

On August 25, 2006, the Board and Dr. Mullett entered into an Administrative Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Mullett's employer advertised non-verifiable superiority (that Dr. Mullett and his practice group were the "most highly trained gastroenterologists in the region, trained at the most renowned institutions in America") in violation of board rules.

ROLLINS, KARI LANE, D.O., FORT WORTH, TX, Lic #G1140

On August 25, 2006, the Board and Dr. Rollins entered into an Administrative Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Rollins advertised that she is board certified by the American Board of Holistic Medicine, a board not recognized by the American Board of Medical Specialties, in violation of board rule 164.4(e).

SADANA, AMIT, M.D., TYLER, TX, Lic. #L9880

On August 25, 2006, the Board and Dr. Sadana entered into an Administrative Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Sadana's employer advertised non-verifiable superiority (that Dr. Sadana and his practice group were the "most highly trained gastroenterologists in the region, trained at the most renowned institutions in America") in violation of board rules.

SATTERFIELD, SCOTT THOMAS, M.D., TYLER, TX, Lic. #G0061

On August 25, 2006, the Board and Dr. Satterfield entered into an Administrative Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Satterfield's employer advertised non-verifiable superiority (that Dr. Satterfield and his practice group were the "most highly trained gastroenterologists in the region, trained at the most renowned institutions in America") in violation of board rules.

WILLIAMS, JEFFREY MALCOLM, M.D., TYLER, TX, Lic. #M0310

On August 25, 2006, the Board and Dr. Williams entered into an Administrative Agreed Order assessing an administrative penalty of \$500. The action was based on allegations that Dr. Williams' employer advertised non-verifiable superiority (that Dr. Williams and his practice group were the "most highly trained gastroenterologists in the region, trained at the most renowned institutions in America") in violation of board rules.

OTHER STATES' BOARD ACTIONS:

CHANCELLOR, JONATHAN DRAKE, M.D., TULSA, OK, Lic. #E2506

On August 25, 2006, the Board and Dr. Chancellor entered into an Administrative Agreed Order requiring Dr. Chancellor to comply with the terms of a 2005 order from the Oklahoma State Board of Medical Licensure, and assessing an administrative penalty of \$500. The action was based on the action by the Oklahoma Board that suspended Dr. Chancellor's license for six months and placed him on probation for five years for failing to report a misdemeanor arrest, and on Dr. Chancellor's failure to report his arrest on his 2005 Texas license renewal application, though he did self-report the action of the Oklahoma Board.

HUFFMAN, MICHAEL STEWART, M.D., HOLLIS, NH, Lic. #G8187

On June 2, 2006, the Board and Dr. Huffman entered into an Agreed Order requiring Dr. Huffman to appear before a panel of board representatives to demonstrate his safety and competency to practice medicine before he may practice medicine in Texas. The action was based on action by the New Hampshire Board of Medicine reprimanding Dr. Huffman and requiring him to have his medical care monitored and to participate in continuing medical education. The action of the New Hampshire Board was based on Dr. Huffman's health, his conduct during office visits, and his failure to timely provide medical records.

PEVSNER, PAUL H., M.D., NEW YORK, NY, Lic. #H5655

On August 25, 2006, the Board and Dr. Pevsner entered into an Agreed Order suspending Dr. Pevsner's license until such time as the New Jersey State Board of Medical Examiners probates the suspension of his New Jersey medical license, and assessing an administrative penalty of \$1,000. The action was based on the suspension of Dr. Pevsner's license by the New Jersey Board for two years in April of 2005 for allegedly violating state laws involving the Professional Corporation Act and administrative rules.

ACTIONS BASED ON CRIMINAL CONVICTIONS:

MAUSKAR, ANANT NILKANTH, M.D., HOUSTON, TX, Lic. #E9300

On June 2, 2006, the Board and Dr. Mauskar entered into an Agreed Order suspending Dr. Mauskar's license indefinitely, staying the suspension and placing him on probation under the following terms and conditions: monitoring of his practice by another physician; monitoring of his billing practices by a person experienced in medical billing; no prescribing durable medical equipment or physical therapy; and a limit of 50 patients per day. If Dr. Mauskar is incarcerated his license shall be permanently revoked. The action was based on Dr. Mauskar's conviction in federal court of conspiracy to commit health care fraud and of health care fraud, which conviction is now on appeal.

PEER REVIEW ACTIONS:

VANDERLEE, MARGARET GAIL, M.D., ODESSA, TX, Lic. #F7254

On June 2, 2006, the Board and Dr. Vanderlee entered into an Agreed Order requiring Dr. Vanderlee to comply with Texas Tech's action plan and assessing an administrative penalty of \$2,000. The action was based on allegations of inappropriate statements and inappropriate conduct, relating to a faulty telephone system in the consultation room at Texas Tech University Health Science Center's Obstetrics and Gynecology Clinic, for which Texas Tech took disciplinary action against Dr. Vanderlee.

VOLUNTARY SURRENDERS:

ANTHONY, JAMES WILLIAM, M.D., HOUSTON, TX, Lic. #D7904

On August 25, 2006, the Board and Dr. Anthony entered into an Agreed Order accepting the voluntary and permanent surrender of Dr. Anthony's medical license. The action was based on Dr. Anthony's alleged non-compliance with the rules related to pain management.

DANKS, KELLY RICHARD, M.D., FAYETTEVILLE, AR, Lic. #H7718

On August 25, 2006, the Board and Dr. Danks entered into an Agreed Order pursuant to which the board accepted the voluntary and permanent surrender of Dr. Danks' medical license. Dr. Danks expressed his desire to surrender his medical license due to personal matters and health concerns.

FERNANDEZ, CARLOS H., M.D., HOUSTON, TX, Lic. #D9438

On August 25, 2006, the Board and Dr. Fernandez entered into an Agreed Order pursuant to which the board accepted the voluntary and permanent surrender of Dr. Fernandez's medical license. Dr. Fernandez believed it would be difficult to practice medicine with reasonable skill and safety by reason of illness, and requested that the voluntary and permanent surrender of his license be accepted.

FERNANDEZ-VILA, WILFREDO, M.D., PASADENA, TX, Lic. #D3864

On August 25, 2006, the Board and Dr. Fernandez-Vila entered into a Voluntary Surrender Agreed Order pursuant to which the board accepted the voluntary and permanent surrender of his medical license. Although not actively practicing medicine, Dr. Fernandez-Vila was prescribing medications to himself and family members without maintaining medical records for this action.

JOHNSON, GERALD WAYNE, M.D., HOUSTON, TX, Lic. #D6462

On August 25, 2006, the Board and Dr. Johnson entered into an Agreed Order accepting the voluntary surrender of Dr. Johnson's medical license. The action was based on Dr. Johnson's health issues that are impacting his ability to safely practice medicine. Dr. Johnson's condition appears to be permanent and progressive, but in the event this is determined not to be so, Dr. Johnson may petition the board for re-licensure, subject to his demonstrating to the board he is safe and competent to practice medicine and that he meets all other requirements for re-licensure.

LEW, STEPHANIE FAY, M.D., DALLAS, TX, PIT Permit #30015834

On August 25, 2006, the Board and Dr. Lew entered into an Agreed Order revoking Dr. Lew's physician-in-training permit. The action was based on Dr. Lew's leaving her residency program and her expressed intention not to pursue a career as a physician.

LYNCH, WILSON L., M.D., PORT ARTHUR, TX, Lic. #D6290

On August 25, 2006, the Board and Dr. Lynch entered into an Agreed Order pursuant to which the board accepted the voluntary and permanent surrender of Dr. Lynch's medical license. The action was based on Dr. Lynch's sentencing of 68 months in federal prison for his conviction on three counts of possession of child pornography, possession of a surreptitious surveillance camera, and one count of destroying evidence.

SOROKOLIT, BOB, M.D., FORT WORTH, TX, Lic. #F0010

On August 25, 2006, the Board and Dr. Sorokolit entered into an Agreed Order pursuant to which the board accepted the voluntary surrender of Dr. Sorokolit's medical license. Dr. Sorokolit has ceased practicing medicine due to physical illness and personal life stressors and wishes to retire his license.

MINIMAL STATUTORY VIOLATIONS:

The following licensees agreed to enter into orders with the board for minimal statutory violations.

Ahmad, Mounaf Ghassan, M.D., Lafayette, LA, Lic. #K2395

Ashley, Pamela Kay Obye, M.D., Austin, TX, Lic. #K6439

Bailey, Daniel Earl, M.D., Childress, TX, Lic. #J5537

Boehme, Donna Marie, M.D., San Antonio, TX, Lic. #G8829

Bossolo, Jose Antonio, M.D., Brownsville, TX, Lic. #K8020

Cadena, Antonio, M.D., Del Rio, TX, Lic. #J6360

Carreno-Caceres, Antonio, M.D., Corpus Christi, TX, Lic. #D1397

Cromack, Douglas Ted, M.D., San Antonio, TX, Lic. #J9650

Douglas, Howard Thomas, M.D., Irving, TX, Lic. #F1511

Echols, Ben Harris, M.D., Houston, TX, Lic. #F6227

Farrar, Virginia Faith, D.O., Fort Worth, TX, Lic. #F9409

Galt, Sheryl Dubois, M.D., Kerrville, TX, Lic. #K3733

Giessel, Barton Elgin, M.D., Dallas, TX., Lic. #K7541

Gogel, Brian Matthew, M.D, Dallas, TX, Lic. #K2156

Gustafson, Wesley Clifford, M.D., Houston, TX, Lic. #C9002

Jaffar, Ali, M.D., Amarillo, TX, Lic. #K1843

Koenigsberg, Alan David, M.D., Plano, TX, Lic. #G7837

Korsah, Kenneth N., M.D., Houston, TX, Lic. #E6827

Lawrence, Courtney Nicole, M.D., San Antonio, TX, Lic. #J0059

Mathias, John Robert, M.D., Kenney, TX, Lic. #H5378

Maurer, Frederick S., M.D., Corpus Christi, TX, Lic. #E4895

Meng, Jianhuan, M.D., Plano, TX, Lic. #K6151

Padua, Federico Pasudag, M.D., San Antonio, TX, Lic. #F6062

Payne, Margaret Lee, M.D., Houston, TX, Lic. #G1747

Pilumeli Di Blasi, Tina, M.D., Del Rio, TX, Lic. #L7952

Rao, Seshagiri, M.D., Plano, TX, Lic. #G0803

Riley, Gayle Edith, M.D., Austin, TX, Lic. #H4646

Roff, Nathalie Kim, M.D., Houston, TX, Lic. #J9546

Rossi, Godofredo Martin, M.D., Houston, TX, Lic. #H1199

Roth, Gregory Scott, M.D., San Antonio, TX, Lic. #K1916

Shalit, Moses N., M.D., New York, NY, Lic. #F0308

Ubinas-Brache, Emmanuel E., M.D., Dallas, TX, Lic. #G7732

Wright, James Turner, M.D., McAllen, TX, Lic. #J0379

Physician Assistant

WELBORN, TRACY BRANT, GALVESTON, TX, Lic. #PA02947

On May 19, 2006, the Physician Assistant Board and Tracy Welborn, P.A., entered into an Agreed Rehabilitation Order requiring Mr. Welborn to participate in the board's drug screening program; to continue psychiatric treatment; requiring him to attend Alcoholics Anonymous or Narcotics Anonymous; limiting his practice to a primary practice site where his supervising physician is present; and prohibiting him from having prescriptive authority. The action was based on Mr. Welborn's abuse of hydrocodone and other drugs, his forging of his supervising physician's signature on stolen prescription pads to obtain the drugs, and his placement on deferred adjudication for the felony charge of possession of a controlled substance by fraud.