2005 Press Releases

Wednesday, October 12, 2005

37 Doctors Disciplined
Since its last Board meeting, the Texas Medical Board has taken disciplinary action against 37 licensed physicians, who received one or more of the following actions: one temporary suspension; one temporary restriction; three surrenders/revocations; two suspensions; 18 restrictions; eight public reprimands; and 19 administrative penalties totaling $58,000.

New Licenses Issued
During its October 6-7 Board meeting, the Board approved the licensure applications of 291 physicians.

Proposed rule changes and information about rule development will be issued in a separate release.

Disciplinary Actions
The following are summaries of the Board actions. The full text of the Board orders will be available on the Boards web site at www.tmb.state.tx.us about 10 days after the Board meeting. The orders provide all information that is public regarding the facts of the case and violations of the law.

Open records requests for orders may be made to openrecords@tmb.state.tx.us; media contact Jill Wiggins at (512) 305-7018 or jill.wiggins@tmb.state.tx.us.

Disciplinary Actions
AHRENDT, DEBORAH KAY, M.D., PALESTINE, TX, Lic. #F3697
On October 7, 2005, the Board and Dr. Ahrendt entered into an Agreed Order whereby Dr. Ahrendt voluntarily surrendered her license because of her desire to retire due to poor health.

AMJADI, ROJAN, M.D., HOUSTON, TX, Lic. #J8439
On October 7, 2005, the Board and Dr. Amjadi entered into an Agreed Order assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Amjadi overcharged for providing copies of medical records for one patient and failed to timely respond to a request from the Board for copies of medical records.

BERG, MICHAEL W., M.D., HARLINGEN, TX, Lic. #F3683
On October 7, 2005, the Board and Dr. Berg entered into a Mediated Agreed Order requiring Dr. Berg to attend 10 hours of continuing medical education in the area of geriatric health care issues, to complete The Physician-Patient Communication Course offered by the University of California at San Diego Physician Assessment and Clinical Education (PACE) Program or an equivalent course and to teach a two-hour course on the issue of informed consent by patients and family members. The action was based on allegations that Dr. Berg violated a Board rule by failing to adequately communicate with patients about procedures and the potential risks.

BROWN, DENNIS GRAEME, M.D., HOUSTON, TX, Lic. #E2148
On October 7, 2005, the Board and Dr. Brown entered into an Agreed Order assessing an administrative penalty of $500. The action was based on an action of the Florida Board of Medicine, which assessed an administrative penalty of $1,000. That action was taken because Dr. Brown, in his application for a Florida license in 2004, incorrectly answered a question, thereby failing to disclose that he repeated some courses at the Baylor College of Medicine in 1965.

BRYANT, SULLIVAN ROSS, D.O., DALLAS, TX, Lic. #E2992

On October 7, 2005, the Board and Dr. Bryant entered into a three-year Agreed Order requiring his practice to be monitored by another physician and that he obtain 10 hours of continuing medical education in medical record-keeping. The action was based on allegations that Dr. Bryant failed to maintain an adequate medical record for one patient.

CAPELLO, JUAN J., M.D., BEDFORD, TX, Lic. #D4061
On October 7, 2005, the Board and Dr. Capello entered into a three-year Agreed Order requiring that Dr. Capello limit his practice to a non-surgical practice. The action was based on allegations that Dr. Capello failed to adequately document up to four surgical procedures. Dr. Capello had voluntarily stopped his surgical practice prior to the investigation by the Board.

CRAIN, BURTON JR., M.D., RUSK, TX, Lic. #D0095
On October 7, 2005, the Board and Dr. Crain entered into an Agreed Order whereby Dr. Crain voluntarily surrendered his license due to his age and his desire to retire after a long and distinguished medical career.

DAMLE, JAYANT SHRIPAD, M.D., GRAND FORKS, ND, Lic. #H9316
On October 7, 2005, the Board and Dr. Damle entered into an Agreed Order requiring him to comply with the terms and conditions imposed by the North Dakota Board of Medical Examiners. The action was based on the action of the North Dakota Board in placing Dr. Damle on probation for one year for nontherapeutic prescribing during his care of three patients.

DIAZ, THOMAS EDWARD, M.D., IRVING, TX, Lic. #H4284
On October 7, 2005, the Board and Dr. Diaz entered into an Agreed Order assessing an administrative penalty of $5,000. The action was based on allegations that Dr. Diaz failed to practice medicine in an acceptable professional manner by selling vitamins and supplements to five patients for prevention and longevity health treatments at a profit and prescribing human growth hormone to one female patient for anti-aging effects.

DUNCAN, CHRISTOPHER W., M.D., SAN ANTONIO, TX, Lic. #G3314
On October 7, 2005, the Board and Dr. Duncan entered into an Agreed Order suspending Dr. Duncans license for six months, after which time he may request to have the suspension lifted. If Dr. Duncan presents clear and convincing evidence to the Board that he is able to safely practice medicine, the suspension may be stayed and he may be placed under probation for 15 years under such terms and conditions the Board determines are necessary to adequately protect the public. The Agreed Order further requires Dr. Duncan to abstain from the consumption of alcohol and other prohibited substances as specified in the Order and to be screened for such substances as requested by the Board. The action was based on allegations that Dr. Duncan has used alcohol or drugs in an intemperate manner that could endanger a patients life.

FULP, RAY R. TREY III, D.O., McALLEN, TX, Lic. #J7963
On October 7, 2005, the Board and Dr. Fulp entered into an Agreed Order requiring Dr. Fulp to complete a medical record-keeping course of at least 25 hours and assessing an administrative penalty of $5,000. The action was based on allegations that Dr. Fulp failed to adequately document office visits for four patients.

GARZA, JIM SANTIAGO, M.D., HOUSTON, TX, Lic. #E4347
On October 7, 2005, the Board and Dr. Garza entered into an Agreed Order requiring that Dr. Garzas practice be monitored by another physician for one year, that he complete 10 hours of courses in each of the areas of record-keeping, risk management and patient safety, and assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Garza breached the standard of care when he failed to ensure that he was not narrowing the esophagus during surgery to repair a Zenkers diverticulum.

GIESSEL, BARTON ELGIN, M.D., ENNIS, TX, Lic. #K7541
On October 7, 2005, the Board and Dr. Giessell entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. Giessell failed to timely provide properly requested medical records within 15 business days of receipt of the request.

HASHMI, SHAKEB, M.D., LITTLE ROCK, AR, Lic. #K9562
On October 7, 2005, the Board and Dr. Hashmi entered into an Agreed Order publicly reprimanding Dr. Hashmi, requiring him to attend 20 hours of continuing medical education in ethics and proper patient boundaries and assessing an administrative penalty of $5,000. The action was based on Dr. Hashmi's misdemeanor conviction for simple assault upon a female.

HENRY, CRAIG B., M.D., ARLINGTON, TX, Lic. #H2942
On October 7, 2005, the Board and Dr. Henry entered into an Agreed Order publicly reprimanding Dr. Henry, requiring that his practice be monitored by another physician for one year, that he complete 10 hours of continuing medical education in each of the areas of medical record-keeping and pain management and assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Henry prescribed a course of Lortab to a patient without sufficient clinical indication and without obtaining records from prior treating physicians, and that he additionally prescribed Ambien to this patient, via telephone, without charting any clinical indication for the prescription.

HORAN, JOHN W. P., M.D., NEW BRAUNFELS, TX, Lic. #J1097
On October 7, 2005, the Board and Dr. Horan entered into an Agreed Order assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Horan failed to timely respond to the Board's request for information concerning an active Board investigation.

KNOERR, ALBERT COPELAND, M.D., TATUM, TX, Lic. #D3301
On October 7, 2005,the Board and Dr. Knoerr entered into an Agreed Order whereby the Board accepted the voluntary surrender of Dr. Knoerrs medical license. The action followed allegations that Dr. Knoerr failed to maintain appropriate medical records for four patients.

KOPECKY, CRAIG TINDALL, M.D., SAN ANTONIO, TX, Lic. #K7177
On October 5, 2005, the Board, acting through a disciplinary panel, entered an Order of Temporary Suspension in which Dr. Kopeckys license was temporarily suspended. The action was based on the panels finding that Dr. Kopecky has abused alcohol and controlled substances, has had his privileges revoked at multiple hospitals, has provided false information to the Board and that his continuation in the practice of medicine would constitute a continuing threat to the public welfare.

MAESE, FEDERICO, M.D., DALLAS, TX, Lic. #J4319
On October 7, 2005, the Board and Dr. Maese entered into a one-year Agreed Order requiring Dr. Maeses practice to be monitored by another physician, requiring him to complete 20 hours of continuing medical education in nuclear cardiology and assessing an administrative penalty of $3,000. The action was based on allegations that Dr. Maese failed to practice medicine in an acceptable professional manner when he used a non-standard protocol for a nuclear perfusion stress test for one patient and interpreted the result as abnormal, when in fact the test as performed was of no diagnostic value.

NAKISSA, NASSER, M.D., SAN ANTONIO, TX, Lic. #G6355
On September 12, 2005, the Board and Dr. Nakissa entered into an Agreed Order publicly reprimanding Dr. Nakissa and requiring that his practice be monitored by another physician, that he pass the Medical Jurisprudence Examination within one year, that he complete courses in record-keeping, pain management, treatment of attention deficit disorder in children and dealing with the difficult patient, and that he maintain a logbook of all prescriptions written for controlled substances or dangerous drugs with addictive potential and refrain from the prescription of any drug unless it is medically indicated. The action was based on allegations that Dr. Nakissa failed to timely terminate the physician-patient relationship with five patients, all of whom belonged to the same family, over whom he lacked control over patient compliance, that he prescribed in a nontherapeutic manner to one or more of these patients, including one suspected of drug-seeking behavior, and that he violated Board rules relating to medical records and pain management with respect to the treatment of these patients.

NGUYEN, CO HAI, M.D., CONROE, TX, Lic. #J0157
On October 7, 2005, the Board and Dr. Nguyen entered into an Agreed Order assessing an administrative penalty of $1,000. The action was based on allegations that Dr. Nguyen failed to provide properly requested medical records of one patient within 15 business days of receipt of the request.

NICOLOSI, JOSEPH VINCENT, M.D., ALEDO, TX, Lic. #K3810
On October 7, 2005, the Board and Dr. Nicolosi entered into a one-year Agreed Order requiring Dr. Nicolosi to complete 10 hours of continuing medical education in medical ethics and risk management, to continue receiving care and treatment from his treating psychiatrist no less than one time every other month and assessing as administrative penalty of $5,000. The action was based on Dr. Nicolosis report of an isolated intemperate use of alcohol the evening of October 6, 2004, that resulted in his appearing impaired the following day.

PAYNE, JOHN BRUCE, D.O., COLLEYVILLE, TX, Lic. #H5943
On October 7, 2005, the Board entered a Final Order revoking Dr. Paynes medical license. The action followed a hearing by an administrative law judge of the Texas State Office of Administrative Hearings of the Boards allegations regarding Dr. Paynes treatment of a patient. In its Order the Board accepted the findings of the administrative law judge, including that Dr. Payne performed surgery on a patient based on insufficient diagnostic results, that Dr. Payne prescribed drugs to the patient in a nontherapeutic manner, and that Dr. Payne failed to provide reliable post-surgical coverage for the patient, who subsequently died. Dr. Payne may file a Motion for Rehearing within 20 days of the Order. If a Motion for Rehearing is filed and the Board denies the motion, the Order is final. If a Motion for Rehearing is filed and the Board grants the motion, the Order is not final and a hearing will be scheduled.

PEDRO, STEVEN DOUGLAS, M.D., FORT WORTH, TX, Lic. #D7240
On October 7, 2005, the Board and Dr. Pedro entered into an Agreed Order requiring Dr. Pedro to complete 12 hours of ethics courses and assessing an administrative penalty of $5,000. The action was based on allegations that Dr. Pedro failed to report on his medical license renewal that he had been convicted for violation of the United States banking laws in the United States District Court, Western District of Louisiana on May 19, 1998.

REYNOLDS, IAN JOHN, M.D., WEBSTER, TX, Lic. #F8994
On October 7, 2005, the Board and Dr. Reynolds entered into an Agreed Order publicly reprimanding Dr. Reynolds and assessing an administrative penalty of $500. The action was based on allegations that Dr. Reynolds behaved in an abusive manner toward a patients family member that could be reasonably expected to adversely impact the quality of care rendered to the patient.

ROSE, FRAN JEAN, M.D., IRVING, TX, Lic. #H9704
On October 7, 2005, the Board, acting through a disciplinary panel, entered a Temporary Restriction Order temporarily restricting Dr. Roses license. Under the terms of the Order, Dr. Rose must immediately cease seeing patients for the diagnosis and treatment of any and all thyroid, adrenal and testosterone conditions/disorders and immediately transfer the care and treatment of all such patients to another physician who is trained in endocrinology. The Order also requires Dr. Rose to obtain a complete cardiovascular evaluation and work-up to determine her fitness to continue the practice of medicine. The action was based on allegations that Dr. Rose, in violation of a prior Board order, continued to fail to meet the standard of care in her treatment of endocrine patients, creating a continuing threat to the public welfare. Dr. Rose is also suffering from certain medical conditions that impact her ability to practice medicine.

SHANNON, THOMAS O., M.D., CONROE, TX, Lic. #J5014
On October 7, 2005, the Board and Dr. Shannon entered into an Agreed Order requiring Dr. Shannon to complete 20 hours of continuing medical education in medical record-keeping and risk management and assessing an administrative penalty of $5,000. The action was based on allegations that Dr. Shannons record-keeping and documentation relating to two surgical procedures were deficient.

SMITH, MICHAEL DEAN, M.D., LEAGUE CITY, TX, Lic. #F4545
On October 7, 2005, the Board and Dr. Smith entered into an Agreed Order restricting Dr. Smiths license for 10 years under terms and conditions that require Dr. Smith to abstain from the consumption of alcohol and other prohibited substances as described in the Order; submit to screening for these substances as requested by the Board; continue to receive care and treatment from his treating psychiatrist at least once per month; participate in Alcoholics Anonymous at least five times per week; participate in the activities of his county or state medical society committee on physician health and rehabilitation; refrain from treating his immediate family; and prohibiting him from supervising a physician assistant or advanced nurse practitioner. The action was based on allegations that Dr. Smith relapsed by ingesting a controlled substance without a legitimate prescription after having previously entered into a rehabilitation agreement with the Board.

SOWKA, LAWRENCE ROBERT, M.D., LUBBOCK, TX, Lic. #BP10018709
On October 7, 2005, the Board and Dr. Sowka entered into an Agreed Order assessing an administrative penalty of $3,000. The action was based on allegations that Dr. Sowka failed to report disciplinary action taken by another state and failed to timely respond to the Boards request for information.

SPINKS, DAVID WAYNE, D.O., DEER PARK, TX, Lic. #F4557
On October 7, 2005, the Board and Dr. Spinks entered into a three-year Agreed Order publicly reprimanding Dr. Spinks and requiring that his practice be monitored by another physician, that he refrain from prescription of any drug for any patient unless the drug is medically indicated and is prescribed in therapeutic doses, that he complete an additional 20 hours of continuing medical education each year of the Order, that he submit a complete set of written policies and procedures with regard to the proper procedures for treating employees and for dispensing sample medications, and assessing an administrative penalty of $5,000. The action was based on allegations that Dr. Spinks failed to maintain adequate medical records for three patients, including one with whom he had a personal relationship and to whom he prescribed controlled substances.

TANG, JANNIE, M.D., SACRAMENTO, CA, Lic. #F8699
On October 7, 2005, the Board and Dr. Tang entered into an Agreed Order publicly reprimanding Dr. Tang. The action was based on the public reprimand issued by the Medical Board of California that was based on allegations that Dr. Tang left her anesthetist station for a telephone call while she was responsible for the anesthetic care of a patient undergoing a spinal MRI body scan.

TRAN, THOMAS TUNG, M.D., ALICE, TX, Lic. #J6043
On October 7, 2005, the Board and Dr. Tran entered into an Agreed Order requiring Dr. Tran to obtain 10 hours each of continuing medical education in record-keeping and ethics and assessing an administrative penalty of $3,000. The action was based on allegations that Dr. Tran entered inaccurate information on some emergency room records regarding the time he began his examination of patients and that, in one instance, Dr. Tran did not complete a full physical examination before admitting a patient to ICU for observation for an overdose of drugs.

WELLS, GUY ALAN, M.D., LUBBOCK, TX, Lic. #E9005
On October 7, 2005, the Board and Dr. Wells entered into an Agreed Order assessing an administrative penalty of $500. The action was based on allegations that Dr. Wells failed to provide properly requested medical records of one patient within 15 business days of receipt of the request.

WORRELL, PAUL STEPHEN, D.O., DALLAS, TX, Lic. #F7329
On October 7, 2005, the Board and Dr. Worrell entered into a one-year Agreed Order requiring that Dr. Worrells practice be monitored by another physician; that he not treat his immediate family; that he attend a total of 25 hours of continuing medical education in the areas of ethics, risk management, medical records and prescribing of controlled substances; and assessing an administrative penalty of $3,000. The action was based on allegations that Dr. Worrell prescribed medications, including controlled substances, to family members without appropriate documentation in medical records and that he failed to meet the standard of care in his prescribing controlled substances to family members.

ZEIFMAN, CLAUDE WILLIAM EVRARD, M.D., EVERETT, WA, Lic. #J5072
On October 7, 2005, the Board and Dr. Zeifman entered into an Agreed Order publicly reprimanding Dr. Zeifman. The action was based on the action of the New York State Board for Professional Medical Conduct imposing a censure and reprimand based on criminal misconduct unrelated to the practice of medicine.

ZIMMER, GERALD HARWICK III, M.D., ATHENS, TX, Lic. #J8853
On October 7, 2005, the Board and Dr. Zimmer entered into an Agreed Order suspending Dr. Zimmers license until such time as he provides clear and convincing evidence to the Board that he is physically, mentally and otherwise competent to safely practice medicine. The action was based on allegations that Dr. Zimmer exhibited drug-seeking behavior and failed to appropriately treat a lesion on a patients head that was later determined to be positive for basal cell carcinoma.

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

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

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

Open records requests for orders may be made to

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