Texas Medical Board
News Release
FOR IMMEDIATE RELEASE
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Medical Board Disciplines a Record 99 Doctors
Since its last Board meeting in June, the Texas Medical Board has taken disciplinary action against 99 licensed physiciansthe largest number of actions taken at any single time in the board's history.

Actions included 24 violations based on quality of care; 12 actions based on unprofessional conduct; three actions based on nontherapeutic prescribing; two actions based on inappropriate conduct involving physician-patient relationships; eight actions based on inadequate medical records; five actions based on impairment due to alcohol or drugs; four actions based on violations of probation or prior orders; seven actions based on advertising violations; two actions based on other state board actions; eight voluntary surrenders; and 24 minimal statutory violations. Administrative penalties totaling $153,250 were assessed.

New Licenses Issued
The board also issued a record number of licenses at the August 24-25 meeting, a total of 894, more than 2½ times the average of the previous five board meetings in Fiscal Year 2006.

Rule Changes
The Board adopted the following proposed rule changes that were published in the *Texas Register:*
Chapter 165, Medical Records, amendments to 165.1 Medical Records and 165.6 Medical Records Regarding an Abortion on an Unemancipated Minor.

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

The Board adopted the following emergency rule:
Chapter 163, Licensure regarding new §163.14 Interpretation of Section 1.51(d), S.B. 419 relating to exam attempt requirements for those applicants in TMB Licensure system as of August 31, 2005.

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

Chapter 163, to include amendments to §163.2, Full Texas Medical License, §163.5, Licensure Documentation, and §163.6, Examinations Accepted for Licensure

Chapter 170, proposed amendments to include repeal of Chapter 170, Authority of Physician to Prescribe for the Treatment of Pain and New Chapter 170, Pain Management.

Chapter 172, to include new §172.14, Temporary and Limited Licenses to include the addition of a Limited License for Practice of Administrative Medicine.

Chapter 190, Disciplinary Guidelines, proposed amendments to §190.8, Violation Guidelines to include standards for Medical Directors.

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

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

QUALITY OF CARE VIOLATIONS:

- **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.
- **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 and 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.
- **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 area 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. #K 2865**
  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.
- **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.
- **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 excluding 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.

- **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 surgery was performed.
- **LONIAN, ROBERT DUKE, M.D., PLANO, 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 complete10 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.
- **MARK F. MCDONNELL, 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.
- **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.
- **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.
- **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.
- **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 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.
- **DESRUISSEAUX, 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.
- **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.
- **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.

- **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.
- **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.

- **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

- **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. Dr. Hughes may file a motion for rehearing within 20 days of the entering of the order by the Board. If a motion for rehearing is filed and the Board denies the motion, the order is final. If the Board grants the motion for rehearing, the order is not final and a hearing will be scheduled.
- **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. Bastaneh 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.
- **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.
- **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.
- **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.
- **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 ALCOHOL OR DRUGS:

- **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.
- **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.
- **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; 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 Respondent'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 ORDER:

- **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.
- **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. Dr. King may file a motion for rehearing within 20 days of the entering of the order by the Board. If a motion for rehearing is filed and the Board denies the motion, the order is final. If the Board grants the motion for rehearing, the order is not final and a hearing will be scheduled.
- **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 he was board certified in anti-aging medicine although he was not.

- **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.
- **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.

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 such as failure to send medical records within 15 business days or failure to complete required continuing medical education.

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

Cadena, Antonio, M.D., Del Rio, TX, Lic. #J6360
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
Giessel, Barton Elgin, M.D., Dallas, TX., Lic. #K7541
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
Padua, Federico Pasudag, M.D., San Antonio, TX, Lic. #F6062
Payne, Margaret Lee, M.D., Houston, TX, Lic. #G1747
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
Ubinas-Brache, Emmanuel E., M.D., Dallas, TX, Lic. #G7732
Wright, James Turner, M.D., McAllen, TX, Lic. #J0379

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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.