

## Texas Medical Board Press Release

**FOR IMMEDIATE RELEASE**

**February 25, 2013**

**Media contact: Leigh Hopper, 512-305-7018**

**Customer service: 512-305-7030 or 800-248-4062**

### **TMB adopts rule changes, disciplines 53 physicians at February meeting**

At its February 7-8, 2013 meeting, the Texas Medical Board disciplined 53 licensed physicians and issued one cease and desist order. The disciplinary actions included one automatic suspension, eight voluntary surrenders/revocations and nineteen orders related to quality-of-care violations.

The Board issued 81 physician licenses at the February board meeting, bringing the total number of physician licenses issued in FY 13 to 1,228. Thirty-two percent of physician licensure applications were completed in 10 days or less.

### **RULE CHANGES ADOPTED**

**General Provisions: §161.3** establishes that board members may not appear at disciplinary or licensure hearings on behalf of licensure applicants or licensees and may not submit a written statement on behalf of a licensee or applicant unless the member receives preapproval from the board's executive committee.

**Licensure: §163.2** permits applicants who graduated from U.S. medical schools that were not LCME-accredited at time of graduation to remain eligible for licensure if board certified; and the amendment clarifies that residency training will not be counted toward the three-year service requirement for applicants who are not U.S. citizens or aliens lawfully admitted for permanent residence, unless the residency training was in a medically underserved area or health professional shortage area.

**Probationer Show Compliance Proceedings: §187.44** establishes a five calendar-day deadline for probationer rebuttal material.

**Office-Based Anesthesia:** Amendment to **§192.1** revises the definitions of analgesics, anesthesia, anesthesia services, anxiolytics, Level IV services, and monitored anesthesia care; and adds definitions for hypnotics, peripheral nerve block and tumescent anesthesia. Amendment to **§192.2** revises the requirements for Level I, II, and III services, for necessary emergency equipment, and reporting to the board of intraoperative and postoperative deaths.

**Pain Management Clinics:** Amendment to **§195.2** provides that if an applicant for a pain management clinic certificate is under investigation by the Board, then a decision on the applicant's initial application will not be decided upon until the investigation is closed.

## **DISCIPLINARY ACTIONS**

### **QUALITY OF CARE**

#### **Benavides, Richard Alex, M.D., Lic. No. F9189, Dallas**

On February 8, 2013, the Board and Richard Alex Benavides, M.D., entered into an Agreed Order requiring Dr. Benavides to complete within one year 24 hours of CME including 16 hours in medical record-keeping and eight hours in risk management and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Benavides failed to meet the standard of care and was disciplined by his peers for failure to maintain adequate and timely medical records.

#### **Brooks, George Alfred, M.D., Lic. No. G4862, Humble**

On February 8, 2013, the Board and George Alfred Brooks, M.D., entered into an Agreed Order publicly reprimanding Dr. Brooks and requiring Dr. Brooks to cease treating chronic pain patients, surrender his DEA and DPS controlled substance certificates, within one year complete 24 hours of CME including eight hours in medical record-keeping, eight hours in identifying drug-seeking behavior and eight hours in risk management and pay an administrative penalty of \$10,000 within 90 days. The Board found Dr. Brooks failed to meet the standard of care and non-therapeutically prescribed controlled substances to multiple patients.

#### **Butka, Gary N., M.D., Lic. No. G6479, Brownwood**

On February 8, 2013, the Board and Gary N. Butka, M.D., entered into an Agreed Order requiring Dr. Butka to have his practice monitored by another physician for four monitoring cycles, pass within one year and within three attempts the Medical Jurisprudence Exam, complete within one year 24 hours of in-person CME including eight hours in pharmacology, eight hours in pain medication and eight hours in medical record-keeping, and pay an administrative penalty of \$2,000 within 180 days. The Board found Dr. Butka failed to meet the standard of care, nontherapeutically prescribed and failed to maintain adequate medical records.

#### **Cordas, Stevane, D.O., Lic. No. D5368, Hurst**

On February 8, 2013, the Board and Stevane Cordas, D.O., entered into a Mediated Agreed Order requiring Dr. Cordas to within one year complete 38 hours of CME, including 15 hours in physician examinations, 15 hours in breast cancer evaluation and treatment, and eight hours in risk management, and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Cordas failed to practice medicine in an acceptable, professional manner. The order resolves a formal complaint filed at the State Office of Administrative Hearings.

#### **Diaz, Ricardo, M.D., Lic. No. J0474, Dallas**

On February 8, 2013, the Board and Ricardo Diaz, M.D., entered into an Agreed Order requiring Dr. Diaz to within one year complete the Maintaining Proper Boundaries course offered by the Center for Professional Health through Vanderbilt University Medical Center, within one year and within three attempts pass the Medical Jurisprudence Exam and within one year complete four hours of CME in medical record-keeping. The Board found Dr. Diaz became personally involved with a patient in an inappropriate manner, inappropriately

prescribed dangerous drugs to someone with whom he had a personal relationship and failed to maintain adequate medical records.

**Fraser, Michael Patrick, D.O., Lic. No. H8051, Dallas**

On February 8, 2013, the Board and Michael Patrick Fraser, D.O., entered into an Agreed Order publicly reprimanding Dr. Fraser and requiring Dr. Fraser to, within 90 days, submit to the Board the name of a neurologist who can evaluate Dr. Fraser regarding his hand tremors and potential impact on his ability to safely practice medicine. In addition, Dr. Fraser must cease treating any chronic pain patients, surrender his DEA and DPS controlled substance certificates, within one year and within three attempts pass the Medical Jurisprudence Exam, have another physician monitor his practice for 12 monitoring cycles, within one year complete the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, and within one year complete eight hours of CME in identifying drug-seeking behavior. In addition, Dr. Fraser must dictate all medical progress notes and other medical documentation and pay an administrative penalty of \$10,000 within six months. The Board found Dr. Fraser, in the case of six patients, failed to maintain adequate medical records regarding the treatment of chronic pain, failed to meet the standard of care and non-therapeutically prescribed drugs.

**Grant, Paul A., M.D., Lic. No. E7608, Fort Worth**

On February 8, 2013, the Board and Paul A. Grant, M.D., entered into an Agreed Order requiring Dr. Grant to have another physician monitor his practice for 12 monitoring cycles, complete within one year 16 hours of CME including four hours in medical records, four hours in drug interactions and eight hours in pain management. The Board found Dr. Grant failed to meet the standard of care, failed to maintain adequate medical records and failed to safeguard against potential complications.

**Hitt, David Michael, D.O., Lic. No. E7981, Grapevine**

On February 8, 2013, the Board and David Michael Hitt, D.O., entered into an Agreed Order requiring Dr. Hitt to complete within one year 14 hours of CME including eight hours in medical record-keeping and six hours in risk management and pay an administrative penalty of \$2,000 within 90 days. The Board found Dr. Hitt failed to meet the standard of care in his treatment of one patient and failed to maintain adequate medical records.

**Hussian, Mohammed, M.D., Lic. No. K4920, Houston**

On February 8, 2013, the Board and Mohammed Hussian, M.D., entered into an Agreed Order requiring Dr. Hussian to have another physician monitor his practice for eight monitoring cycles, complete within two years eight hours of CME in medical record-keeping, eight hours in risk management, eight hours in treatment of psychiatric disorders and 16 hours in pain management. In addition, Dr. Hussain must pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Hussian failed to use proper diligence in his practice and violated Board rules regarding medical records and pain management guidelines.

**Landry, Robert Kieth, Jr., M.D., Lic. No. L8405, Cleveland**

On February 8, 2013, the Board and Robert Kieth Landry, Jr., M.D., entered into an Agreed Order requiring Dr. Landry to complete within one year five hours of in-person CME in recognition and treatment of sepsis, five

hours of in-person CME in critical care and five hours of CME in risk management. The Board found Dr. Landry failed to meet the standard of care in his treatment of one patient.

**Nutis, Mario, M.D., Lic. No. L5854, El Paso**

On February 8, 2013, the Board and Mario Nutis, M.D., entered into an Agreed Order requiring Dr. Nutis to have another physician monitor his practice for eight monitoring cycles, complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, complete within one year 16 hours of CME including management and treatment of high-risk obstetric patients and eight hours in risk management. The Board found Dr. Nutis behaved in an abusive manner towards a patient, failed to meet the standard of care and failed to maintain adequate medical records.

**Olusola, Benedict Oladipo, M.D., Lic. No. J7118, Desoto**

On February 8, 2013, the Board and Benedict Oladipo Olusola, M.D., entered into an Agreed Order requiring Dr. Olusola to complete within six months the clinical competence assessment, including Phase I and Phase II, offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program and complete any recommended retraining and remedial measures. In addition, Dr. Olusola must remove any reference to board certification in cosmetic surgery and wound care from his web site; complete within one year eight hours of CME in risk management and ethics; and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Olusola failed to release medical records in a timely manner, failed to practice medicine in an acceptable, professional manner, failed to meet the standard of care and used false or misleading advertising.

**Osborne, John Andrew, M.D., Lic. No. K4180, Grapevine**

On February 8, 2013, the Board and John Andrew Osborne, M.D., entered into an Agreed Order requiring Dr. Osborne to have another physician monitor his practice for eight monitoring cycles and pay an administrative penalty of \$3,000 within six months. The Board found Dr. Osborne failed to meet the standard of care, engaged in unprofessional conduct and failed to adequately supervise those acting under his supervision.

**Patel, Pinakin R., M.D., Lic. No. J2727, Houston**

On February 8, 2013, the Board and Pinakin R. Patel, M.D., entered into an Agreed Order requiring Dr. Patel to pass within one year and within three attempts the Medical Jurisprudence Exam, have another physician monitor his practice for eight monitoring cycles, complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, complete within one year eight hours of CME in identifying drug-seeking behavior and pay an administrative penalty of \$12,000 within six months. The Board found Dr. Patel failed to meet the standard of care, non-therapeutically prescribed hydrocodone-based cough syrup to a female patient over a prolonged period of time, continued to prescribe despite signs the patient was addicted, non-therapeutically prescribed the same formulations to the patient's mother and two sons and failed to maintain adequate medical records.

**Phillips, Gregory K., M.D., Lic. No. H6511, Roanoke**

On February 8, 2013, the Board and Gregory K. Phillips, M.D., entered into an Agreed Order permanently restricting Dr. Phillips to administrative medicine and prohibiting him from any practice of medicine that involves direct or indirect patient contact. The Board found Dr. Phillips failed to use diligence in his professional practice, engaged in non-therapeutic prescribing and is unable to safely practice medicine due to a physical condition. This order supersedes all existing actions taken by the Board against Dr. Phillips.

**Powell, Bethany Elise, M.D., Lic. No. L3073, Galveston**

On February 8, 2013, the Board and Bethany Elise Powell, M.D., entered into an Agreed Order requiring Dr. Powell to provide a copy of this order to her treating psychotherapist within 30 days, maintain a quarterly logbook of all prescriptions for Schedule II and III controlled substances for one year, have her practice monitored by another physician for four monitoring cycles, pass within one year and within three attempts the Medical Jurisprudence Exam, complete within one year 16 hours of CME including eight hours in risk management and eight hours in ethics and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Powell failed to meet the standard of care and inappropriately prescribed dangerous drugs or controlled substances to a male patient to whom she was married at the time and who was a known abuser of drugs.

**Rousch, Daniel Eric, D.O., Lic. No. J4488, Bedford**

On February 8, 2013, the Board and Daniel Eric Rousch, D.O., entered into an Agreed Order requiring Dr. Rousch to have his practice monitored by another physician for 12 monitoring cycles, complete within one year 44 hours of CME including 24 hours in pediatric bipolar disorder, eight hours in medical record-keeping and 12 hours in monitoring for adverse effects of drug interactions, and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Rousch failed to meet the standard of care and non-therapeutically prescribed psychotropic medications to two minor patients.

**Surapaneni, Veena, M.D., Lic. No. K6938, Cedar Park**

On February 8, 2013, the Board and Veena Surapaneni, M.D., entered into an Agreed Order requiring Dr. Surapaneni to have another physician monitor her practice for eight monitoring cycles, complete within one year 32 hours of CME including eight hours in treating ADHD in adults, eight hours in risk management and eight hours in treating psychiatric disorders and pay an administrative penalty of \$3,000 within 90 days. The Board Found Dr. Surapaneni failed to meet the standard of care and wrote prescriptions for a known abuser of dangerous drugs.

**Villacres, David F., M.D., Lic. No. H7099, Kingwood**

On February 8, 2013, the Board and David F. Villacres, M.D., entered into an Agreed Order requiring Dr. Villacres to refrain from serving as a physician for his immediate family, and refrain from prescribing controlled substances to himself or his immediate family. In addition, Dr. Villacres must pass within one year and within three attempts the Medical Jurisprudence Exam, complete within one year 16 hours of CME including eight hours in medical record-keeping and eight hours in ethics and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Villacres violated Board guidelines for the treatment of chronic

pain, failed to use diligence in his professional practice, and non-therapeutically prescribed controlled substances and failed to maintain adequate medical records in his treatment of himself and family members.

## **SUSPENSION**

### **Smith, Michael Dean, M.D., Lic. No. F4545, South Padre Island**

On January 25, 2013, a disciplinary panel of the Texas Medical Board entered an Automatic Suspension Order regarding Michael Dean Smith, M.D., requiring Dr. Smith to immediately cease practicing as a physician in Texas. The Board found Dr. Smith violated his 2008 Order as modified in 2010 when he was observed by multiple persons consuming alcohol in public after relapsing into opiate dependency. Dr. Smith remains suspended until he requests in writing to have the suspension stayed or lifted, and personally appears before the Board and provides evidence and information that proves, at the discretion of the Board, that he is in compliance with all terms and conditions of his 2008 Order, as subsequently modified.

## **OTHER STATES' ACTION**

### **Dunnington, David Arthur, M.D., Lic. No. F1518, Arlington WA**

On February 8, 2013, the Board and David Arthur Dunnington, M.D., entered into an Agreed Order requiring Dr. Dunnington to comply with the terms and conditions imposed by the State of Washington Department of Health Medical Quality Assurance Commission. The Board found Dr. Dunnington was disciplined in Washington for non-therapeutic prescribing of pain medications to two patients.

### **Eniola, Razaak Alabi, M.D., Lic. No. K4416, Berlin MD**

On February 8, 2013, the Board and Razaak Alabi Eniola, M.D., entered into an Agreed Order publicly reprimanding Dr. Eniola. The Board found Dr. Eniola was the subject of disciplinary action by the Virginia Board of Medicine for failure to adequately evaluate and diagnose a patient.

### **Konasiewicz, Stefan J., M.D., Lic. No. K2517, El Paso**

On February 8, 2013, the Board and Stefan J. Konasiewicz, M.D., entered into an Agreed Order requiring Dr. Konasiewicz to complete within one year 16 hours of CME including eight hours in medical record-keeping and eight hours, to be attended in-person, in the subject of risk management. The Board found Dr. Konasiewicz was disciplined by the Minnesota Board of Medical Practice, and failed to safeguard against potential complications, but that he met the standard of care in his treatment of two of the patients in question.

### **Morrison, David Gay, M.D., Lic. No. H9468, New Orleans LA**

On February 8, 2013, the Board and David Gay Morrison, M.D., entered into an Agreed Order requiring Dr. Morrison to cease practicing medicine in Texas until he provides clear and convincing evidence and information that he is competent to safely practice medicine, including proof that he has satisfied the terms and conditions of the Alabama Remediation Program and has been re-licensed to practice medicine in Alabama. The Board found Dr. Morrison was disciplined by the Alabama State Board of Medical Examiners.

### **Reyes, Robert Raymond, M.D., Lic. No. H8955, McAllen**

On February 8, 2013, the Board and Robert Raymond Reyes, M.D., entered into an Agreed Order requiring Dr. Reyes to complete within one year eight hours of CME in ethics and complete within one year and within

three attempts the Medical Jurisprudence Exam. The Board found Dr. Reyes failed to notify the Board of a disciplinary action taken against him by the Colorado Medical Board.

**Samuels, Todd Louis, M.D., Lic. No. TM00330, Leesburg VA**

On February 8, 2013, the Board and Todd Louis Samuels, M.D., entered into an Agreed Order requiring Dr. Samuels to complete within one year eight hours of CME in medical record-keeping and pay an administrative penalty of \$500 within 60 days. The Board found Dr. Samuels failed to meet the standard of care, failed to use diligence in his medical practice and was disciplined by another state.

**Siddiqui, Abdul Sami Fawad, Lic. No. N4748, Las Vegas NV**

On February 8, 2013, the Board and Abudul Sami Fawad Siddiqui, M.D., entered into an Agreed Order publicly reprimanding Dr. Siddiqui and requiring Dr. Siddiqui to complete within one year six hours of CME in medical record-keeping. The Board found Dr. Siddiqui was disciplined by the Nevada State Board of Medical Examiners.

**Walker, Bradley Steven, M.D., Lic. No. J3648, Garden Grove CA**

On February 8, 2013, the Board and Bradley Steven Walker, M.D., entered into an Agreed Order requiring Dr. Walker to pass within one year and within three attempts the Medical Jurisprudence Exam, complete within one year eight hours of CME in ethics and pay an administrative penalty of \$500 within 60 days. The Board found Dr. Walker was disciplined by medical boards in Idaho, California, Nevada and New York.

**VOLUNTARY SURRENDER/REVOCAATION**

**Cherian, Francis, M.D., Lic. No. F8052, Houston**

On February 8, 2013, the Board and Francis Cherian, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Cherian voluntarily surrendered his Texas medical license and agreed not to petition the Board for reinstatement for two years, in lieu of further disciplinary proceedings. Dr. Cherian was under investigation by the Board related to his prescribing practices. In addition, Dr. Cherian admits he is impaired by a mental or physical condition that renders him unable to practice medicine at this time.

**Graham, Akili, M.D., Lic. No. K7161, Houston**

On February 8, 2013, the Board and Akili Graham, M.D., entered into an Agreed Order of Voluntary Revocation, revoking Dr. Graham's license and requiring him to immediately cease practicing medicine. The Board found Dr. Graham failed to meet the standard of care.

**Melcher, Stephen Francis, M.D., Lic. No. J0120, Sacramento CA**

On February 8, 2013, the Board and Stephen Francis Melcher, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Melcher agreed to surrender his license and cease practicing in Texas in lieu of further disciplinary proceedings. The Board found Dr. Melcher was convicted in a California court for commission of a lewd and lascivious act on an 11-year-old child.

**Ogin, Gary Arthur, M.D., Lic. No. G9176, Southlake**

On February 8, 2013, the Board and Gary Arthur Ogin, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Ogin agreed to voluntarily and permanently surrender his medical license and cease practicing medicine in Texas. The Board found Dr. Ogin non-therapeutically prescribed medications, including controlled substances, to 19 patients.

**Perry, Thomas Clement, M.D., Lic. No. K6233, Sour Lake**

On February 8, 2013, the Board and Thomas Clement Perry, M.D., entered into an Agreed Order of Voluntary Revocation in which Dr. Perry's license was revoked and Dr. Perry was ordered to immediately cease practice in Texas. The Board found Perry is unable to practice medicine because of a medical condition.

**Roman, Ernest, M.D., Lic. No. H6938, Spring**

On February 8, 2013, the Board and Ernest Roman, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Roman voluntarily and permanently surrendered his Texas medical license. Dr. Roman must immediately cease practice in Texas. Dr. Roman was under investigation by the Board for alleged improper operation of a pain management clinic. This order resolves any and all complaints currently before the Board.

**Scroggins, Timothy Allen, M.D., J4506**

On February 8, 2013, the Board and Timothy Allen Scroggins, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Scroggins agreed to voluntarily and permanently surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Scroggins asked to surrender his medical license due to disciplinary actions in another state.

**Smith, Charles Thomas, M.D., Lic. No. F0679**

On February 8, 2013, the Board and Charles Thomas Smith, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Smith voluntarily and permanently surrendered his Texas medical license. The Board found Dr. Smith is not currently practicing medicine due to physical impairment.

**UNPROFESSIONAL CONDUCT**

**Cwikla, Mark Joseph, M.D., Lic. No. F3838**

On February 8, 2013, the Board and Mark Joseph Cwikla, M.D., entered into an Agreed Order requiring Dr. Cwikla to within one year complete the anger management course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, within one year and within three attempts pass the Medical Jurisprudence Exam, and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Cwikla engaged in disruptive behavior and was disciplined by peers.

**Rodriguez-Salinas, Filiberto, M.D., Lic. No. G4201**

On February 8, 2013, the Board and Filiberto Rodriguez-Salinas, M.D., entered into an Agreed Order requiring Dr. Rodriguez-Salinas, M.D., to complete within one year four hours of CME in interpersonal communication and pay an administrative penalty of \$500 within 60 days. The Board found Dr. Rodriguez-Salinas behaved in a disruptive manner toward a nurse.



## **VIOLATION OF PRIOR ORDER**

### **Do, Phu M., M.D., Lic. No. L2224,**

On February 8, 2013, the Board and Phu M. Do, M.D., entered into an Agreed Order Modifying Dr. Do's 2011 Agreed Order, requiring Dr. Do to complete within 18 months at least eight hours of CME in risk management and eight hours in identifying and treating surgical complications, and pay an administrative penalty of \$5750 within 16 months. All other terms and conditions of the 2011 order remain in force. The Board found Dr. Do failed to comply with his 2011 order.

### **McBath, J. Mark, M.D., Lic. No. G8265**

On February 8, 2013, the Board and J. Mark McBath, M.D., entered into an Agreed Order requiring Dr. McBath to pass within one year and within three attempts the Medical Jurisprudence Exam or face immediate suspension. In addition, McBath must complete within one year eight hours of CME in ethics and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. McBath failed to complete CME required by a previous board order.

### **Roberts, Dennis Donald, M.D., Lic. No. M6362, Woodville**

On February 8, 2013, the Board and Dennis Donald Roberts, M.D., entered into an Agreed Order publicly reprimanding Dr. Roberts and requiring Dr. Roberts to undergo an independent medical evaluation by a psychiatrist, follow all recommendations by the psychiatrist for care and treatment, and appear before the board to address issues related to Dr. Roberts' compliance with this order. In addition, Dr. Roberts' 2008 order, as modified in 2010, remains in full force and is not superseded by this order. The Board found Dr. Roberts tested positive for a prohibited substance.

### **Weaver, Harry T., Jr., M.D., Lic. No. H4784, Levelland**

On February 8, 2013, the Board and Harry T. Weaver, Jr., M.D., entered into an Agreed Order requiring Dr. Weaver to complete within six months five hours of CME including three hours in risk management and two hours in ethics. The Board found Dr. Weaver failed to complete CME in anger management required by his 2011 order. This order supersedes Dr. Weaver's 2011 Order.

## **IMPAIRMENT**

### **Moran, Cynthia Hartmann, M.D., Lic. No. H3251, Houston**

On February 8, 2013, the Board and Cynthia Hartmann Moran, M.D., entered into an Agreed Order lifting Dr. Moran's July 2012 Temporary Suspension and requiring Dr. Moran to limit her practice to an approved, group or institutional setting; pass within one year and within three attempts the Medical Jurisprudence Exam; submit to an evaluation by the Physician Health Program within 30 days; complete within one year 24 hours of CME including eight hours in medical record-keeping, eight hours in physician-patient boundaries and eight hours in risk management. The Board found Dr. Moran engaged in unprofessional conduct, used drugs in an intemperate manner and inappropriately prescribed to herself.

## **PEER REVIEW ACTION**

### **Gross, Robert Hadley, M.D., Lic. No. G5125, San Angelo**

On February 8, 2013, the Board and Robert Hadley Gross, M.D., entered into a Mediated Agreed Order requiring Dr. Gross to within 90 days have his practice evaluated by the Texas Medical Association's Practice Counseling Services with a specific emphasis on billing and coding, risk management and operational assessment; and within one year complete 18 hours of CME including 10 hours in risk management, four hours in medical coding and four hours in medical billing. The Board found Dr. Gross failed to adequately supervise the activities of those acting under his supervision, was subject to disciplinary action by peers and failed to maintain adequate medical records. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

### **Hamid, Bassam Ahmad, M.D., Lic. No. J8261, Baytown**

On February 8, 2013, the Board and Bassam Ahmad Hamid, M.D., entered into a Mediated Agreed Order requiring Dr. Hamid to complete within one year the TMB Remedial Coaching Program at the U.T. Dallas School of Management. The Board found Dr. Hamid engaged in disruptive behavior and had his hospital privileges revoked. The order resolves a formal complaint filed at the State Office of Administrative Hearings.

## **TEXAS ELECTRONIC DEATH REGISTRY VIOLATIONS**

### **Attar, Mohammed, M.D., Lic. No. E5344**

On February 8, 2013, the Board and Mohammed Attar, M.D., entered into an Agreed Order requiring Dr. Attar to complete within one year four hours of CME in ethics and/or risk management and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Attar failed to utilize the Texas Electronic Death Registry to file the death certificate of one patient and failed to respond to Board requests for information.

### **McFarland, Michael Alan, M.D., Lic. No. G8271**

On February 8, 2013, the Board and Michael Alan McFarland, M.D., entered into an Agreed Order requiring Dr. McFarland to complete within one year eight hours of CME in risk management and pay an administrative penalty of \$500 within 60 days. The Board found Dr. McFarland failed to timely certify a death certificate using the Texas Electronic Death Registry.

## **NONTHERAPEUTIC PRESCRIBING**

### **Kopecky, Charles Rayner, M.D., Lic. No. H0532**

On February 8, 2013, the Board and Charles Rayner Kopecky, M.D., entered into an Agreed Order publicly reprimanding Dr. Kopecky and requiring Dr. Kopecky to cease serving as a physician to his immediate family, pass within one year and within three attempts the Medical Jurisprudence Exam, complete 16 hours of CME including eight hours in risk management and eight hours in ethics and pay an administrative penalty of \$3,000 within 180 days. The Board found Dr. Kopecky non-therapeutically prescribed to a family member and did not maintain an adequate medical record.

### **Murchison, Ira Odell, D.O., Lic. No. F9861**

On February 8, 2013, the Board and Ira Odell Murchison, D.O., entered into an Agreed Order publicly reprimanding Dr. Murchison and requiring Dr. Murchison to refrain from treating immediate family with

controlled substances or dangerous drugs with addictive potential, pass within one year and within three attempts the Medical Jurisprudence Exam, complete within one year 24 hours of CME including 16 hours in ethics and eight hours in medical record-keeping. The Board found Dr. Murchison inappropriately prescribed, engaged in unprofessional conduct and failed to maintain adequate medical records.

#### **INADEQUATE SUPERVISION**

##### **Tanhui, Eduardo Sy, M.D., Lic. No. K4263, Nacogdoches**

On February 8, 2013, the Board and Eduardo Sy Tanhui, M.D., entered into a Agreed Order requiring Dr. Tanhui to pass within one year and within three attempts the Medical Jurisprudence Exam, complete within one year 28 hours of CME including 12 hours in supervision and delegation, eight hours in risk management and eight hours in ethics, and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Tanhui presigned prescription forms for controlled substances, failed to supervise adequately those acting under his supervision and delegating and delegated professional medical responsibility to an unqualified person.

#### **CRIMINAL BEHAVIOR**

##### **Molina, Julio Cesar, M.D., Lic. No. H5010**

On February 8, 2013, the Board and Julio Cesar Molina, M.D., entered into an Agreed Order requiring Dr. Molina to submit to an evaluation by the Physician Health Program within 30 days, pass within one year and within three attempts the Medical Jurisprudence Exam, complete within one year eight hours of CME in ethics and pay an administrative penalty of \$5,000 within 60 days. The Board found Dr. Molina failed to report to the Board his arrest and conviction in 2008 for DWI and his arrest for assault and public intoxication in 2011.

#### **INADEQUATE MEDICAL RECORDS**

##### **Chuong, Tony Tuan, M.D., Lic. No. K3136**

On February 8, 2013, the Board and Tony Tuan Chuong, M.D., entered into an Agreed Order requiring Dr. Chuong to complete within one year 15 hours of CME including 10 hours in treatment of hepatitis and five hours in risk management, pay an administrative penalty of \$1,500 within 90 days and within 60 days correct his medical record documentation to include a section for "lab, x-ray and other." The Board found Dr. Chuong failed to maintain an adequate medical record or use diligence in his treatment of one patient.

##### **Locke, James Perry, M.D., Lic. No. K4489**

On February 8, 2013, the Board and James Perry Locke, M.D., entered into an Agreed Order requiring Dr. Locke to complete within one year 18 hours of CME including 10 hours in geriatric medicine and eight hours in medical record-keeping. The Board found Dr. Locke failed to use diligence and failed to maintain medical records. This order resolves a formal complaint at the State Office of Administrative Hearings.

#### **CEASE AND DESIST**

##### **Santillan, Claudia, No License, Grand Prairie**

On February 8, 2013, the Board and Claudia Santillan entered into an Agreed Cease and Desist Order prohibiting Ms. Santillan from acting as or holding herself out to be a licensed physician in Texas. The Board

found Ms. Santillan examined an adult female and indicated that the individual had a urinary tract infection or a tumor. The individual was in fact pregnant.

Texas Medical Board Press Release  
FOR IMMEDIATE RELEASE  
April 1, 2013

Media contact: Leigh Hopper, 512-305-7018  
Customer service: 512-305-7030 or 800-248-4062

## **TMB suspends Austin psychiatrist**

On March 29, 2013, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the medical license of David Williams Cardwell, M.D., of Austin, after determining that Dr. Cardwell poses a continuing threat to the public welfare.

The Board found Dr. Cardwell, a psychiatrist, was arrested and charged with felony sexual assault on March 7, 2013.

In January 2013, Dr. Cardwell invited a longtime patient to his office for the purpose of evaluating her on a different dose or type of medication. While at the clinic, Dr. Cardwell gave the patient two pills which the patient reported made her feel groggy. Dr. Cardwell then is alleged to have sexually assaulted the patient.

The suspension requires Dr. Cardwell to immediately cease practicing medicine. A temporary suspension hearing with notice will be held as soon as practicable with 10 days' notice to Dr. Cardwell, unless the hearing is specifically waived by Dr. Cardwell. The suspension remains in effect until the Board takes further action.

Texas Medical Board Press Release  
FOR IMMEDIATE RELEASE  
April 8, 2013

Media contact: Leigh Hopper, 512-305-7018  
Customer service: 512-305-7030 or 800-248-4062

## **TMB suspends physician and Houston pain clinics**

On March 29, 2013, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the medical license of Subramaniam V. Ramanathan, M.D., as well as the certificates of two Houston pain clinics operated by Dr. Ramanathan.

The Board determined that Dr. Ramanathan poses a continuing threat to the public welfare due to his violation of a previous order.

In December 2012, the Board entered an Agreed Order of Temporary Restriction, with Dr. Ramanathan's consent, which required Dr. Ramanathan to cease treating chronic pain patients. In addition, the order barred him from supervising or delegating prescriptive authority to physician extenders, required him to surrender his DPS and DEA controlled substance certificates and required him to surrender his pain management clinic certificates.

The Board found Dr. Ramanathan has not surrendered his pain management clinic certificates and that his controlled substances registration is still active. As recently as March 10, 2013, Dr. Ramanathan was still issuing prescriptions for controlled substances.

A temporary suspension hearing with notice will be held as soon as practicable with 10 days' notice to Dr. Ramanathan, unless the hearing is specifically waived by Dr. Ramanathan. The suspension remains in effect until the Board takes further action.

###

Texas Medical Board Press Release  
FOR IMMEDIATE RELEASE  
April 8, 2013

Media contact: Leigh Hopper, 512-305-7018  
Customer service: 512-305-7030 or 800-248-4062

## **TMB finds Bellaire doctor a "continuing threat"**

On April 5, 2013, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the medical license of Owen Surgent Maat, M.D., of Bellaire after determining that Dr. Maat's continuation in the practice of medicine would constitute a continuing threat to the public welfare.

The Board determined that Dr. Maathas been practicing medicine under an impairment due to the intemperate use of alcohol.

A temporary suspension hearing with notice will be held as soon as practicable with 10 days' notice to Dr. Maat, unless the hearing is specifically waived by Dr. Maat. The suspension remains in effect until the Board takes further action.

###

**Texas Medical Board Press Release**

**FOR IMMEDIATE RELEASE**

**April 16, 2013**

**Media contact: Leigh Hopper, 512-305-7018**

**Customer service: 512-305-7030 or 800-248-4062**

## **TMB suspends Houston doctor operating pain clinic**

On April 10, 2013, a disciplinary panel of the Texas Medical Board temporarily suspended, with notice, the Texas medical license of Chau Doan Khuu, M.D., of Houston, after determining that Dr. Khuu posed a continuing threat to the public welfare.

The order requires Dr. Khuu to immediately cease practicing medicine in Texas.

On October 25, 2012, Board staff in conjunction with the Drug Enforcement Administration executed a search warrant at Life's Good Medical Clinic in Houston, where Dr. Khuu was employed.

Evidence obtained at the clinic demonstrated Dr. Khuu improperly and illegally operated the pain clinic, failed to properly supervise those acting under his supervision and inappropriately prescribed controlled substances.

The temporary suspension remains in place until the Board takes further action.

**# # #**



**Texas Medical Board Press Release**  
**FOR IMMEDIATE RELEASE**  
**April 23, 2013**

**Media contact: Leigh Hopper, 512-305-7018**  
**Customer service: 512-305-7030 or 800-248-4062**

## **TMB adopts rule changes, disciplines 39 physicians at April meeting**

At its April 11-12, 2013 meeting, the Texas Medical Board disciplined for 39 licensed physicians and issued three cease and desist orders. The disciplinary actions included one revocation, six voluntary surrenders/revocations, five orders related to unprofessional conduct, 12 orders related to quality-of-care violations, one order due to impairment, four based on other states' actions, two related to peer review actions, two related to non-therapeutic prescribing, three related to inadequate medical records and three related to violations of other Board rules.

The Board issued 192 physician licenses at the April board meeting, bringing the total number of physician licenses issued in FY 13 to 1,972. Thirty-six percent of physician licensure applications were completed in 10 days or less.

### **RULE CHANGES ADOPTED**

**Chapter 163. LICENSURE:** Amendment to **§163.6**, concerning Examinations Accepted for Licensure, revises the rule related to licensure examinations so that the rule is consistent with the statute requiring passage of licensure examinations within a seven-year time period.

Amendment to **§163.7**, concerning the 10-year rule for applicants who have not passed a licensure examination listed in **§163.6**, adds the practice of medicine for at least six months under a faculty temporary license as a substitute for specialty certification.

**Chapter 172. TEMPORARY AND LIMITED LICENSES:** Amendment to **§172.8**, concerning Faculty Temporary Licenses, clarifies that time spent under a Faculty Temporary License (FTL) may satisfy the 10-year rule requirement for specialty training.

**Chapter 175. FEES AND PENALTIES:** Amendment to **§175.5**, concerning Payment of Fees or Penalties, provides that if an applicant or licensee dies more than 90 days after having paid a fee, the applicant's survivors may submit a written request for a refund demonstrating good cause for a prorated refund.

**Chapter 187. PROCEDURAL RULES:** Amendment to **§187.57**, concerning the Charge of the Disciplinary Panel, corrects a typographical error in the rule that was adopted previously by the Board.

**Chapter 196. VOLUNTARY RELINQUISHMENT OR SURRENDER OF A MEDICAL LICENSE:** Amendment to **§196.2**, concerning Surrender Associated with Disciplinary Action, corrects the language of the rule to indicate that a licensee may agree to surrender license in lieu of further investigation or hearing.

**Chapter 197. EMERGENCY MEDICAL SERVICE:** Amendment to **§197.3**, concerning Off-line Medical Directors, provides that a physician may not be an off-line medical director if the physician has been suspended or revoked for cause by any governmental agency or the physician has been excluded from Medicare, Medicaid, or CHIP.

## **DISCIPLINARY ACTIONS**

### **QUALITY OF CARE**

#### **Battle, Clinton Charles, M.D., Lic. No. F1368, Fort Worth**

On April 12, 2013, the Board and Clinton Charles Battle, M.D., entered into an Agreed Order publicly reprimanding Dr. Battle and requiring Dr. Battle to have his practice monitored by another physician for four monitoring cycles, complete within one year 16 hours of CME including eight hours in medical record-keeping and eight hours in risk management and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Battle failed to meet the standard of care, failed to maintain adequate medical records and engaged in unprofessional conduct.

#### **Blackwell, Michael Lee, M.D., Lic. No. J3695, Tomball**

On April 12, 2013, the Board and Michael Lee Blackwell, M.D., entered into an Agreed Order requiring Dr. Blackwell to within one year complete 12 hours of CME including four hours in surgical safety checklists and eight hours in MRI examination of the knee and pay an administrative penalty of \$500 within 60 days. The Board found Dr. Blackwell failed to exercise proper diligence and to document fully his findings and rationale for treatment.

#### **Boswell, James Lewis, II, M.D., Lic. No. N2958, Corpus Christi**

On April 12, 2013, the Board and James Lewis Boswell, II, M.D., entered into a Mediated Agreed Order requiring Dr. Boswell to within one year complete 24 hours of in-person CME including eight hours in ethics, eight hours in risk management and eight hours in physician-patient boundaries, and pay an administrative penalty of \$5,000 within 60 days. The Board found Dr. Boswell failed to meet the standard of care, prescribed dangerous drugs or controlled substances without first establishing a proper professional relationship with a patient, prescribed without performing a proper physical exam or creating and maintaining adequate medical records. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

#### **Canadas-Zizzias, Rafael, M.D., Lic. No. K1382, Dallas**

On April 12, 2013, the Board and Rafael Canadas-Zizzias, M.D., entered into a Mediated Agreed Order publicly reprimanding Dr. Canadas-Zizzias and requiring Dr. Canadas-Zizzias to within one year complete eight hours of CME in medical record-keeping and pay an administrative penalty of \$5,000 within 60

days. The Board found Dr. Canadas-Zizzias prescribed controlled substances to a patient with whom he was romantically involved without any corresponding medical records. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Chatha, Rupinder Kaur, M.D., Lic. No. J6374, Houston**

On April 12, 2013, the Board and Rupinder Kaur Chatha, M.D., entered into an Agreed Order requiring Dr. Chatha to pass within one year and within three attempts the Medical Jurisprudence Exam, complete within one year eight hours of CME including four hours in ethics and four hours in treatment of chronic pain. The Board found Dr. Chatha improperly prescribed controlled substances to a family member without maintaining adequate medical records.

**Curvin, Thomas Joseph, M.D., Lic. No. H8616, Cedar Park**

On April 12, 2013, the Board and Thomas Joseph Curvin, M.D., entered into a Mediated Agreed Order requiring Dr. Curvin to have his practice monitored by another physician for eight monitoring cycles, refrain from serving as a physician to persons with whom he has a close personal relationship, within one year pass the Medical Jurisprudence exam within three attempts and within one year complete an eight-hour review course for the American Board of Emergency Medicine Certification Exam. The Board found Dr. Curvin violated the standard of care regarding nine patients, failed to maintain adequate medical records and prescribed medications in a non-therapeutic manner, including controlled substances, to a person with whom he had a close personal relationship. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Gonino, V. John, D.O., Lic. No. J2032, Rockwall**

On April 12, 2013, the Board and V. John Gonino, M.D., entered into a Mediated Agreed Order requiring Dr. Gonino to within one year attend and participate in a nationally or internationally recognized conference for integrative medicine which includes 17 hours of CME, revise his disclosure and consent forms, within one year pass the Medical Jurisprudence Exam within three attempts, within one year complete the medical record-keeping course offered by the University of California San Diego PACE program, and within one year complete 16 hours of CME including eight hours in billing and eight hours in ethics. The Board found Dr. Gonino failed to adequately supervise those acting under his supervision, violated Board rules related to the practice of alternative and complementary medicine and inappropriately prescribed to others in which there was a close personal relationship. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Guerrero, Jorge, M.D., Lic. No. G8154, Houston**

On April 12, 2013, the Board and Jorge Guerrero, M.D., entered into an Agreed Order publicly reprimanding Dr. Guerrero and requiring Dr. Guerrero to pass the Medical Jurisprudence Exam within one year and within three attempts, within one year complete 44 hours of CME including 24 hours in ethics, 12 hours in medical record-keeping and eight hours in physician-patient boundaries and pay an administrative penalty of \$5,000 within 90 days. The Board found Dr. Guerrero failed to meet the standard of care in his treatment of seven athletes competing in boxing and submitted falsified lab results to the Texas Department of Licensing and Regulation on behalf of the patients.

**Hugg, Terry Wayne, M.D., Lic. No. F7677, Houston**

On April 12, 2013, the Board and Terry Wayne Hugg, M.D., entered into a Mediated Agreed Order requiring Dr. Hugg to cease treating patients for chronic pain, refer all pain patients to appropriate practitioners, have his practice monitored by another physician for 12 monitoring cycles, within one year complete 16 hours of CME including eight hours in medical record-keeping and eight hours in contraindications and side effects of commonly prescribed medications and pay an administrative penalty of \$1,000 within 120 days. The Board found Dr. Hugg violated Board guidelines for the treatment of chronic pain, failed to use diligence in his professional practice and non-therapeutically prescribed medications. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Moolamalla, Praveen, M.D., Lic. No. K3346, McKinney**

On April 12, 2013, the Board and Praveen Moolamalla, M.D., entered into an Agreed Order requiring Dr. Moolamalla to have another physician monitor his practice for eight monitoring cycles, within one year complete 16 hours of CME including eight hours in pharmacology and eight hours in medical record-keeping and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Moolamalla failed to meet the standard of care, non-therapeutically prescribed drugs and failed to follow guidelines for treatment of chronic pain.

**Torres, Frank, M.D., Lic. No. L1483, San Benito**

On April 12, 2013, the Board and Frank Torres, M.D., entered into an Agreed Order requiring Dr. Torres to refrain from treating chronic pain patients and treat patients for acute pain only, within one year pass the Special Purpose Examination within three attempts, within one year complete the medical record-keeping course offered by the University of California San Diego PACE program, within one year complete 32 hours of CME including eight hours in diagnosing adult ADHD, eight hours of diagnosing ADHD to be taken in person, eight hours in chronic pain management and eight hours in psychopharmacology, and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Torres failed to meet the standard of care, failed to safeguard against potential complications, failed to adhere to guidelines for prescription of pain medications and prescribed to a known abuser of controlled substances.

**Weldon, Lloyd Kent, D.O., Lic. No. E6947, Fort Worth**

On April 12, 2013, the Board and Lloyd Kent Weldon, M.D., entered into a Mediated Agreed Order publicly reprimanding Dr. Weldon and requiring Dr. Weldon to within seven days request modification of his DEA/DPS controlled substance registrations to eliminate Schedule II controlled substances, refrain from treating chronic pain patients, cease administering office-based anesthesia, within one year pass the Special Purpose Examination within three attempts and within one year complete 30 hours of CME in medical record-keeping. The Board found Dr. Weldon failed to adopt chart monitor recommendations as stipulated by a previous order, failed to meet the standard of care and failed to comply with Board rules regarding office-based anesthesia. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

## **UNPROFESSIONAL CONDUCT**

### **Biggers, Jerel Raymond, D.O., Lic. No. G2646, Dallas**

On April 12, 2013, the Board and Jerel Raymond Biggers, D.O., entered into an Agreed Order requiring Dr. Biggers to have his billing and medical records reviewed for two years by an independent auditor, within one year complete 16 hours of CME including eight hours in medical record-keeping and eight hours in billing/coding. The Board found Dr. Biggers submitted improper bills and did not have adequate medical record documentation to support his billing for services

### **Cantu, Philip Martinez, M.D., Lic. No. K2865, Orange**

On April 12, 2013, the Board and Philip Martinez Cantu, M.D., entered into an Agreed Order requiring Dr. Cantu to pass the Medical Jurisprudence Exam within one year and within three attempts, within one year complete the professional boundaries course offered by the University of California San Diego PACE program or an approved equivalent course and complete within one year eight hours of CME in ethics. The Board found Dr. Cantu became involved with a patient in an inappropriate manner.

### **Novoa, Julio Cesar, Jr., M.D., Lic. No. K8386, El Paso**

On April 12, 2013, the Board and Julio Cesar Novoa, Jr., M.D., entered into an Agreed Order requiring Dr. Novoa to within one year pass the Medical Jurisprudence Exam within three attempts, within one year complete 16 hours of CME including eight hours in physician-patient boundaries and eight hours in medical record-keeping. The Board found Dr. Novoa performed surgery on his employees, failed to document appropriate surgical follow-up for eight patients and failed to document indications for repeat procedures for two patients.

### **Ogdee, Robert George, M.D., Lic. No. H6482, Abilene**

On April 12, 2013, the Board and Robert George Ogdee entered into an Agreed Order requiring Dr. Ogdee to pass within one year and within three attempts the Medical Jurisprudence Exam, complete within one year the professional boundaries course offered by the University of California San Diego PACE program, or the professional boundaries course offered by Vanderbilt University, or the professional boundaries course offered by the University of Texas and the Santé Institute of Professional Education and Research, or an approved equivalent course and complete within one year eight hours of CME in ethics. The Board found Dr. Ogdee became personally involved with a patient in an inappropriate manner.

### **Pena, Jose Fernando, M.D., Lic. No. J9264, Donna**

On April 12, 2013, the Board and Jose Fernando Pena, M.D., entered into an Agreed Order publicly reprimanding Dr. Pena requiring Dr. Pena to within one year complete eight hours of CME in risk management and pay an administrative penalty of \$500 within 60 days. The Board found Dr. Pena failed to maintain the confidentiality of a patient and failed to use diligence in his professional practice.

## **IMPAIRMENT**

### **Shilling, Steven Lee, M.D., Lic. No. H4699, Irving**

On April 12, 2013, the Board and Steven Lee Shilling, M.D., entered into an Agreed Order requiring Dr. Shilling to submit to an evaluation by the Texas Physician Health Program within 30 days and comply with any and all recommendations. The Board found Dr. Shilling consumed an alcoholic beverage prior to reporting to work to evaluate a patient in December 2010 and surrendered his hospital privileges while under investigation for the incident. Dr. Shilling is currently not practicing medicine and has no immediate plans to return to practice. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

#### **OTHER STATES' ACTION**

##### **Cobb, Tyson King, M.D., Lic. No. J3297, Davenport IA**

On April 12, 2013, the Board and Tyson King Cobb, M.D., entered into an Agreed Order requiring Dr. Cobb to submit to the Texas Physician Health Program for an evaluation prior to practicing medicine in Texas. The Board found Dr. Cobb was disciplined by the Iowa medical board for disruptive behavior, unprofessional conduct and for performing a surgical procedure on the wrong anatomical site.

##### **Kufof, Ernesto Antonio, M.D., Lic. No. K2520, De Ridder LA**

On April 12, 2013, the Board and Ernesto Antonio Kufof, M.D., entered into an Agreed Order barring Dr. Kufof from practicing in Texas until he requests permission in writing and provides sufficient evidence and information that he has complied with the terms of his order entered by the Louisiana State Board of Medical Examiners. The Board found Dr. Kufof was disciplined by the Louisiana State Board of Medical Examiners for failing to monitor a patient's condition following a surgical procedure in his office that led to the patient's demise.

##### **Livingstone, Edgar Franklin, M.D., Lic. No. N7636, Lake Havasu City AZ**

On April 12, 2013, the Board and Edgar Franklin Livingstone, M.D., entered into an Agreed Order barring Dr. Livingstone from practicing in Texas until he requests permission in writing, appears before the Board to orally petition for permission to resume practice and provides sufficient evidence that Dr. Livingstone is competent to safely practice medicine. The Board found Dr. Livingstone was formally disciplined by the Arizona Medical Board following charges of engaging in sexually inappropriate behavior or comments directed toward a patient.

##### **Sanders, Kenneth Wayne, M.D., Lic. No. TM00103, Shreveport LA**

On April 12, 2013, the Board and Kenneth Wayne Sanders, M.D., entered into an Agreed Order publicly reprimanding Dr. Sanders and requiring Dr. Sanders to within one year complete eight hours of CME in the topic of supervision and delegation and pay an administrative penalty of \$1,000. The Board found Dr. Sanders was disciplined by the Louisiana State Board of Medical Examiners for delegating professional medical responsibility to an unlicensed person at a diagnostic sleep facility.

#### **PEER REVIEW ACTION**

##### **Earp, Gary Wayne, D.O., Lic. No. E1566, Haltom City**

On April 12, 2013, the Board and Gary Wayne Earp, D.O., entered into an Agreed Order publicly reprimanding Dr. Earp and requiring Dr. Earp to complete within one year four hours of CME in ethics.

The Board found Dr. Earp was subject to disciplinary action by his peers and that he resigned his clinical privileges at the University of North Texas Health Science Center while under investigation for failing to disclose information on his application for clinical privileges.

**Horndeski, Gary Michael, M.D., Lic. No. G2390, Sugar Land**

On April 12, 2013, the Board and Gary Michael Horndeski, M.D., entered into an Agreed Order requiring Dr. Horndeski to obtain within 30 days an independent medical evaluation from a psychiatrist and follow all recommendations for continued care and treatment, within one year complete 16 hours of CME including eight hours in risk management and eight hours in communications skills with professional colleagues and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Horndeski was disciplined by peers at Angleton Danbury Medical Center regarding issues related to competency, conduct and behavior and had his membership and privileges at ADMC revoked.

**NONTHERAPEUTIC PRESCRIBING**

**Mann, Christopher Rolan, D.O., Lic. No. H2559, Hurst**

On April 12, 2013, the Board and Christopher Rolan Mann, D.O., entered into an Agreed Order requiring Dr. Mann to refrain from treating patients for chronic pain, have another physician monitor his practice for four monitoring cycles, within one year complete eight hours of CME in medical record-keeping and pay an administrative penalty of \$500 within 60 days. The Board found Dr. Mann prescribed medications in a nontherapeutic manner, kept inadequate medical records and failed to follow Board guidelines for the treatment of pain with respect to eight patients.

**Stedman, Horis Tilton, Jr., M.D., Lic. No. J1574, Marble Falls**

On April 12, 2013, the Board and Horis Tilton Stedman, Jr., M.D., entered into an Agreed Order requiring Dr. Stedman have his practice monitored by another physician for eight monitoring cycles, within one year complete 16 hours of CME including eight hours in risk management and eight hours in medical record-keeping and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Stedman failed to safeguard against potential complications, violated Board rules regarding treatment of chronic pain, non-therapeutically prescribed and engaged in unprofessional conduct.

**VOLUNTARY REVOCATION/SURRENDER**

**Freemyer, Harold Paul, M.D., Lic. No. D6424, Helotes**

On April 12, 2013, the Board and Harold Paul Freemyer, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Freemyer voluntarily and permanently surrendered his license in lieu of further disciplinary proceedings. Dr. Freemyer was under investigation by the Board regarding alleged violations of the standard of care regarding his emergency room care of one patient. Dr. Freemyer neither agrees with nor denies the findings in this Order.

**Hamid, Stacy Elise, M.D., Lic. No. N5095, Frisco**

On April 12, 2013, the Board and Stacy Elise Hamid, M.D., entered into an Agreed Order of Voluntary Revocation requiring Dr. Hamid to immediately cease practicing medicine. Dr. Hamid indicated her desire to enter into the order in lieu of further disciplinary proceedings.

**Sams, William Columbus, III, M.D., Lic. No. D7291, Gulfport MS**

On April 12, 2013, the Board and William Columbus Sams, III, M.D., entered into an Agreed Voluntary and Permanent Surrender Order in which Dr. Sams gave up his Texas medical license. The Board found Dr. Sams' Mississippi medical license was suspended indefinitely due to Dr. Sams' substance abuse history.

**Shook, James Bernard, D.O., Lic. No. F3336, Victoria**

On April 12, 2013, the Board and James Bernard Shook, D.O., entered into an Agreed Order of Voluntary Surrender in which Dr. Shook voluntarily and permanently surrendered his license in lieu of further disciplinary proceedings. Dr. Shook was under investigation by the Board regarding his physical ability to practice medicine.

**Soignier, Wayne A., M.D., Lic. No. G9665, Dallas**

On April 12, 2013, the Board and Wayne A. Soignier, M.D., entered into an Agreed Voluntary and Permanent Surrender Order based on Dr. Soignier's inability to practice medicine with reasonable skill and safety to patients as a result of a mental or physical condition.

**Weldon, Bill E., D.O., Lic. No. F4669, Fort Worth**

On April 12, 2013, the Board and Bill E. Weldon, D.O., entered into an Agreed Order of Voluntary Revocation requiring him to immediately cease practicing in Texas. Dr. Weldon, who was under investigation by the Board regarding allegations that he failed to comply with a Board Order, requested the revocation in lieu of further disciplinary proceedings.

**REVOCAATION**

**Dyke, Marshall James, M.D., Lic. No. D1619, Conroe**

On April 12, 2013, the Board approved a final order revoking the Texas medical license of Marshall James Dyke, M.D. The action was based on the findings of an administrative law judge who heard the case at the State Office of Administrative Hearings.

**INADEQUATE MEDICAL RECORDS**

**Cwikla, Mark Joseph, M.D., Lic. No. F3878, Dallas**

On April 12, 2013, the Board and Mark Joseph Cwikla, M.D., entered into an Agreed Order requiring Dr. Cwikla to complete within one year the medical record-keeping course offered by the University of California San Diego PACE program and furnish a copy of this order to all health care entities where Dr. Cwikla has privileges. The Board found Dr. Cwikla's post-operative notes for a patient were inadequate.

**Escobar-Vazquez, Edwin, M.D., Lic. No. J1085, Dallas**



On April 12, 2013, the Board and Edwin Escobar-Vazquez, M.D., entered into an Agreed Order requiring Dr. Escobar-Vazquez to complete eight hours of CME including four hours in risk management and four hours in ethics and pay an administrative penalty of \$500 within one year. The Board found Dr. Escobar-Vazquez violated Board Rules requiring that billing codes reported on insurance claim forms or billing statements be supported by documentation in the medical record.

**Somerville, Judson Jeffrey, M.D., Lic. No. H6622, Laredo**

On April 12, 2013, the Board and Judson Jeffrey Somerville, M.D., entered into a Mediated Agreed Order requiring Dr. Somerville to have his practice monitored by another physician for four monitoring cycles. The Board found Dr. Somerville did not maintain adequate medical records in his treatment of six patients. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**VIOLATION OF A BOARD RULE**

**Garvin, Clifford David, M.D., Lic. No. F9469, Denison**

On April 12, 2013, the Board and Clifford David Garvin, M.D., entered into an Agreed Order requiring Dr. Garvin to within one year complete 12 hours of CME including eight hours in pain management and four hours in medical record-keeping. The Board found Dr. Garvin violated rules regarding the treatment of chronic pain.

**Parveen, Shaista, M.D., Lic. No. K1612, Ukiah CA**

On April 12, 2013, the Board and Shaista Parveen, M.D., entered into an Agreed Order requiring Dr. Parveen to within 60 days complete all delinquent CME from the last reporting/renewal term and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Parveen failed to timely obtain and document required CME during the audit period of March 1, 2010 to February 28, 2012.

**Schwartz, John Paul, D.O., Lic. No. G0083, Marfa**

On April 12, 2013, the Board and John Paul Schwartz, D.O., entered into an Agreed Order requiring Dr. Schwartz to pass the Medical Jurisprudence Exam within one year and within three attempts, complete 48 hours of CME within one year including two hours in ethics and no more than 24 hours of self-study credits, complete eight hours of risk management CME within one year and pay an administrative penalty of \$1,500 within 60 days. The Board found Dr. Schwartz failed to timely obtain and document required CME during the audit period of December 1, 2009 to November 30, 2011.

**CEASE AND DESIST**

**Duncan, John J., Ph.D., No License, Irving, TX**

On April 12, 2013, the Board and John J. Duncan entered into an Agreed Cease and Desist Order prohibiting Mr. Duncan, who does not hold a Texas medical license, from practicing medicine in Texas. The Board found Mr. Duncan indicated he is licensed to practice medicine in Texas by referencing patient consent forms on his website and implying treatment by a physician. Mr. Duncan does not admit to or deny the allegations but agreed to the order to avoid further litigation.

**Hobbins, William B., M.D., No License**

On April 12, 2013, the Board and William B. Hobbins entered into an Agreed Cease and Desist Order prohibiting Mr. Hobbins, who does not hold a Texas medical license, from practicing medicine in Texas. The Board found Mr. Hobbins interpreted breast thermography images taken by a Certified Thermology Technician in conjunction with her Texas business. The CTT informed patients that their thermology images would be reviewed by a doctor. Mr. Hobbins surrendered his license to practice medicine in Wisconsin in September 2009.

**Tejeda, Leilani, Certified Thermology Technician**

On April 12, 2013, the Board and Leilani Tejeda entered into an Agreed Cease and Desist Order prohibiting Ms. Tejeda, who does not hold a Texas medical license, from practicing medicine in Texas. The Board found Ms. Tejeda offered diagnostic services for the detection of breast cancer and used a non-licensed physician to interpret the breast thermography images taken by Ms. Tejeda.

**OTHER RECENT ACTIONS**

**Campbell, Amanda, Non-Certified Radiologic Technician, Permit No. NC05296, Dallas**

On April 9, 2013, the Board entered an order of automatic suspension regarding the non-certified radiologic technician permit of Amanda Campbell. The Board suspended Ms. Campbell's permit and ordered her to cease practicing as an NCT in Texas, due to unprofessional conduct, specifically, defaulting on her student loan repayment.

**Texas Medical Board  
NEWS RELEASE  
May 10, 2013**

**Media contact: Leigh Hopper, 512-305-7018  
Customer service: 512-305-7030 or 800-248-4062**

The Texas Medical Board and Texas Physician Assistant Board have taken recent disciplinary actions including three temporary suspensions, one automatic suspension and one cease and desist order.

**Burks, Joseph Emerson, M.D., Lic. No. E0839, Victoria**

On May 2, 2013, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the Texas medical license of Joseph Emerson Burks, M.D., after determining that Dr. Burks' continuation in the practice of medicine presents a continuing threat to the public welfare. The Board found Dr. Burks, whose self-reported history of substance abuse was being monitored through an agreement with the Texas Physician Health Program (TXPHP), has repeatedly tested positive for prohibited substances. In addition, Dr. Burks has repeatedly missed his drug-testing check-ins and tests, without explanation, in violation of his agreement with TXPHP.

**Gorden, Shawn, M.D., Lic. No. L3666, El Paso**

On May 2, 2013, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the Texas medical license of Shawn Gorden, M.D., after determining that Dr. Gorden's continuation in the practice of medicine presents a continuing threat to the public welfare. The Board found Dr. Gorden failed to comply with the terms of his agreement with the Texas Physician Health Program, and did not comply with recommendations for in-patient treatment for substance dependency.

**Corona, Tony Morales, NCT Permit No. NC03667, Burleson**

On May 2, 2013, the Texas Medical Board entered an order of automatic suspension regarding Tony Morales Corona, a Texas Non-Certified Radiologic Technician, barring Mr. Corona from practicing in Texas. The Board found Dr. Corona defaulted on his student loan.

**Baker, Merrimon Walters, M.D., Not Licensed to Practice Medicine**

On May 3, 2013 the Texas Medical Board entered a Cease and Desist Order regarding Merrimon Walters Baker, M.D., who does not hold a Texas medical license, prohibiting him from practicing medicine or holding himself out to be a medical doctor. The Board found Dr. Baker has engaged in the unlicensed practice of medicine by referring to himself as "Dr. Spike" and negotiating with a supplier of Medtronic devices for use in the office of Dr. Ajay Kumar Aggarwal, M.D. In addition, Dr. Baker engaged in unlicensed practice of medicine by placing needles in one patient's back as part of the implantation of a dorsal column stimulator.

**Murphy, Kasey, PA, Lic. No. PA02276, DeSoto**

On May 7, 2013, a disciplinary panel of the Texas Physician Assistant Board temporarily suspended, without notice, the license of Kasey Murphy, P.A., after determining that Ms. Murphy's continuation in the practice of medicine presents a continuing threat to the public welfare. The Board found Ms. Murphy failed to comply with the terms of her agreement with the Texas Physician Health Program, and has repeatedly tested positive for alcohol.



Texas Medical Board Press Release  
FOR IMMEDIATE RELEASE  
May 28, 2013

Media contact: Leigh Hopper, 512-305-7018  
Customer service: 512-305-7030 or 800-248-4062

## **TMB suspends San Marcos physician**

On May 24, 2013, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the Texas medical license of San Marcos pediatrician William Brandt Garner, M.D., after determining that Dr. Garner's continuation in the practice of medicine constitutes a threat to the public welfare due to his impaired status.

The Board found Dr. Garner violated a five-year agreement with the Texas Physician Health Program, testing positive on several occasions for alcohol.

The temporary suspension remains in place until the Board takes further action.

###

Texas Medical Board Press Release  
FOR IMMEDIATE RELEASE  
June 24, 2013

Media contact: Leigh Hopper, 512-305-7018  
Customer service: 512-305-7030 or 800-248-4062

## **Dallas physician suspended for deceptive and assaultive conduct**

On June 21, 2013, a disciplinary panel of the Texas Medical Board temporarily suspended, with notice, the Texas medical license of Dallas physician Alireza Atef-Zafarmand, M.D., after determining that Dr. Atef-Zafarmand's pattern of deception and escalating assaultive and criminal conduct demonstrated that Dr. Atef-Zafarmand poses a continuing threat to public health and safety.

The Board found Dr. Atef-Zafarmand sexually assaulted four women and exhibited sexually inappropriate behavior toward six others during the time period between 2005 and 2011.

In 2006, as an internal medicine intern with the University of Texas Southwestern Medical Center at Dallas, Dr. Atef-Zafarmand was investigated by Veterans Affairs North Texas Healthcare System after he approached women on staff with offers of massages and hypnosis and asked another staff member to feign unconsciousness while he fondled her breasts without her consent. Following that investigation, he was disciplined by UT Southwestern but failed to report this information to the Board on several occasions.

In 2006 at Parkland Hospital in Dallas, Dr. Atef-Zafarmand put his hands around the neck of a female patient until she had difficulty breathing. In 2010 and 2011, Dr. Atef-Zafarmand choked and raped two women who reported the assaults to the Dallas and Collin County Police Departments.

The suspension remains in effect until the Board takes further action.

Texas Medical Board Press Release  
FOR IMMEDIATE RELEASE  
June 26, 2013

Media contact: Leigh Hopper, 512-305-7018  
Customer service: 512-305-7030 or 800-248-4062

**Plano neurological surgeon suspended after patient deaths, injuries**

On Wednesday, June 26, 2013, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the medical license of Plano neurological surgeon Christopher Daniel Duntsch, M.D., after determining that Dr. Duntsch's lack of competence, impaired status and failure to adequately care for his patients poses a continuing threat to the public welfare.

The Board found Dr. Duntsch's pattern of failing to follow appropriate preoperative planning standards and failing to recognize and respond to complications during surgery and postoperatively puts Dr. Duntsch's patients at significant risk of harm.

Within a span of 16 months, two of Dr. Duntsch's patients died following procedures and two others were severely injured. The patients suffered excessive blood loss and one was left paralyzed from the neck down. Another patient sustained a large tear to the esophagus. Additionally, Dr. Duntsch failed to identify a sponge left in a patient despite the sponge being evident in an early postoperative chest x-ray.

The Board also found Dr. Duntsch, 42, is unable to practice medicine with reasonable skill and safety due to impairment from drugs or alcohol. His privileges at University General Hospital Dallas were suspended June 17, 2013.

A temporary suspension hearing with notice will be scheduled as soon as practicable. The suspension remains in place until the Board takes further action.

###

To view disciplinary orders, visit the TMB website, click on "Look Up A Doctor," accept the usage terms, then type in a doctor's name. Click on the name shown in the search results to view the doctor's full profile. Within that profile is a button that says "View Orders."

**Texas Medical Board Press Release**

**FOR IMMEDIATE RELEASE**

**June 28, 2013**

**Media contact: Megan Goode, 512-305-7044**

**Customer service: 512-305-7030 or 800-248-4062**

## **Fifty-seven physicians disciplined by Texas Medical Board at June meeting**

At its June 13-14, 2013 meeting, the Texas Medical Board disciplined 57 licensed physicians and issued three cease and desist orders. The disciplinary actions included 29 orders related to quality-of-care violations, eight orders related to unprofessional conduct, three based on peer review actions, eight voluntary surrenders and revocations, two pain clinic actions, one order based on criminal behavior, three orders based on inadequate medical records, one violation of a prior order, two based on other states' actions and three violations of Texas Physician Health Program agreements. In addition, one non-certified radiologic technician was disciplined.

The Board issued 120 physician licenses at the June board meeting, bringing the total number of physician licenses issued in FY 13 to 2,740. Thirty six percent of physician licensure applications were completed in 10 days or less.

### **QUALITY OF CARE**

#### **Akin, William Orlan, M.D., Lic. No. C8181, Abilene**

On June 14, 2013, the Board and William Orlan Akin, M.D., entered into an Agreed Order requiring Dr. Akin to complete within one year eight hours of CME including four hours in medical record-keeping and four hours in risk management, and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Akin inappropriately prescribed dangerous drugs or controlled substances to himself and family members and failed to maintain adequate medical records.

#### **Alvear, Joel, M.D., Lic. No. L1514, Katy**

On June 14, 2013, the Board and Joel Alvear, M.D., entered into an Agreed Order requiring Dr. Alvear to surrender his DEA/DPS controlled substances certificates within seven days and not reregister or obtain Controlled Substances Registrations within the first year of this Order. The Board found Dr. Alvear failed to maintain adequate medical records for a patient, prescribed without showing therapeutic benefit, and refilled medications without seeing the patient for long periods of time.

#### **Bonikowski, Frank P., M.D., Lic. No. H2098, Corpus Christi**

On June 14, 2013, the Board and Frank P. Bonikowski, M.D., entered into an Agreed Order requiring Dr. Bonikowski to have his practice monitored by another physician for eight monitoring cycles, within one year complete the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program and within one year complete 16 hours of



CME in the treatment of pain. The Board found Dr. Bonikowski engaged in non-therapeutic prescribing, failed to use diligence in his professional practice and failed to comply with Board guidelines for the use of pain medications.

**Boyd, Gary D., M.D., Lic. No. F9226, Tyler**

On June 14, 2013, the Board entered a Final Order publicly reprimanding Gary D. Boyd, M.D., and requiring Dr. Boyd to have his practice monitored by another physician for eight monitoring cycles, within 90 days contact the Texas A&M Health Science Center Rural and Community Health Institute (K-STAR) for the purpose of scheduling a two-day assessment, within one year complete the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, within one year pass the Medical Jurisprudence Exam within three attempts, within 30 days reimburse the patient's family all out-of-pocket expenses, within one year complete 40 hours of CME including eight hours in ethics, eight hours in risk management, eight hours in use of EGDs, eight hours in treating esophageal ulcers and eight hours in physician-patient communications, and pay an administrative penalty of \$15,000 within six months. The Board found Dr. Boyd subjected a patient to nontherapeutic procedures, failed to meet the standard of care, was negligent in performing medical services and kept inadequate medical records.

**Brown, Forrest Carroll, M.D., Lic. No. D3169, Dallas**

On June 14, 2013, the Board and Forrest Carroll Brown, M.D., entered into an Agreed Order restricting Dr. Brown's practice to dermatology and requiring Dr. Brown to have his practice monitored by another physician for eight monitoring cycles, refrain from treating his immediate family or anyone with whom Dr. Brown has a close relationship, develop and implement pain contracts for chronic pain patients, within one year pass the Medical Jurisprudence Exam within three attempts, within one year complete CME required for licensure maintenance, within one year complete 24 hours of CME including eight hours in medical record-keeping, eight hours in risk management and eight hours in identifying drug-seeking behavior, and pay an administrative penalty of \$4,000 within 120 days. The Board found Dr. Brown failed to meet the standard of care, prescribed inappropriately and failed to maintain adequate medical records for one patient. In addition, Dr. Brown inappropriately self-prescribed medications.

**Bussey, Jimmie Dale, M.D., Lic. No. D4393, Newton**

On June 14, 2013, the Board and Jimmie Dale Bussey, M.D., entered into an Agreed Order requiring Dr. Bussey to have his practice monitored by another physician for 12 monitoring cycles, complete within one year 32 hours of CME including 16 hours in pain management and 16 hours in medical record-keeping. The Board found Dr. Bussey failed to meet the standard of care, prescribed to a known abuser of narcotic drugs, engaged in nontherapeutic prescribing and failed to maintain adequate medical records.

**Caruth, Jeffrey C., M.D., Lic. No. H6102, Plano**

On June 14, 2013, the Board and Jeffrey C. Caruth, M.D., entered into an Agreed Order requiring Dr. Caruth to within one year complete 16 hours of CME in the topic of breast augmentation and pay an

administrative penalty of \$3,000 within 60 days. The Board found Dr. Caruth did not adequately address a patient's post-surgical complications following breast implant surgery.

**Dutta, Paritosh Chandra, M.D., Lic. No. E7900, Richardson**

On June 14, 2013, the Board and Paritosh Chandra Dutta, M.D., entered into a Mediated Agreed Order requiring Dr. Dutta to within one year complete 20 hours of CME including eight hours in medical record-keeping, eight hours in risk management and four hours in pharmacological management of obesity. The Board found Dr. Dutta failed to adequately monitor a patient's use of a weight loss medication and failed to keep adequate medical records. This order resolves a formal complaint filed by the Board at the State Office of Administrative Hearings.

**Felder, Diane Johnson, M.D., Lic. No. H5122, Houston**

On June 14, 2013, the Board and Diane Johnson Felder, M.D., entered into an Agreed Order requiring Dr. Felder to within one year complete the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, within one year complete eight hours of CME in ethics and pay an administrative penalty of \$5,000 within 60 days. The Board found Dr. Felder failed to meet the standard of care for 10 patients at a residential treatment center, contracted unlicensed personnel to work as licensed professional counselors at another residential treatment center, failed to maintain adequate medical records and engaged in unprofessional conduct.

**Gibson, Donald M., M.D., Lic. No. F3137, Houston**

On June 14, 2013, the Board and Donald M. Gibson, M.D., entered into an Agreed Order requiring Dr. Gibson to restrict his on-call status to 15 days per month, within one year pass the Medical Jurisprudence Exam within three attempts and within one year complete eight hours of CME in ethics. The Board found Dr. Gibson, the thoracic surgeon on-call at a hospital, failed to respond to numerous telephone calls to report to the emergency room.

**Herding, Pierre, M.D., Lic. No. H8684, Mesquite**

On June 14, 2013, the Board and Pierre Herding, M.D., entered into an Agreed Order requiring Dr. Herding to have another physician monitor his practice for eight monitoring cycles, within one year complete 16 hours of CME including four hours in medical record-keeping, four hours in risk management and eight hours in treatment of chronic pain. The Board found Dr. Herding failed to adhere to Board guidelines for the treatment of pain, failed to meet the standard of care and prescribed to a known abuser of narcotic drugs. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Herrera, Carlos Alberto, M.D., Lic. No. J8573, Edinburg**

On June 14, 2013, the Board and Carlos Alberto Herrera, M.D., entered into an Agreed Order publicly reprimanding Dr. Herrera and requiring Dr. Herrera to have his practice monitored by another physician for 12 monitoring cycles, within one year complete 16 hours of CME including eight hours in risk management and eight hours in medical record-keeping, within one year pass the Medical

Jurisprudence Exam within three attempts and pay an administrative penalty of \$4,000 within 60 days. The Board found Dr. Herrera failed to comply with record-keeping requirements for controlled substances and failed to use diligence in his professional practice.

**Johnson, Shawn R., M.D., Lic. No. K8919, Pearland**

On June 14, 2013, the Board and Shawn R. Johnson, M.D., entered into an Agreed Order publicly reprimanding Dr. Johnson and requiring Dr. Johnson to have his practice monitored by another physician for eight monitoring cycles, within one year complete the Medical Jurisprudence Exam within three attempts and within one year complete at least eight hours of CME to be divided as follows: four hours in risk management and four hours in supervising midlevels. The Board found Dr. Johnson non-therapeutically prescribed controlled substances to 20 patients, failed to adequately supervise midlevels, and failed to keep adequate medical records.

**Leffingwell, Thomas F., M.D., Lic. No. G7260, Arlington**

On June 14, 2013, the Board and Thomas F. Leffingwell, M.D., entered into an Agreed Order publicly reprimanding Dr. Leffingwell and prohibiting Dr. Leffingwell from reregistering or obtaining Controlled Substances Registrations until a written authorization has been received from the Board. In addition, Dr. Leffingwell must within one year complete the Medical Jurisprudence Exam within three attempts, within one year complete 16 hours of CME including eight hours in the topic of medical ethics and eight hours in the topic of medical record-keeping, and pay an administrative penalty of \$5,000 within 60 days. The Board found Dr. Leffingwell improperly self-prescribed large amounts of hydrocodone he purchased from a manufacturer, failed to maintain and keep appropriate records related to purchasing and failed to maintain medical records for his self-prescribing.

**Lopez, Jesus Antonio, M.D., Lic No. L1649, San Antonio**

On June 14, 2013, the Board and Jesus Antonio Lopez, M.D., entered into an Agreed Order prohibiting Dr. Lopez from prescribing any controlled substances or dangerous drugs with addictive potential except as is necessary for treatment of acute pain or for inpatient treatment of patients in a hospital setting, hospice, or nursing home where Dr. Lopez has privileges or practices medicine. In addition, Dr. Lopez must have another physician monitor his practice for eight monitoring cycles, complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education program and within one year complete eight hours of continuing medical education in the topic of risk management. The Board found Dr. Lopez failed to keep adequate medical records, prescribed controlled substances to two patients after they tested positive for illegal substances, and voluntarily surrendered his DEA and DPS Controlled Substances Registration Certificates as the result of an investigation into his prescribing practices.

**Marks, Timothy, M.D., Lic. No. J3719, Houston**

On June 14, 2013, the Board and Timothy Marks, M.D., entered into an Agreed Order prohibiting Dr. Marks from supervising physician extenders except for certified registered nurse anesthetists in a procedure conducted in a hospital, surgical center or Board-approved office-based anesthesia setting. Dr. Marks is also prohibited from prescribing scheduled drugs except while providing anesthesia services

in a hospital. He is also prohibited from treating chronic pain patients and must pass within one year and within three attempts the Medical Jurisprudence Exam. The Board found Dr. Marks prescribed controlled substances to 15 patients without adequately documenting a medical rationale or justifications for the medication, failed to adequately supervise mid-level providers, and violated Board rules regarding maintenance of adequate medical records.

**Matthews, Jonathan Richard, D.O., Lic. No. L9803, Trophy Club**

On June 14, 2013, the Board and Jonathan Richard Matthews, D.O., entered into an Agreed Order requiring Dr. Matthews to undergo an independent medical evaluation by a board-designated psychiatrist and follow all recommendations for care and treatment, within one year complete 28 hours of CME including 12 hours in medical record-keeping and 12 hours in ethics and four hours in prescribing controlled substances, and pay an administrative penalty of \$15,000 within 180 days. The Board found Dr. Matthews failed to meet the standard of care and exercise diligence in his professional practice, was subject to disciplinary action by his peers, failed to comply with Board requests for information and pre-signed prescriptions for controlled substances.

**Matthews, Jonathan Richard, D.O., Lic. No. L9803, Trophy Club**

On June 14, 2013, the Board and Jonathan Richard Matthews, D.O., entered into an Agreed Order limiting Dr. Matthews' practice to 200 hours per month including administrative functions, on-call and patient care. In addition, the order requires Dr. Matthews to within one year complete 24 hours of CME including 16 hours in fluid and electrolyte management and eight hours, in-person, in risk management. The Board found Dr. Matthews failed to meet the standard of care and safeguard against potential complications in his treatment of one patient.

**McFarland, Michael Allen, M.D., Lic. No. G8271, Jourdanton**

On June 14, 2013, the Board and Michael Allen McFarland entered into an Agreed Order requiring Dr. McFarland to have another physician monitor his practice for eight monitoring cycles, within one year complete 20 hours of CME including eight hours in medical record-keeping, eight hours in management of chronic pain and four hours in treating adult ADHD. The Board found Dr. McFarland failed to meet the standard of care for seven patients, non-therapeutically prescribed controlled substances and failed to maintain adequate medical records.

**Naberhaus, Daniel Robert, M.D., Lic. No. H3920, Arlington**

On June 14, 2013, the Board and Daniel Robert Naberhaus, M.D., entered into an Agreed Order requiring Dr. Naberhaus to cease treating patients for chronic pain, have his practice monitored by another physician for eight monitoring cycles, within one year complete the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program and within one year complete 16 hours of CME including eight hours in psychopharmacology and eight hours in risk management and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Naberhaus failed to meet the standard of care when he prescribed escalating doses of controlled substances without a reasonable basis and failed to provide adequate documentation to support his diagnoses or treatment plans.

**Pang, John, D.O., Lic. No. K5175, Sunnyvale**

On June 14, 2013, the Board and John Pang, D.O., entered into an Agreed Order requiring Dr. Pang to have his practice monitored by another physician for eight monitoring cycles, within one year complete 32 hours of CME including 16 hours in pain management, eight hours in medical record-keeping and eight hours in risk management and pay an administrative penalty of \$1,500 within 60 days. The Board found Dr. Pang failed to maintain adequate medical records, failed to meet the standard of care and engaged in non-therapeutic prescribing for 10 patients.

**Pratho, Scott Mason, M.D., Lic. No. G8350, Willow Park**

On June 14, 2013, the Board and Scott Mason Pratho, M.D., entered into an Agreed Order publicly reprimanding Dr. Pratho and requiring Dr. Pratho to within one year complete 16 hours of CME including eight hours in risk management and eight hours in drug interactions, and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Pratho failed to meet the standard of care when he failed to verify one patient's allergies before administering a medication.

**Raj, Jhansi M., M.D., Lic. No. G8735, Fort Worth**

On June 14, 2013, the Board and Jhansi M. Raj, M.D., entered into a Mediated Agreed Order requiring Dr. Raj to have his practice monitored by another physician for eight monitoring cycles and within one year complete 16 hours of CME including eight hours in risk management, four hours in treating difficult psychiatric patients and four hours in diagnosis and treatment of patients at high risk for suicide. The Board found Dr. Raj failed to meet the standard of care for one patient who was prematurely discharged from the psychiatric ward of a hospital and who committed suicide within three hours of discharge. This order resolves a formal complaint filed by the Board at the State Office of Administrative Hearings.

**Reis, Marcos, M.D., Lic. No. G0810, Brownsville**

On June 14, 2013, the Board and Marcos Reis, M.D., entered into an Agreed Order requiring Dr. Reis to have another physician monitor his practice for eight monitoring cycles, within one year complete 20 hours of CME including four hours in medical record-keeping, four hours in ethics, four hours in physician-patient communications, four hours in prescribing for a geriatric population and four hours in risk management. The Board found Dr. Reis failed to use proper diligence in his professional practice.

**Rossel, Anibal F., M.D., Lic. No. H9415, Houston**

On June 14, 2013, the Board and Anibal F. Rossel, M.D., entered into an Agreed Order requiring Dr. Rossel to refrain from serving as a physician for his immediate family, have another physician monitor his practice for eight monitoring cycles, within one year pass the Medical Jurisprudence Exam within three attempts. The Board found Dr. Rossel failed to meet the standard of care when he improperly prescribed medication to a close family member without maintaining an adequate medical record.

**Seshadri, Lakshmi, M.D., Lic. No. L1741, Houston**

On June 14, 2013, the Board and Lakshmi Seshadri, M.D., entered into an Agreed Order requiring Dr. Seshadri to within one year complete 24 hours of CME including eight hours in medical record-keeping, eight hours in risk management and eight hours in physician-patient communication. The Board found Dr. Seshadri failed to practice medicine in an acceptable professional manner consistent with public health and welfare and failed to timely evaluate a hospital patient.

**Stenger, Earl Martin, M.D., Lic. No. D7315, San Antonio**

On June 14, 2013, the Board and Earl Martin Stenger, M.D., entered into an Agreed Order requiring Dr. Stenger to have his practice monitored by another physician for eight monitoring cycles and within one year complete eight hours of in-person CME in medical record-keeping. The Board found Dr. Stenger failed to maintain adequate medical records and prescribed benzodiazepines without adequately evaluating the patient and providing sufficient instructions.

**Swain, Timothy Whitzel, III, M.D., Lic. No. N7883, Corpus Christi**

On June 14, 2013, the Board and Timothy Whitzel Swain, III, M.D., entered into an Agreed Order requiring Dr. Swain to within one year complete 24 hours of CME including 16 hours in the management of prosthetic valve complications and eight hours in physician/patient/family communication. The Board found Dr. Swain failed to meet the standard of care for one patient when he did not timely perform the indicated surgery on a patient as she was rapidly declining.

**Vines, Victor, M.D., Lic. No. G8483, Argyle**

On June 14, 2013, the Board and Victor Vines, M.D., entered into a Mediated Agreed Order requiring Dr. Vines to within one year complete 16 hours of CME including eight hours in risk management and eight hours in ethics and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Vines prescribed a dangerous drug without first establishing a proper professional relationship with the patient. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**UNPROFESSIONAL CONDUCT**

**Baker, Jack L., M.D., Lic. No. J2489, Friendswood**

On June 14, 2013, the Board and Jack L. Baker, M.D., entered into an Agreed Order publicly reprimanding Dr. Baker and requiring Dr. Baker to within one year pass the Medical Jurisprudence Exam within three attempts, within one year complete 24 hours of CME in ethics with a focus on billing practices. The Board found Dr. Baker engaged in unprofessional conduct, provided medically unnecessary services and submitted improper billing statements.

**Caldwell, Daniel W., M.D., Lic. No. J6078, Denton**

On June 14, 2013, the Board and Daniel W. Caldwell, M.D., entered into an Agreed Order requiring Dr. Caldwell to use a chaperone any time he examines a female patient, undergo a psychiatric examination and follow recommendations for care and treatment, within one year pass the Medical Jurisprudence Exam within three attempts, within one year complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program,

within one year complete 16 hours of CME including eight hours in ethics and eight hours in risk management and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Caldwell failed to report his 2004 arrest and 2005 conviction for DWI, that he engaged in sexual relationships with two female patients and submitted to the Board false or misleading information.

**Gutierrez, Michael Louis, M.D., Lic. No. H8097, Austin**

On June 14, 2013, the Board and Michael Louis Gutierrez, M.D., entered into an Agreed Order requiring Dr. Gutierrez to within one year complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, within one year pass the Medical Jurisprudence Exam within three attempts, within one year complete four hours of CME in ethics and four hours in risk management and within 90 days refund to the patient all out-of-pocket expenses for services rendered May 4, 2012. The Board found Dr. Gutierrez engaged in a sexually inappropriate conversation with a patient.

**Li, Yih-Chang, M.D., Lic. No. N6459, Katy**

On June 14, 2013, the Board and Yih-Chang Li, M.D., entered into an Agreed Order publicly reprimanding Dr. Li and requiring Dr. Li to within one year pass the Medical Jurisprudence Exam within three attempts and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Li was arrested for simple domestic assault in 2011 and entered a “no contest” plea which resulted in a deferred adjudication agreement with numerous requirements.

**Martinez, Jose Ricardo, M.D., Lic. No. J5108, Mineola**

On June 14, 2013, the Board and Jose Ricardo Martinez, M.D., entered into an Agreed Order requiring Dr. Martinez to within one year complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, within one year pass the Medical Jurisprudence Exam within three attempts and within one year complete four hours of CME in ethics. The Board found Dr. Martinez provided false information to the Board and engaged in sexual contact with a patient.

**Maul, R. Greg, D.O., Lic. No. E9798, Rowlett**

On June 14, 2013, the Board and R. Greg Maul, D.O., entered into an Agreed Order requiring Dr. Maul to have his billing and medical records reviewed by an independent auditor for the next two years, within 60 days begin holding and documenting monthly meetings between Dr. Maul and his staff to ensure all billing and coding functions are performed by properly trained personnel, within one year complete 16 hours of CME including eight hours in medical record-keeping and eight hours in coding/billing and pay an administrative penalty of \$2,000. The Board found Dr. Maul billed improperly for his services and that his medical records did not support the bills submitted for payment.

**Simmons, Jason Levon, M.D., Lic. No. N4103, Bronx NY**

On June 14, 2013, the Board entered a Final Order regarding Jason Levon Simmons, M.D., publicly reprimanding Dr. Simmons and requiring Dr. Simmons to not practice medicine in Texas until Dr. Simmons fulfills the following terms: Undergoes an Independent Medical Evaluation with a psychiatrist and complies with all recommendations for care and treatment, passes within one year the Medical Jurisprudence Exam within three attempts, within one year completes the Vanderbilt Disruptive Physician's Course, within one year completes the anger management course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, within one year completes 16 hours of CME including eight hours in ethics and eight hours in professionalism and pays an administrative penalty of \$15,000 within six months. This order resolves a formal complaint filed at the State Board of Administrative Hearings. The Board found Dr. Simmons engaged in disruptive behavior, was disciplined by his peers, and failed to practice medicine in an acceptable professional manner.

**Thompson, Marcel Dwaine, M.D., Lic. No. L7220, Houston**

On June 14, 2013, the Board and Marcel Dwaine Thompson, D.O., entered into an Agreed Order publicly reprimanding Dr. Thompson and requiring Dr. Thompson to pay an administrative penalty of \$5,000 within 90 days. The board found that Dr. Thompson submitted false information to the National Practitioner Data Bank.

**PEER REVIEW ACTIONS**

**Abdelsayed, Magdy, M.D., Lic. No. E9504, Baytown**

On June 14, 2013, the Board and Magdy Abdelsayed, M.D., entered into an Agreed Order requiring Dr. Abdelsayed to within one year complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, within one year complete 16 hours of CME including eight hours in ethics and eight hours in risk management and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Abdelsayed was subject to discipline by peers for unprofessional conduct that could adversely impact the quality of care rendered to a patient.

**Kilaru, Ramanadham, M.D., Lic. No. E9268, Dallas**

On June 14, 2013, the Board and Ramanadham Kilaru, M.D., entered into an Agreed Order requiring Dr. Kilaru to refrain from interpretation of mammography and limit his practice to interpretation of plain film radiography. The Board found Dr. Kilaru misinterpreted mammograms for multiple patients and was disciplined by his employer.

**Lopez, Ruben Montelongo, M.D., Lic. No. J9173, Harlingen**

On June 14, 2013, the Board and Ruben Montelongo Lopez, M.D., entered into an Agreed Order requiring Dr. Lopez to within one year complete 24 hours of CME including eight hours in anger management, eight hours in ethics and eight hours in billing or medical record-keeping and pay an administrative penalty of \$5,000 within 90 days. The Board found Dr. Lopez was subject to disciplinary



action by his peers, that he behaved in a disruptive manner, failed to use proper diligence in his professional practice and failed to maintain adequate medical records.

#### **VOLUNTARY SURRENDER/SUSPENSION/REVOCAATION**

##### **Covacha-Rosal, Vivina, M.D., Lic. No. E9589, West Bloomfield MI**

On June 14, 2013, the Board and Vivina Covacha-Rosal, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Covacha-Rosal voluntarily and permanently surrendered her Texas medical license. The Board found Dr. Covacha-Rosal surrendered her Michigan medical license and that she provided false information to the Board in a license renewal application.

##### **Daniels, Ron, D.O., Lic. No. E3246, Quitman**

On June 14, 2013, the Board and Ron Daniels, D.O., entered into an Agreed Order of Voluntary Surrender in which Dr. Daniels voluntarily and permanently surrendered his Texas medical license. The Board found Dr. Daniels self-reported a medical condition which precludes him from practicing medicine with reasonable skill and safety to patients.

##### **Echols, Ben Harris, M.D., Lic. No. F6227, Houston**

On June 14, 2013, the Board and Ben Harris Echols, M.D., entered into an Agreed Order granting Dr. Echols a voluntary suspension of his medical license. The Board found Dr. Echols was convicted of seven counts of conspiracy to commit Medicare fraud and sentenced to prison for 63 months. Dr. Echols is appealing his conviction and does not admit to or deny the findings in this Agreed Order.

##### **Exline, Albert Lobdell, M.D., Lic. No. C2851, Austin**

On June 14, 2013, the Board and Albert Lobdell Exline, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Exline voluntarily and permanently surrendered his Texas medical license. Dr. Exline, who is 89, requested the surrender in lieu of further disciplinary action.

##### **Wimmer, Patrick J., M.D., Lic. No. J2418, Bedford**

On June 14, 2013, the Board and Patrick J. Wimmer, M.D., entered into an Agreed Order suspending Dr. Wimmer's license until Dr. Wimmer requests in writing to have the suspension stayed or lifted and provides clear and convincing evidence that he is competent to safely practice medicine, complete all delinquent CME from the last reporting/renewal term within 60 days. The Board found Dr. Wimmer pled guilty to DWI, self-reported his criminal history, alcohol dependence, and bipolar disorder.

##### **Ritchey, Elizabeth Elliot, M.D., Lic. No. G6604, New Braunfels**

On June 14, 2013, the Board and Elizabeth Elliot Ritchey, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Ritchey voluntarily and permanently surrendered her license. The Board found Dr. Ritchey requested that she surrender her medical license due to her wish to retire and in lieu of litigation of allegations that she failed to practice medicine in an acceptable and professional manner.

##### **Dobson, Walter Albert, D.O., Lic. No. F2636, Grand Prairie**

On June 14, 2013, the Board and Walter Albert Dobson, D.O., entered into an Agreed Order of Revocation requiring Dr. Dobson to immediately cease practicing medicine. Dr. Dobson agreed to the order in lieu of fulfilling the terms of his 2011 suspension order.

#### **REVOCAATION**

##### **Wagner, Harold Glen, D.O., Lic. No. H6679, Dallas**

On June 14, 2013, the Board entered a Final Order revoking the Texas medical license of Harold Glen Wagner, D.O. The Board found Dr. Wagner was convicted of a felony.

#### **CRIMINAL BEHAVIOR**

##### **Alexander, Bill, M.D., Lic. No. D4009, Fort Worth**

On June 14, 2013, the Board and Bill Alexander, M.D., entered into an Agreed Order publicly reprimanding Dr. Alexander and restricting Dr. Alexander to the practice of administrative medicine and prohibiting him from any practice of medicine that involves direct or indirect patient contact. In addition, Dr. Alexander is to not reregister or obtain Controlled Substances Registrations until a written authorization has been received from the Board and pay an administrative penalty in the amount of \$3,000 within 60 days. The Board found Dr. Alexander was arrested for transporting marijuana for drug traffickers and used drugs recreationally.

#### **PAIN CLINIC ACTIONS**

##### **St. Theresa's Outpatient Wound Clinic, Cert. No. PMC00192, Houston**

On June 14, 2013, the Board and Allan Dee Ahlschier, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Ahlschier surrendered his Pain Management Clinic Certificate for St. Theresa's Outpatient Wound Clinic in lieu of further disciplinary proceedings. The surrender requires Dr. Ahlschier to immediately cease operating the clinic.

##### **San Jacinto Clinic & Rehabilitation, Cert. No. PMC00269, Houston**

On June 14, 2013, the Board entered into an Agreed Voluntary Surrender Order with Ngoc Xuan Nguyen, M.D., the holder of the pain management clinic certificate of San Jacinto Clinic & Rehabilitation. The Board accepted the voluntary and permanent surrender of the clinic's pain management clinic certificate in lieu of further disciplinary proceedings. The order required Dr. Nguyen to immediately cease operating San Jacinto Clinic & Rehabilitation as a pain clinic in Texas and withdraw any and all PMC applications, if any, currently pending before the Board.

#### **INADEQUATE MEDICAL RECORDS**

##### **Garza, Jim Santiago, M.D., Lic. No. E4347, Houston**

On June 14, 2013, the Board and Jim Santiago Garza, M.D., entered into an Agreed Order requiring Dr. Garza to within one year complete eight hours of CME including four hours in medical record-keeping and four hours in risk management and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Garza failed to maintain an adequate medical record for one patient.

##### **Huggins, Timothy Lebron, M.D., Lic. No. J2612, Weatherford**

On June 14, 2013, the Board and Timothy Lebron Huggins entered into an Agreed Order requiring Dr. Huggins to within one year complete 10 hours of CME including six hours in medical record-keeping and four hours in risk management. The Board found Dr. Huggins failed to maintain adequate medical records for one patient.

**Thomas, James Herman, Jr., M.D., Lic. No. G0199, Houston**

On June 14, 2013, the Board and James Herman Thomas, Jr., M.D., entered into a Mediated Agreed Order requiring Dr. Thomas to within one year complete the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program and within one year complete 16 hours of CME in the treatment of pain. The Board found Dr. Thomas failed to maintain adequate medical records. This order resolves a formal complaint filed by the Board at the State Office of Administrative Hearings.

**Violation of Prior Order**

**Henry, Bruce Allen, M.D., Lic. No. H2454, Arlington**

On June 14, 2013, the Board and Bruce Allen Henry, M.D., entered into a Mediated Agreed Order of Temporary Suspension, which suspended Dr. Henry's license until such time that Dr. Henry requests to have the suspension stayed or lifted and personally appears before the Board and provides clear and convincing evidence that he is competent to safely practice medicine. The Board found Dr. Henry was not in compliance with his 2011 Order. This Order resolves a formal complaint filed at the State Office of Administrative Hearings.

**OTHER STATES' ACTION**

**Robinson, Patrick Randall, M.D., Lic. No. M9616, Ocala FL**

On June 14, 2013, the Board and Patrick Randall Robinson, M.D., entered into an Agreed Order requiring Dr. Robinson to within one year complete 12 hours of CME including five hours in chronic pain management, five hours in addiction medicine and two hours in risk management. The Board found Dr. Robinson was disciplined by the Michigan Board of Medicine for negligence in the delivery of medical care.

**Zapata, Helio, M.D., Lic. No. M4990, McAllen**

On June 14, 2013, the Board and Helio Zapata, M.D., entered into an Agreed Order requiring Dr. Zapata to pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Zapata was disciplined by the Illinois Department of Professional Regulation based upon an allegation of unnecessary surgical intervention.

**TXPHP AGREEMENT VIOLATION**

**Ghanem, Fadi George, M.D., Lic. No. H8071, The Woodlands**

On June 14, 2013, the Board and Fadi George Ghanem, M.D., entered into an Agreed Order requiring Dr. Ghanem submit to an evaluation by the Texas Physician Health Program within 30 days and comply with any and all recommendations made by TXPHP. The Board found Dr. Ghanem's agreement with the Texas

Physician Health Program was terminated due to non-compliance by testing positive for alcohol once and failing to call in as required on four occasions.

**Clark, James Allen, M.D., Lic. No. P1740, Woodville**

On June 14, 2013, the Board and James Allen Clark, M.D., entered into an Agreed Order requiring Dr. Clark to within 30 days submit to an evaluation by the Texas Physician Health Program and comply with all recommendations and pay an administrative penalty of \$500 within 60 days. The Board found Dr. Clark failed to comply with the terms of his TXPHP agreement, which led to his termination from the program.

**Merriman, Garrett Lance, M.D., Lic. No. BP10040392, El Paso**

On June 14, 2013, the Board and Garrett Lance Merriman, M.D., entered into an Agreed Order requiring Dr. Merriman to within 30 days submit to the Board names of up to three board-certified psychiatrists who agree to treat him, comply with recommendations for care and treatment, abstain from prohibited substances, participate in AA or Narcotics Anonymous two times per week and participate in Caduceus once per week. The Board found Dr. Merriman failed to comply with the terms of his agreement with the Texas Physicians Health Program (TXPHP).

**CEASE AND DESIST**

**Hubbard, Richard, M.D., No Texas License**

On June 14, 2013, the Board and Richard Hubbard, M.D., entered into an Agreed Cease and Desist Order prohibiting Dr. Hubbard from engaging in unlicensed practice of medicine in Texas. The Board found Dr. Hubbard, who is in California, interpreted a nerve conduction study performed on a patient in Killeen.

**Hacker, Bruce, Ph.D., No Medical License**

On June 14, 2013, the Board and Bruce Hacker, Ph.D., entered into an Agreed Cease and Desist Order requiring Mr. Hacker to refrain from holding himself out as “Dr. Bruce” and “Dr. Hacker” and “Dr. Bruce Hacker, Ph.D.” without clearly designating that he is not a medical doctor. The Board found Mr. Hacker held himself out as a doctor without adequately disclosing that he holds a Ph.D. and is not a licensed physician.

**Padilla, Alex, No Medical License**

On June 14, 2013, the Board and Alex Padilla entered into an Agreed Cease and Desist Order requiring Mr. Padilla to immediately cease practicing medicine. The Board received a complaint that Mr. Padilla performed liposuction and other cosmetic procedures on patients in the residence of an unlicensed person and prescribed medications to patients. Mr. Padilla did not admit to or deny the Board’s findings.

**NON-CERTIFIED RADIOLOGIC TECHNICIAN ACTION**

**Trujillo, Sylvia Marie, N.C.T., Lic No. NC03677**

On June 14, 2013, the Board entered a Default Order regarding Sylvia Marie Trujillo, N.C.T., revoking Ms. Trujillo’s non-certified radiologic technician license. The Board found Ms. Trujillo defaulted on a student

loan and failed to comply with Board requests for more information. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

Texas Medical Board Press Release

FOR IMMEDIATE RELEASE

July 3, 2013

Media contact: Megan Goode, 512-305-7044

Customer service: 512-305-7030 or 800-248-4062

## **TMB suspends impaired physician**

On July 2, 2013, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the Texas medical license of Susan W. Kirkpatrick, M.D., after determining that Dr. Kirkpatrick's continuation in the practice of medicine is a threat to the public welfare.

The Board found Dr. Kirkpatrick, a Dallas psychiatrist, is unable to safely practice medicine due to a physical or mental impairment. In March, an application for the appointment of a guardian for Dr. Kirkpatrick was filed on her behalf with the Dallas County Probate Court.

The temporary suspension remains in effect until the Board takes further action.

###

Texas Medical Board Press Release  
FOR IMMEDIATE RELEASE  
July 12, 2013

Media contact: Megan Goode, 512-305-7044  
Customer service: 512-305-7030 or 800-248-4062

## **TMB suspends Tyler physician**

On July 12, 2013, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the Texas medical license of Tyler physician William Edward Brown, M.D., after determining that Dr. Brown's continuation in the practice of medicine constitutes a threat to the public welfare due to his impaired status.

The Board found Dr. Brown violated terms of a five-year agreement with the Texas Physician Health Program in May 2013, including failure to complete required drug testing as well as a psychiatric evaluation. In June 2013, Dr. Brown violated an agreement with the Compliance Division of the Board by testing positive for prohibited substances.

The temporary suspension remains in place until the Board takes further action.

###

To view disciplinary orders, visit the TMB website, click on "Look Up A Doctor," accept the usage terms, then type in a doctor's name. Click on the name shown in the search results to view the doctor's full profile. Within that profile is a button that says "View Orders."

# Texas Medical Board Press Release

## FOR IMMEDIATE RELEASE

September 13, 2013

Media contact: [Jarrett Schneider](#), 512-305-7018  
Customer service: 512-305-7030 or 800-248-4062

## TMB disciplines 41 physicians at August meeting, proposes rule changes

At its August 29-30, 2013 meeting, the Texas Medical Board disciplined 41 licensed physicians and issued two cease and desist orders. The disciplinary actions included two suspensions, eight voluntary surrenders/revocations, two orders based on other states' actions, five orders related to unprofessional conduct, three violations of prior orders, one order due to impairment, one order due to a death registry violation, five orders related to non-therapeutic prescribing, two orders related to criminal behavior, one order due to inadequate medical records, and eleven orders related to quality-of-care violations.

The Board issued 149 physician licenses at the August board meeting, bringing the total number of physician licenses issued in FY 13 to 3,594. Thirty-two percent of physician licensure applications were completed in 10 days or less.

### RULE CHANGES PROPOSED

#### Chapter 193. Standing Delegation Orders

The Texas Medical Board (Board) proposes the repeal of §§193.1-193.12, and the replacement with new §§193.1-193.20 in Chapter 193, Standing Delegation Orders. The new sections of Chapter 193 are proposed to conform Chapter 193 with changes made to the Texas Occupation Code Annotated Chapter 157, Subchapter B, concerning delegation to advanced practice registered nurses and physician assistants, by Senate Bill 406, 83<sup>rd</sup> Legislature, Regular Session (2013).

Proposed rule changes can be viewed in the latest Texas Register at [www.sos.state.tx.us/texreg/sos/Proposed%20Rules/22.EXAMINING%20BOARDS.html#69](http://www.sos.state.tx.us/texreg/sos/Proposed%20Rules/22.EXAMINING%20BOARDS.html#69) and will be available on the TMB website at [www.tmb.state.tx.us/rules/rules.php](http://www.tmb.state.tx.us/rules/rules.php).

Additional proposed rules approved by the Board at the August meeting will be published on September 27, 2013 in the Texas Register and will be available on the TMB site.

### DISCIPLINARY ACTIONS

#### QUALITY OF CARE

##### Armstrong, Davill, M.D., Lic. No. F3025, Houston

On August 30, 2013, the Board and Davill Armstrong, M.D., entered into an Agreed Order requiring Dr. Armstrong to refrain from clinical practice, and applying for hospital privileges until he completes the Knowledge, Skills, Training, Assessment, and Research (KSTAR) program's Clinical Competency Assessment or a board approved mini-residence program of at least 90 days; further requiring Dr. Armstrong to undergo an independent medical evaluation by a psychiatrist, follow all recommendations by the psychiatrist for care and treatment; and upon successful completion of KSTAR, or mini-residency, have his practice monitored by another physician for four monitoring cycles. The Board found that a chart monitor raised concerns regarding Dr. Armstrong's quality of care. This Order supersedes all other previous orders by the Board.

##### Hamilton, Yolanda, M.D., Lic. No. K9295, Houston

On August 30, 2013, the Board and Yolanda Hamilton, M.D., entered into an Agreed Order requiring Dr. Hamilton to refrain from treating chronic pain patients; have her practice monitored by another physician for eight monitoring cycles; within one year complete the medical record-keeping course offered by the



University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete four hours of CME in the topic of risk management; and pay an administrative penalty of \$2,500. The Board found Dr. Hamilton failed to maintain adequate medical records and in some instances lacked full justification for the continued prescriptions of opiates and muscle relaxers to patients and failed to regularly monitor the patients for abuse of the controlled substances prescribed. This order resolves a formal complaint at the State Office of Administrative Hearings.

**Hyde, Linda Carol, M.D., Lic. No. J0011, Conroe**

On August 30, 2013, the Board and Linda Carol Hyde, M.D., entered into an Agreed Order publicly reprimanding Dr. Hyde and prohibiting Dr. Hyde from re-registering or obtaining Controlled Substances Registrations until she has received written authorization from the Board; that Dr. Hyde refrain from serving as a physician for herself or family, and refrain from prescribing controlled substances to her immediate family; further requiring Dr. Hyde to have her practice monitored by another physician for 8 monitoring cycles and pass within one year and three attempts the Medical Jurisprudence Exam. The Board found Dr. Hyde failed to adequately supervise the activities of those acting under her supervision and prescribed controlled substances to family members for periods greater than 72 hours.

**Jarrah, Taysir Fawzi, M.D., Lic. No. E6438, McKinney**

On August 30, 2013, the Board and Taysir Fawzi Jarrah, M.D., entered into an Agreed Order requiring Dr. Jarrah to have his practice monitored by another physician for four monitoring cycles; complete within one year 10 hours of CME, including eight hours in medical record keeping, and two hours in ethics; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Jarrah failed to meet the standard of care, performed interventional cardiology procedures on 10 patients that were not medically necessary and had his hospital privileges revoked.

**Koval, Robert John, M.D., Lic. No. G1694, Dallas**

On August 30, 2013, the Board and Robert John Koval, M.D., entered into a Mediated Agreed Order publicly reprimanding Dr. Koval and requiring Dr. Koval to refrain from engaging in the treatment of any chronic pain; have his practice monitored by another physician for eight monitoring cycles; within one year complete 45 hours of CME in the following topics, divided as follows: medical record-keeping (15 hours), pain management (15 hours), and internal medicine for primary care physicians (15 hours); and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Koval failed to meet the standard of care with respect to several patients by routinely prescribing medications without documenting and/or performing appropriate patient assessments and evaluations. This order resolves a formal complaint at the State Office of Administrative Hearings.

**Molina, Hector Oscar, M.D., Lic. No. K2755, Dallas**

On August 30, 2013, the Board and Hector Oscar Molina, M.D., entered into an Agreed Order publicly reprimanding Dr. Molina and requiring him to complete within one year and three attempts, the Medical Jurisprudence Examination and complete within one year 20 hours of CME, divided as follows: 12 hours in medical ethics and eight hours in wound care. The Board found Dr. Molina performed cosmetic surgery on two patients in inappropriate settings and that the procedures resulted in complications for both patients. The Board also found Dr. Molina admitted that he lied in sworn testimony to the Nevada Athletic Commission and that his testimony related to his practice of medicine.

**Parikh, Samir P., M.D., Lic. No. N4649, Frisco**

On August, 30, 2013, the Board and Samir P. Parikh, M.D., entered into an Agreed Order requiring Dr. Parikh complete within one year the Texas Medical Board Remedial Coaching Program at the University of Texas at Dallas School of Management; within one year complete at least 12 hours of continuing medical education (CME), including four hours in ethics, four hours in risk management, and four hours in patient communication; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Parikh failed to appropriately respond to an emergency while on call.

**Pauza, Kevin Joseph, M.D., Lic. No. J7127, Tyler**

On August 30, 2013, the Board and Kevin Joseph Pauza, M.D., entered into an Agreed Order requiring Dr. Pauza to have his practice monitored by another physician for four monitoring cycles; and within one

year complete 20 hours of CME, including eight hours in opioid therapy and four hours in risk management. The Board found Dr. Pauza failed to meet the standard of care, failed to follow the Board's guidelines for the treatment of pain, failed to keep adequate medical records and failed to cooperate with Board staff.

**Pinkerton, Jody Lyn, M.D., Lic. No. J7791, Sugar Land**

On August 30, 2013, the Board and Jody Lyn Pinkerton, M.D., entered into an Agreed Order requiring Dr. Pinkerton within one year, complete at least 24 hours of CME, divided as follows: eight hours in medical recordkeeping, eight hours in high risk pregnancies, eight hours in performing/interpreting obstetric ultrasounds; and pay and administrative penalty of \$1,000 within 60 days. The Board found Dr. Pinkerton failed to meet the standard of care by wrongly diagnosing a patient's viable pregnancy and failed to make an effort to confirm the diagnosis through other measures.

**Shelton, Kevin James, M.D., Lic. No. N1893, Celina**

On August 30, 2013, the Board and Kevin James Shelton, M.D., entered into an Agreed Order requiring Dr. Shelton within one year complete at least 16 hours of continuing medical education (CME), including at least eight hours in endocrinology; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Shelton failed to perform an adequate medical workup of a patient prior to treatment and failed to maintain adequate medical records.

**Williams, Lucia Leigh, M.D., Lic. No. G9013, Jacksonville**

On August 30, 2013, the Board and Lucia Leigh Williams, M.D., entered into a Mediated Agreed Order requiring Dr. Williams to within one year complete 16 hours of CME, divided into the following topics: eight hours in risk management and eight hours in managing high risk obstetrics patients; and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Williams failed to diagnose and treat a pregnant patient's chronic hypertension and failed to order further testing to confirm fetal well-being. This order resolves a formal complaint at the State Office of Administrative Hearings.

## **SUSPENSION**

**Nwora, Emmanuel Mbanefo, M.D., Lic. No. M2428, Houston**

On August 30, 2013, the Board and Emmanuel Mbanefo Nwora, M.D., entered into an Agreed Order of Suspension regarding Dr. Nwora, suspending Dr. Nwora's Texas medical license until the final disposition of the contested case currently at the State Office of Administrative Hearings. The Board found Dr. Nwora is facing federal charges related to the practice of medicine and criminal proceedings related to those charges are ongoing in Federal district court.

**Strickland, Michael Lynn, M.D., Lic. No. G5660, Lubbock**

On August 30, 2013, the Board and Michael Lynn Strickland, M.D., entered into an Agreed Order of Suspension, suspending Dr. Strickland's license until such time as he appears before the Board and provides clear and convincing evidence that he is physically, mentally and otherwise competent to safely practice medicine. The Board found Dr. Strickland is unable to practice medicine with reasonable skill and safety to patients because of illness or as a result of a mental or physical condition.

## **OTHER STATES' ACTIONS**

**Farina, Gloria E., M.D., Lic. No. H0334, Vero Beach, FL**

On August 30, 2013, the Board and Gloria E. Farina, M.D., entered into an Agreed Order requiring Dr. Farina to cease practicing medicine in Texas until she provides sufficient evidence that she is competent to safely practice medicine, including proof that she has satisfied the terms and conditions of the State of Florida Department of Health/Board of Medicine. The Board found Dr. Farina was disciplined by the Florida Board of Medicine for inappropriately prescribing weight loss medications to a patient.

**Lore, Steven Clarence, M.D., Lic. No. M0154, Hill Air Force Base, UT**

On August 30, 2013, the Board and Steven Clarence Lore, M.D., entered into an Agreed Order requiring Dr. Lore to cease practicing in Texas until he provides sufficient evidence and information that he is competent to safely practice medicine. The Board found Dr. Lore's clinical privileges at Hill Air Force Base

were terminated based on a peer review that found his treatment of patients and medical record documentation to be below the standard of care.

### **VOLUNTARY SURRENDER/REVOCAION**

#### **Burks, Joseph Emerson, M.D., Lic. No. E0839, Victoria**

On August 30, 2013, the Board and Joseph Emerson Burks, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Burks voluntarily and permanently surrendered his Texas medical license. Dr. Burks voluntarily surrendered his medical license due to his physical condition in lieu of further disciplinary action.

#### **Camati, Mirian, M.D., Lic. No. L3884, Houston**

On August 30, 2013, the Board and Mirian Camati, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Camati voluntarily and permanently surrendered her Texas medical license and was ordered to immediately cease practicing in Texas. Dr. Camati agreed not to petition the board for reinstatement of her license in lieu of further disciplinary proceedings. Dr. Camati was under investigation by the Board related to her prescribing practices. The Board found Dr. Camati is unable to practice medicine because of a medical condition and decided to surrender her license and retire from the practice of medicine rather than continue contesting the investigation.

#### **Dorman, John Wesley, M.D., Lic. No. D5375, Houston**

On August 30, 2013, the Board and John Wesley Dorman, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Dorman voluntarily and permanently surrendered his Texas medical license. The Board found Dr. Dorman is retiring due to a medical condition which makes it difficult for him to practice medicine.

#### **Nguyen, Ngoc Xuan, M.D., Lic. No. J3173, Houston**

On August 30, 2013, the Board and Ngoc Xuan Nguyen, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Nguyen voluntarily and permanently surrendered his medical license and was ordered to immediately cease practicing in Texas. Dr. Nguyen agreed not to petition the board for reinstatement of his license in lieu of further disciplinary proceedings. Dr. Nguyen was under investigation by the Board regarding allegations that he operated a pain management clinic in violation of Board rules and non-therapeutically prescribed controlled substances.

#### **Potterf, Raymond Dewayne, M.D., Lic. No. E8824, San Antonio**

On August 30, 2013, the Board and Raymond Dewayne Potterf, M.D. , entered into an Agreed Order of Voluntary Surrender in which Dr. Potterf voluntarily and permanently surrendered his Texas medical license and agreed not to petition the Board for reinstatement in lieu of further disciplinary proceedings. Dr. Potterf was under investigation by the Board related to allegations that he non-therapeutically prescribed controlled substances to one patient and engaged in inappropriate conduct with another patient.

#### **Small, Andrew Buchanan, III, M.D., Lic. No. D6175, Dallas**

On August 30, 2013, the Board and Andrew Buchanan Small, III, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Buchanan agreed to voluntarily and permanently surrender his medical license and cease practicing in Texas in lieu of further disciplinary proceedings. Dr. Buchanan reported to the Board that he has a medical condition that precludes him from continuing in the practice of medicine and precludes him from fulfilling terms of his 2012 Mediated Agreed Order.

#### **Sorokolit, Walter T., M.D., Lic. No. F2456, Fort Worth**

On August 30, 2013, the Board and Walter T. Sorokolit, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Sorokolit voluntarily and permanently surrendered his Texas medical license. Dr. Sorokolit requested the surrender in lieu of further disciplinary proceedings. The Board found Dr. Sorokolit resigned his clinical privileges at a medical facility during the course of an investigation by the facility and later withdrew that resignation.

**Winslow, Grover Cleveland, Jr., M.D., Lic. No. C3918, Hemphill**

On August 30, 2013, the Board and Grover Cleveland Winslow, Jr., M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Winslow voluntarily and permanently surrendered his medical license due to an illness or physical condition rendering him unable to practice medicine with reasonable skill and safety to patients.

**UNPROFESSIONAL CONDUCT**

**Gossett, Carl W., M.D., Lic. No. G3403, Fort Worth**

On August 30, 2013, the Board and Carl W. Gossett, M.D., entered into a Mediated Agreed Order requiring Dr. Gossett to refrain from prescribing any controlled substance to himself, his family or any other person to which he has a close personal relationship, and may not order medications from any online source; undergo an independent medical evaluation by a psychiatrist, follow all recommendations by the psychiatrist for care and treatment; not possess, administer, dispense or prescribe any Schedule II-IV controlled substances, except as medically necessary for treatment of patients seen in a hospital setting, urgent care setting and/or Emergency Department when he has privileges; complete within one year and three attempts the Medical Jurisprudence Exam; within one year complete the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found from 2008-2011, Dr. Gossett ordered large quantities of controlled substances from online wholesale pharmacies for both his personal use and for family members, failed to maintain adequate medical records, and was charged with unprofessional treatment of patients and staff. This order resolves a formal complaint at the State Office of Administrative Hearings.

**Kufoy, Ernesto A., M.D., Lic. No. K2520, De Ridder, LA**

On August 30, 2013, the Board and Ernesto A. Kufoy, M.D., entered into an Agreed Order requiring Dr. Kufoy to complete within one year and three attempts, the Medical Jurisprudence Exam; within one year complete at least eight hours of CME in the topic of ethics; and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Kufoy has been the subject of at least six medical malpractice claims between 2008 and 2012 that resulted in either settlements or judgments in favor of the claimants and that he failed to report these claims, as required, on his 2012 license renewal application.

**Smith, Stephen Harkness, M.D., Lic. No. J0271, San Angelo**

On August 30, 2013, the Board and Stephen Harkness Smith, M.D., entered into an Agreed Order requiring Dr. Smith to submit proof of an agreement for the repayment of his student loan within 30 days and complete within one year eight hours of CME in the topic of ethics. The Board found Dr. Smith defaulted on his student loan.

**Werner, Jan Reinert, Jr., M.D., Lic. No. E7533, Amarillo**

On August 30, 2013, the Board and Jan Reinert Werner, Jr., M.D., entered into an Agreed Order publicly reprimanding Dr. Werner and requiring Dr. Werner to complete within one year the TMB Remedial Coaching Program at U.T. Dallas School of Management. The Board found Dr. Werner had been subject to disciplinary action by peers based on complaints he made unprofessional comments towards patients, patients' family members and medical staff.

**Wilkinson, Tolbert Siener, M.D., Lic. No. D8842, Fort Worth**

On August 30, 2013, the Board and Tolbert Siener Wilkinson, M.D., entered into a Mediated Agreed Order requiring Dr. Siener to within one year complete 16 hours of CME in risk management and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Wilkinson provided false information to the Board when he completed applications for renewal of his Texas medical license. This order resolves a formal complaint at the State Office of Administrative Hearings.

**VIOLATION OF PRIOR ORDER**

**Cox, Bruce Edward, M.D., E4272, Big Spring**

On August 30, 2013, the Board and Bruce Edward Cox, M.D., entered into an Agreed Order Modifying Dr. Cox's 2012 Order, requiring Dr. Cox to notify, in writing, his compliance officer the date upon which he resumes practicing medicine, and within one year of resuming practice, complete the K-STAR or PACE

program as required by his previous order. All other terms and conditions of the 2012 order remain in force. The Board found Dr. Cox failed to comply with his 2012 Order.

**Dudley, Samuel W., III, M.D., Lic. No. L4347, Harlingen**

On August 30, 2013, the Board and Samuel W. Dudley, III, M.D., entered into an Agreed Order Modifying Dr. Dudley's 2011 Agreed Order, requiring Dr. Dudley to within a year complete 30 hours of CME, in the following subjects: risk management (10 hours) and critical care and pediatric medicine (20 hours, in person). All other terms and conditions of the 2011 order remain in full force. The Board found Dr. Dudley failed to complete CME required by a previous board order.

**Perez, Michael Joseph, D.O., Lic. No. H8949, Woodville**

On August 30, 2013, the Board and Michael Joseph Perez, D.O., entered into an Agreed Order Modifying Dr. Perez's 2012 Agreed Order, which required Dr. Perez to complete 24 hours of CME, divided as follows: four hours in diagnosis and treatment of chronic pain, four hours in the practice of addiction medicine, eight hours in risk management and eight hours in medical record-keeping. The Board found Dr. Perez failed to timely prove completion of the CME required by the 2012 Order and modified the 2012 Order to allow additional time to demonstrate completion of the requirements of the 2012 Order.

## **IMPAIRMENT**

**Briggs, Edward Dickon, M.D., Lic. No. L9635, San Antonio**

On August 30, 2013, the Board and Edward Dickon Briggs, M.D., entered into an Agreed Order suspending the license of Dr. Briggs, staying the suspension, and placing Dr. Briggs on probation for 10 years under the following terms and conditions: refrain from practicing medicine until he has been evaluated by a Board approved psychiatrist; he must be evaluated by a psychiatrist and follow all recommendations for continued care and treatment; for three months after returning to practice, limit his practice of medicine to no more than two days per week; after three months and during the remainder of his Order, he may not practice more than 40 hours per week; for six months after returning to practice, he shall not handle any obstetric cases or serve as the on-call physician in any capacity; his practice must be limited to a group or institutional setting with a supervising physician; abstain from the consumption of alcohol and dangerous drugs; participate in the Board's drug testing program; participate in Alcoholics Anonymous; and pay an administrative penalty of \$5,000 within 60 days. The Board found Dr. Briggs was observed by hospital staff abusing and diverting Propofol for personal use while working as an anesthesiologist on a surgical team, tested positive for the presence of Propofol and benzodiazepines during a drug screen test, and admitted he had been abusing Propofol for approximately three months prior to the incident. Dr. Briggs also admitted he had been abusing alcohol.

## **TEXAS ELECTRONIC DEATH REGISTRY VIOLATIONS**

**Hussain, Syed K., M.D., Lic. No. M1157, Brownsville**

On August 30, 2013, the Board and Syed K. Hussain, M.D., entered into an Agreed Order requiring Dr. Hussain to, within one year and three attempts, pass the Medical Jurisprudence Exam; complete 12 hours of CME, in the following topics: 8 hours in medical record keeping and 4 hours in risk management; and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Hussain failed to timely certify a death certificate using the Texas Electronic Death Registry.

## **NONTHERAPEUTIC PRESCRIBING**

**Levy, Steven Robert, M.D., Lic. No. H0563, Houston**

On August 30, 2013, the Board and Steven Robert Levy, M.D., entered into an Agreed Order requiring Dr. Levy to cease prescribing any controlled substances except for medications medically necessary for the treatment of attention deficit disorder (ADD) or attention deficit hyperactivity disorder (ADHD); refrain from serving as a physician for his immediate family, and refrain from prescribing controlled substances to himself or his immediate family; be monitored by another physician for eight monitoring cycles; complete within one year and three attempts the Medical Jurisprudence Exam; complete within one year the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete 16 hours of CME in the following topics: identifying drug-seeking behavior (eight hours) and medical ethics (eight hours); and pay an

administrative penalty of \$5,000 within 60 days. The Board found Dr. Levy non-therapeutically prescribed controlled substances to a patient, including Vicodin and Soma, without maintaining adequate medical records to justify the types and amounts of drugs prescribed, that Dr. Levy continued to prescribe controlled substances to the patient after the patient threatened him with physical harm, issued false prescriptions to the patient for controlled substances for the patient's family members and friends whom he had never seen or treated. Dr. Levy also admitted to the Board that he had an inappropriate, intimate relationship with the patient and wrote false prescriptions.

**Nichols, Dwight James, M.D., Lic. No. D0985 Breckenridge**

On August 30, 2013, the Board and Dwight James Nichols, M.D., entered into an Agreed Order publicly reprimanding Dr. Nichols and requiring Dr. Nichols to surrender his DEA and DPS controlled substance certificates; within one year and three attempts pass the Special Purpose Examination (SPEX); have another physician monitor his practice for 12 monitoring cycles; and pay an administrative penalty of \$5,000 within 90 days. The Board found Dr. Nichols non-therapeutically prescribed medication to patients without support for the prescriptions; failed to maintain adequate medical records; and knowingly prescribed to an individual who was diverting the medication to another person.

**Ordonez, Robert Lee, M.D., Lic. No. F1871, Lubbock**

On August 30, 2013, the Board and Robert Lee Ordonez, M.D., entered into an Agreed Order requiring Dr. Ordonez to within one year and three attempts, pass the Medical Jurisprudence Exam; within one year complete 40 hours of CME, divided as follows: nine hours in medical record keeping, eight hours of risk management, 23 hours in prescribing controlled substances, including the University of California at San Diego "PACE" course in Physician Prescribing or its equivalent. The Board found Dr. Ordonez improperly prescribed controlled substances to a patient and failed to maintain adequate medical records.

**Garner, William Brandt, M.D., Lic. No. N3661, Austin**

On August 30, 2013, the Board and William Brandt Garner, M.D., entered into an Agreed Order requiring Dr. Garner to within 30 days submit to the Board names of up to three board-certified psychiatrists who agree to treat him and comply with recommendations for care and treatment; abstain from the consumption of prohibited substances; participate in AA programs; limit medical practice to a group or an institutional setting that has been approved in advance; have his practice monitored by a supervising physician; refrain from treating his immediate family or prescribe to himself or immediate family any controlled substances; and complete within one year and three attempts the Medical Jurisprudence Exam. The Board found Dr. Garner, while under contract with the Texas Physician Health Program, relapsed and was terminated. Dr. Garner admitted to drinking while under contract.

**Maat, Owen Surgent, M.D., Lic. No. J5609, Bellaire**

On August 30, 2013, the Board and Owen Surgent Maat, M.D., entered into a Mediated Agreed Order publicly reprimanding Dr. Maat and suspending Dr. Maat's license, staying the suspension and placing him on probation for fifteen years under the following terms and conditions: abstain from the consumption of prohibited substances, participate in the Board's drug testing program; continue participating in AA no less than seven times a week; submit to and obtain an independent medical evaluations from a Board designated psychiatrist; complete within a year and three attempts, the Medical Jurisprudence Exam; within one year complete 16 hours of CME in the following topics: medical ethics (8 hours) and risk management (8 hours); and pay an administrative penalty of \$2,000 within 120 days. Dr. Maat's practice is also restricted under the following conditions for ten years: shall not obtain or maintain hospital privileges at more than one hospital; and shall not practice medicine beyond forty hours per week. The Board found Dr. Maat violated his prior 2004 and 2008 Orders by testing positive for alcohol on two occasions in 2011 and on multiple occasions in 2012.

## **CRIMINAL BEHAVIOR**

**Brammer, Gregory Ray, M.D., Lic. No. K5830, Tacoma, WA**

On August 30, 2013, the Board and Gregory Ray Brammer, M.D., entered into an Agreed Order publicly reprimanding Dr. Brammer and suspending Dr. Brammer's Texas medical license for a period of no less than 90 days until he requests in writing to have the suspension stayed or lifted, and personally appears

before the Board and provides evidence and information that proves, at the discretion of the Board, that he is physically, mentally, and otherwise competent to safely practice medicine; within one year Dr. Brammer must complete 16 hours of CME in the topic of anger management; and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Brammer entered a plea of guilty to a charge of Harassment (Bodily Injury) and was sentenced to probation for two years in Tacoma, Washington.

**Garcia, Pedro Espinoza, Jr., M.D., Lic. No. E4345, Mission**

On August 30, 2013, the Board and Pedro Espinoza Garcia, Jr., M.D., entered into an Agreed Order publicly reprimanding Dr. Garcia and prohibiting him from administering, dispensing, prescribing or refilling a prescription for any Schedule II or III controlled substance; and surrender, within seven days, his DEA and DPS controlled substances certificates. The Board found Dr. Garcia did not renew his DPS and DEA registrations, failed to update his address and wrote prescriptions for controlled substances with an expired DEA/DPS number.

**INADEQUATE MEDICAL RECORDS**

**Benson, Leslie Wayne, M.D., Lic. No. H2243, Dallas**

On August 30, 2013, the Board and Leslie Wayne Benson, M.D., entered into an Agreed Order requiring Dr. Benson to complete within one year 16 hours of CME, including eight hours in risk management and eight hours in medical recordkeeping; and pay an administrative penalty of \$3,000. The Board found Dr. Benson failed to maintain adequate medical records. This order resolves a formal complaint at the State Office of Administrative Hearings.

**CEASE AND DESIST**

**Beck, Jamie, Unlicensed, Houston**

On August 19, 2013 the Texas Medical Board entered a Cease and Desist Order regarding Jamie Beck prohibiting her from practicing medicine or holding herself out to be a physician. The Board found Ms. Beck had been engaging in the unlicensed practice of medicine. Specifically, Ms. Beck owned and operated a pain management clinic.

**Russ, Melissa, N.D., No Medical License**

On August 30, 2013, the Board and Melissa Russ, N.D., entered into an Agreed Cease and Desist Order requiring Ms. Russ to refrain from holding herself out as "Dr. Melissa", "Dr. Russ", "Dr. Melissa Russ", and "Dr. Melissa Russ, N.D.", without clearly designating that she is not a medical doctor. The Board received a complaint that Ms. Russ engaged in the unlicensed practice of medicine by: being referred to as a "doctor" on her employer's website and in an instructional video, without referring to what authority under which the title is used or what degree gives rise to the use of the title.

**###**

*To view disciplinary orders, visit the TMB website, click on "Look Up A Doctor," accept the usage terms, then type in a doctor's name. Click on the name shown in the search results to view the doctor's full profile. Within that profile is a button that says "View Orders."*

## **Texas Medical Board Press Release**

### **FOR IMMEDIATE RELEASE**

October 8, 2013

Media contact: [Jarrett Schneider](#), 512-305-7018  
Customer service: 512-305-7030 or 800-248-4062

### **TMB suspends San Antonio psychiatrist**

On October 4, 2013, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the Texas medical license of San Antonio psychiatrist Shawna Mohny Deeves, M.D., after determining that Dr. Deeves' aggressive conduct and documented deteriorating mental state demonstrated that Dr. Deeves poses a continuing threat to public health and safety.

The Board found Dr. Deeves has been diagnosed with significant psychiatric illness and that her communications with other physicians as well as the staff of the Texas Physician Health Program have been delusional and threatening.

A temporary suspension hearing with notice will be held as soon as practicable with 10 days' notice to Dr. Deeves, unless the hearing is specifically waived by Dr. Deeves. The temporary suspension remains in place until the Board takes further action.

# # #

*To view disciplinary orders, visit the TMB website, click on "Look Up A Doctor," accept the usage terms, then type in a doctor's name. Click on the name shown in the search results to view the doctor's full profile. Within that profile is a button that says "View Orders."*

*All releases and publications are also available on the TMB website under the "News" heading.*



## Texas Medical Board Press Release

### FOR IMMEDIATE RELEASE

October 30, 2013

Media contact: Jarrett Schneider, 512-305-7018  
Customer service: 512-305-7030 or 800-248-4062

### **TMB disciplines 36 physicians at October meeting, adopts rule changes**

At its October 18, 2013 meeting, the Texas Medical Board disciplined 36 licensed physicians and issued one cease and desist order. The disciplinary actions included fourteen orders related to quality of care violations, eight orders related to unprofessional conduct, two orders related to non-therapeutic prescribing, one order based on other states' actions, one suspension, four voluntary surrenders, three orders related to peer review actions, one order related to Texas Physicians' Health Program violations, one order related to inadequate medical records, and one pain clinic action.

The Board did not issue physician licenses at its October meeting.

### **RULE CHANGES ADOPTED**

#### **Chapter 193. Standing Delegation Orders**

The Texas Medical Board adopted the repeal of §§193.1-193.10 and 193.12 and the replacement with new §§193.1-193.20 in Chapter 193, Standing Delegation Orders. A majority of the new sections of Chapter 193 were adopted to conform Chapter 193 with changes made to the Texas Occupation Code Annotated Chapter 157, Subchapter B, concerning delegation to advanced practice registered nurses and physician assistants, by Senate Bill 406, 83<sup>rd</sup> Legislature, Regular Session (2013).

Rule changes are effective November 7, 2013 and will be published in the Friday, November 1, 2013 issue of the Texas Register: <http://www.sos.state.tx.us/texreg/index.shtml>. (Note: Click on links under Current Issue on right side of webpage.)

### **CHAPTER 193. STANDING DELEGATION ORDERS**

#### **§193.1 - Purpose**

This section describes the intended purpose of Chapter 193 and sets forth its statutory basis.

#### **§193.2 - Definitions**

This section provides definitions for important terms and phrases used in Chapter 193. New terms and phrases defined include: prescriptive authority agreement, device, facility based practice site, health professional shortage areas (HSPA), hospital, medication order, nonprescription drug, physician group practice, practice serving a medically underserved area, prescribe or order a drug or device, and prescription drug.

#### **§193.3 - Exclusion from the Provisions of this Chapter**

This section sets forth certain limited exclusions to the operation of the Chapter 193.

#### **§193.4 - Scope of Standing Delegation Orders**

This section describes the scope of standing delegation orders and incorporates new terms and definitions consistent with the changes to Chapter 157 of the Occupations Code.

#### **§193.5 - Physician Liability for Delegated Acts and Enforcement**

This section sets forth the applicable limitation on the liability of physicians based solely on signing a prescriptive authority agreement or delegation order. This section further states that delegating physicians remain responsible to the Board and their patients for acts performed under the physician's delegated authority.

#### **§193.6 - Delegation of Prescribing and Ordering Drugs and Devices**

This section sets forth the general requirements and limitations related to the delegation and prescribing and ordering of drugs or devices. This section also prohibits the delegation of the prescriptive authority for Schedule II drugs, except in facility based practices under Section 157.054 of the Occupations Code. Prescribing under prescriptive authority agreements eliminates former requirements for site based supervision.

#### **§193.7 - Prescriptive Authority Agreements Generally**

This section provides that physicians may delegate to advanced practice registered nurses and physician assistants the act of prescribing or ordering a drug or device through a prescriptive authority agreement and limits the combined number of advanced practice registered nurses and physician assistants with whom a physician may enter into a prescriptive authority agreement to seven. The section sets forth an exclusion to the limit of seven prescriptive authority agreements for prescriptive authority agreements when exercised in facility based practices in hospitals or long term care facilities, subject to certain limitations, and in practices serving medically underserved populations. Prescribing under prescriptive authority agreements pursuant to this section eliminates former requirements for site based supervision.

#### **§193.8 - Prescriptive Authority Agreements: Minimum Requirements**

This section sets forth minimum requirements for valid prescriptive authority agreements, including requirements for periodic face to face-to-meetings with the supervising physicians to discuss patient care and improvement of patient care.

#### **§193.9 - Delegation of Prescriptive Authority at Facility Based Practice Sites**

This section describes the requirements for delegating the prescribing or ordering of a drug or device at a facility-based practice site. This section states that the limitations on the number of advanced practice registered nurses and physician assistants delegated to under prescriptive authority agreements do not apply to a physician whose practice is facility-based under Chapter 193, subject to certain limitations. This section also addresses requirements for physician supervision and states that the constant physical presence of a physician is not required.

#### **§193.10 - Registration of Delegation and Prescriptive Authority Agreements**

This section describes the requirements for physicians to register information with the Board regarding prescriptive authority agreements entered into with advanced practice registered nurses and physician assistants. This section also states that the Board shall maintain and exchange information with the Texas Board of Nursing and Physician Assistant Board as well as creating and making available to the public, an online list of physicians, advanced practice registered nurses, and physician assistants who have entered into prescriptive authority agreements.

### **§193.11 - Prescription Forms**

This section provides that prescription forms shall comply with applicable rules adopted by the Board of Pharmacy.

### **§193.12 - Prescriptive Authority Agreements**

This section provides the Board authority to enter, with reasonable notice, a site where a party to a prescriptive authority agreement is practicing, to inspect and audit records or activities related to the implementation and operation of the agreement.

### **193.13 - Delegation to Certified Registered Nurse Anesthetists**

This section authorizes the delegation of the ordering of drugs and devices to a certified nurse anesthetist in a licensed hospital or ambulatory surgical center, for the purpose of the nurse anesthetist administering an anesthetic or anesthesia-related service ordered by a physician.

### **§193.14 - Delegation Related to Obstetrical Services**

This section describes the authority, requirements, and limitations, related to delegating to physicians assistants offering obstetrical services and advance practice registered nurses recognized by the Texas State Board of Nurse Examiners as nurse midwives, the act or acts of administering controlled substances related to intra-partum and post-partum care.

### **§193.15 - Delegated Drug Therapy Management**

This section describes the authorization for, and requirements, and limitations, related to the delegation by physicians to pharmacists of drug therapy management.

### **§193.16 - Delegated Administration of Immunizations or Vaccinations by a Pharmacist under Written Protocol**

This section describes the authorization for, requirements, and limitations, related to the delegation of the administration of immunizations and vaccinations to a pharmacist.

### **§193.17 - Nonsurgical Medical Cosmetic Procedures**

This section describes the duties and responsibilities of a physician who performs or who delegates the performance of nonsurgical medical cosmetic procedures.

### **§193.18 - Pronouncement of Death**

This section authorizes physicians to receive information from Texas licensed vocational nurses through electronic communication for the purposes of making a pronouncement of death.

### **§193.19 - Collaborative Management of Glaucoma**

This section sets forth the minimum standards for the collaborative treatment of glaucoma.

### **§193.20 - Immunization of Persons Over 65 by Physician's Offices**

This section sets forth requirements that physicians providing ongoing primary or principal care to persons over 65 (elderly persons) to offer, to the extent possible, pneumococcal and influenza vaccines to each elderly person receiving care at the office.

## **DISCIPLINARY ACTIONS**

### **QUALITY OF CARE**

#### **Agim, Onyinye Amara, M.D., Lic. No. N2360, Houston**

On October 18, 2013, the Board and Onyinye Amara Agim, M.D., entered into an Agreed Order requiring Dr. Agim to complete at least 16 hours of CME, divided as follows: 8 hours in ethics and 8 hours in risk management (including supervision of mid-level providers) and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Agim did not adequately supervise the employees under her direction at the clinic, including the advanced practice nurse and had no written protocols in place during her supervision.

#### **Barrow, Justin Boone, M.D., Lic. No. K8607, College Station**

On October 18, 2013, the Board and Justin Boone Barrow, M.D., entered into an Agreed Order requiring Dr. Barrow to within one year complete at least 8 hours of CME in evaluation of chest pain. The Board found Dr. Barrow failed to appropriately evaluate and treat a patient for chest pain.

#### **Carreras, Jose R., M.D., Lic. No. G8678, Mission**

On October 18, 2013, the Board and Jose R. Carreras, M.D., entered into a Mediated Agreed Order requiring Dr. Carreras to within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Carreras failed to meet the standard for one patient in his surgical care by not performing a complete examination and establish plan of care prior to his surgical intervention.

#### **Gleason, Patrick Langham, M.D., Lic. No. L6913, Corpus Christi**

On October 18, 2013, the Board and Patrick Langham Gleason, M.D., entered into an Agreed Order requiring Dr. Gleason to have his practice monitored by another physician for four monitoring cycles; within one year complete at least 12 hours of CME, divided as follows: four hours in medical record-keeping, four hours in risk management, and four hours in post-operative complications; and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Gleason failed to use proper diligence in his treatment of one patient and failed to safeguard against potential complications that led to the vascular injury and death of said patient.

#### **Hogan, Matthew James, M.D., Lic. No. H5777, Atlanta**

On October 18, 2013, the Board and Matthew James Hogan, M.D., entered into a Mediated Agreed Order requiring Dr. Hogan to within one year complete eight hours of CME in diagnosing cardiopulmonary emergencies and eight hours in medical record keeping; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Hogan failed to meet the standard of care in regards to one patient by failing to adequately evaluate the patient for a pulmonary embolism.

#### **Lester, R. Anton, III, D.O., Lic. No. F3204, Tyler**

On October 18, 2013, the Board and R. Anton Lester, III, D.O., entered into an Agreed Order requiring Dr. Lester to have his practice monitored by another physician for 12 monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in risk management and eight hours in ethics; not prescribe, dispense, administer or authorize controlled substances or dangerous drugs to himself for his own use or in his name for use by patients; separate from patient records, Dr. Lester shall maintain a log consisting of a record of every sample of controlled substances or dangerous drugs provided to patients in chronological order by date issued; and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Lester's medical records were inadequate with the treatment of one patient and that Dr. Lester admitted to prescribing in his name in order to provide medications to his patients.

#### **Lewis, Adolphus Ray, D.O., Lic. No. H2532, Fort Worth**

On October 18, 2013, the Board and Adolphus Ray Lewis, D.O., entered into an Agreed Order requiring Dr. Lewis to have his practice monitored by another physician for eight monitoring cycles; and within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Lewis failed to meet the standard of care in his treatment of a patient's skin ulcers and maintained inadequate medical records.

**Miller, Dwayne, C., M.D., Lic. No. H0638, Comanche**

On October 18, 2013, the Board and Dwayne C. Miller, M.D., entered into an Agreed Order requiring Dr. Miller to within one year complete at least 16 hours of CME, divided as follows: 8 hours in medical recordkeeping and 8 hours in heart failure/blockage. The Board found Dr. Miller failed to meet the standard of care in the treatment of one patient when he failed to obtain an echocardiogram after complications developed following the placing of a cardiac pacemaker and failed to seek assistance when complications developed during the procedure.

**Mittal, Piyush, M.D., Lic. No. L7816, Lubbock**

On October 18, 2013, the Board and Piyush Mittal, M.D., entered into an Agreed Order requiring Dr. Piyush to complete at least 16 hours of CME, divided as follows: 8 hours in risk management and 8 hours in medical record-keeping. The Board found Dr. Piyush failed to meet the standard of care in the treatment of a patient by not maintaining continuity of care in the transfer of a patient between hospital facilities.

**CORRECTED ORDER 10/31/13: Noble, DeCarlo, M.D., Lic. No. L5851, Denton**

On October 18, 2013, the Board approved a Final Order requiring Dr. Noble to have his practice monitored by another physician for eight monitoring cycles; and within one year complete at least 36 hours of CME, divided as follows: eight hours in high risk obstetrics and gynecology, eight hours in medical recordkeeping, eight hours in risk management, and eight hours in ethics. The action was based on the findings of an administrative law judge who heard the case at the State Office of Administrative Hearings.

**Park, Jin Sup, M.D., Lic. No. E8797, Houston**

On October 18, 2013, the Board approved a Final Order publicly reprimanding Dr. Park and requiring Dr. Park to within 180 days complete the Clinical Competence Assessment, including Phase I and Phase II, offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year and three attempts pass the Special Purpose Examination (SPEX) and the Medical Jurisprudence Examination (JP Exam); have his practice monitored by a physician for eight cycles; and obtain 32 hours continuing medical education, divided as follows: eight hours in performing liver biopsies, eight hours in reading diagnostic mammograms, eight hours in medical record keeping and eight hours in risk management; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Park failed to meet the standard of care in his treatment of two patients, and failed to keep adequate medical records with respect to one of those patients. The action was based on the findings of an administrative law judge who heard the case at the State Office of Administrative Hearings.

**Robledo, Jaime De Jesus, M.D., Lic. No. K6916, Katy**

On October 18, 2013, the Board and Jaime De Jesus Robledo, M.D., entered into an Agreed Order requiring Dr. Robledo to have his practice monitored by another physician for four monitoring cycles; and within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Robledo failed to meet the standard of care and non-therapeutically prescribed controlled substances to one patient without adequately documenting his examination of the patient and his rationale for treatment.

**Wieck, Bryan Robert, M.D., Lic. No. J0361, Wichita Falls**

On October 18, 2013, the Board and Bryan Robert Wieck, M.D., entered into an Agreed Order requiring Dr. Wieck to within one year and three attempts complete the Medical Jurisprudence Examination (JP Exam); within 90 days submit a copy of his physician assistants and advance nurse practitioners written protocols; and within one year complete at least 16 hours of CME, divided as follows: 8 hours in pharmacology in the treatment of psychiatric patients and 8 hours in supervision and delegation. The Board found Dr. Wieck failed to adequately supervise his delegate, an NP and psychiatric nurse, in her care of two patients. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Xu, Jianzhang, M.D., Lic. No. J7253, Houston**

On October 18, 2013, the Board and Jianzhang Xu, M.D., entered into an Agreed Order requiring Dr. Xu to within one year complete at least 16 hours of CME, divided as follows: 8 hours in identifying drug seeking behavior and 8 hours

medical record keeping. The Board found Dr. Xu prescribed substances to a patient without appropriate indications and/or documentation reflecting appropriate indications and failed to recognize the patient's request for hydrocodone, alprazolam, and promethazine-codeine cough syrup as possible drug seeking behavior.

## **UNPROFESSIONAL CONDUCT**

### **Dickson, John Ervin, M.D., Lic. No. J7470, San Antonio**

On October 18, 2013, the Board and John Ervin Dickson, M.D., entered into an Agreed Order requiring Dr. Dickson to within 90 days complete all required hours of CME regarding his license renewal period of September 1, 2010, to August 31, 2012, with at least 2 hours in medical ethics and/or professional responsibility as required by Board rule; within one year complete at least 16 additional hours of CME, divided as follows: eight hours medical ethics, four hours management of anger and other disruptive behaviors, and four hours physician-patient communications; within one year and three attempts complete the Medical Jurisprudence Examination (JP Exam); and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Dickson engaged in unprofessional and abusive conduct towards one patient and his staff by making embarrassing, insulting or demeaning comments and that Dr. Dickson failed to obtain or document the required number of hours of CME credits regarding the license renewal audit.

### **Elemuren-Ogunmuyiwa, Iyabo Abiola, M.D., Lic. No. K4050, Harker Heights**

On October 18, 2013, the Board and Iyabo Abiola Elemuren-Ogunmuyiwa, M.D., entered into an Agreed Order publicly reprimanding Dr. Elemuren-Ogunmuyiwa and requiring Dr. Elemuren-Ogunmuyiwa to have her practice monitored by another physician for eight monitoring cycles; and within one year complete at least eight hours of in-person CME in the topic of proper billing practices. The Board found Dr. Elemuren-Ogunmuyiwa engaged in unprofessional conduct for improper billing. Specifically, Dr. Elemuren-Ogunmuyiwa was under investigation concerning her Tri-Care patient charts.

### **Free, Marcus Kyle, M.D., Lic. No. L0799, Sandusky, MI**

On October 18, 2013, the Board and Marcus Kyle Free, M.D., entered into a Mediated Agreed Order requiring Dr. Free to undergo an independent medical evaluation by a Board-designated psychiatrist and follow all recommendations for care and treatment. The Board found Dr. Free committed unprofessional conduct relating to a civil matter between him and his spouse.

### **Holmes, Michael Wesley, M.D., Lic. No. E7118, Beaumont**

On October 18, 2013, the Board and Michael Wesley Holmes, M.D., entered into an Agreed Order requiring Dr. Holmes to within 30 days tender a letter of apology, issue a refund to his patient; and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Holmes failed to reimburse a patient for an over-payment and failed to respond to the patient's request for a written explanation of the patient's bill.

### **Hume, Thaddeus William, M.D., Lic. No. F0526, Houston**

On October 18, 2013, the Board and Thaddeus William Hume, M.D., entered into an Agreed Order requiring Dr. Hume to complete within one year and three attempts the Medical Jurisprudence Examination (JP Exam); complete within one year at least 16 hours of CME, divided as follows: 8 hours in ethics and 8 hours risk management; and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Hume admitted that he supplied incorrect answers on his May 2010 licensure renewal form after being indicted in U.S. District Court for the Southern District of Texas approximately two months prior to his negative response to a question asking if he had ever been "arrested, fined (over \$250), charged with or convicted of a crime, indicted, imprisoned, placed on probation, or placed on deferred adjudication," since his most recent licensure with the Board and that based on the 2010 indictment, Dr. Hume was subject of peer review and disciplinary action taken by St. Joseph's Medical Center.

### **Hurly, James Matthew, M.D., Lic. No. J7996, Amarillo**

On October 18, 2013, the Board and James Matthew Hurly, M.D., entered into an Agreed Order requiring Dr. Hurly to complete the anger management course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, or an equivalent; and pay an administrative penalty of \$2,000 within 60 days. The

Board found Dr. Hurly pled guilty and received deferred adjudication for Misdemeanor Class A Assault Causing Bodily Injury.

**Rodriguez, Armand R., M.D., Lic. No. G0021, San Antonio**

On October 18, 2013, the Board and Armand R. Rodriguez, M.D., entered into an Agreed Order publicly reprimanding Dr. Rodriguez and requiring Dr. Rodriguez to limit his work as a physician to no more than 40 hours per week. The Board found Dr. Rodriguez diverted Demerol at a surgery center for his own personal use, was confronted by staff at the center about the diversion, admitted to it and resigned his privileges. Dr. Rodriguez sought inpatient treatment related to his Demerol use soon after resigning his privileges at the center.

**Skiba, William Edward, M.D., Lic. No. H2785, Houston**

On October 18, 2013, the Board and William Edward Skiba, M.D., entered into an Agreed Order requiring Dr. Skiba to undergo an independent medical evaluation by a Board-designated psychiatrist and follow all recommendations for care and treatment. The Board found Dr. Skiba self-reported a deferred disposition of a misdemeanor charge of disorderly conduct and indecent exposure.

**NONTHERAPEUTIC PRESCRIBING**

**Lee, Kang Sun, M.D., Lic. No. K6088, Corpus Christi**

On October 18, 2013, the Board and Kang Sun Lee, M.D., entered into an Agreed Order publicly reprimanding Dr. Lee and requiring Dr. Lee to surrender within seven days his DEA and DPS Controlled Substances Registration Certificates; limit his practice to a group or institutional setting; have his practice monitored by another physician for eight monitoring cycles; within one year and three attempts complete the Medical Jurisprudence Examination (JP Exam); within one year complete the prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete at least eight hours of CME in medical record keeping; and pay an administrative penalty of \$15,000 within six months. The Board found Dr. Lee practiced medicine and supervised mid-level practitioners at two unregistered pain clinics in Houston, Texas, that operated as illegal pill mills; failed to adequately supervise his mid-levels who failed to meet the standard of care, non-therapeutically prescribed controlled substances, and failed to maintain adequate medical records in their care and treatment of patients.

**Sparkman, Chris Alan, M.D., Lic. No. L5571, The Woodlands**

On October 18, 2013, the Board and Chris Alan Sparkman, M.D., entered into a Mediated Agreed Order publicly reprimanding Dr. Sparkman and requiring Dr. Sparkman to refrain from engaging in the practice of pain management; shall not possess, administer, dispense, or prescribe any Schedule II controlled substances; limit his medical practice to a group or an institutional setting; have his practice monitored by another physician for eight monitoring cycles; within one year and three attempts complete the Medical Jurisprudence Examination (JP Exam); and pay an administrative penalty of \$15,000. The Board found Dr. Sparkman practiced medicine at an unregistered pain clinic that was owned by non-physicians and functioned as a "pill mill" for controlled substances. Dr. Sparkman failed to meet the standard of care, failed to maintain adequate medical records, and non-therapeutically prescribed controlled substances to patients at the clinic. The order resolves a formal complaint filed at the State Office of Administrative Hearings.

**OTHER STATES' ACTIONS**

**Sanders, Thomas Joe, M.D., Lic. No. G0055, Reno, NV**

On October 18, 2013, the Board and Thomas Joe Sanders, M.D., entered into an Agreed Order requiring Dr. Sanders to cease practicing in Texas until such a time as he personally appears before the Board and provides clear and convincing evidence that he is competent to safely practice medicine. The Board found Dr. Sanders was disciplined by the Nevada Medical Board for diverting hydrocodone for personal use resulting in the voluntary surrender of his DEA controlled substance registration.

## **SUSPENSION**

### **Terrell, Gregory Scott, M.D., Lic. No. K1695, Tyler**

On October 18, 2013, the Board and Gregory Scott Terrell, M.D., entered into an Agreed Order of Suspension, suspending Dr. Terrell's Texas medical license until such time as he appears before the Board and provides clear and convincing evidence that he is competent to safely practice medicine. The Board found Dr. Terrell was arrested on July 31, 2013 for diversion of controlled substances for another person's use.

## **VOLUNTARY SURRENDER**

### **Craig, Randall Gordon, M.D., Lic. No. G9084, Tyler**

On October 18, 2013, the Board and Randall Gordon Craig, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Craig voluntarily and permanently surrendered his Texas medical license. The Board found Dr. Craig pled guilty to and was convicted of a misdemeanor offense for failing to file a tax return. Dr. Craig requested that the voluntary surrender of his medical license be accepted in lieu of further disciplinary proceedings.

### **Nakissa, Nasser, M.D., Lic. No. G6355, San Antonio**

On October 18, 2013, the Board and Nasser Nakissa, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Nakissa voluntarily and permanently surrendered his Texas medical license in lieu of further disciplinary proceedings. Dr. Nakissa was under investigation related to allegations that he engaged in non-therapeutic prescribing of drugs in violation of the Medical Practice Act. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

### **Rao, Turlapati R., M.D., Lic. No. F5004, Lubbock**

On October 18, 2013, the Board and Turlapati R. Rao, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Rao voluntarily and permanently surrendered his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Rao surrendered his hospital privileges at two facilities while subject to peer review.

### **Routh, Lisa Carole, M.D., Lic. No. H2742, Houston**

On October 18, 2013, the Board and Lisa Carole Routh, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Routh voluntarily surrendered her Texas medical license. Dr. Routh was under investigation related to allegations that she violated the standard of care in her treatment of patients; failed to cooperate with Board staff; and engaged in substance abuse. Dr. Routh voluntarily surrendered her medical license due to her medical condition and in lieu of further disciplinary proceedings.

## **PEER REVIEW ACTIONS**

### **Cantu, Dennis David, M.D., Lic. No. F1430, Laredo**

On October 18, 2013, the Board and Dennis David Cantu, M.D., entered into an Agreed Order publicly reprimanding Dr. Cantu and requiring Dr. Cantu to use a chaperone any time he examines a female patient; within one year and three attempts complete the Medical Jurisprudence Examination (JP Exam); within one year complete at least eight hours of CME in risk management; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Cantu was granted a leave of absence by Laredo Medical Center following the filing of a police report by hospital staff alleging inappropriate conduct with a patient. Two statements were submitted by eye witnesses involving Dr. Cantu's alleged boundary violations, though Dr. Cantu denied engaging in any sexual contact with the patient.

### **Gladden, Jeffrey R., M.D., Lic. No. H4934, Plano**

On October 18, 2013, the Board and Jeffrey R. Gladden, M.D., entered into an Agreed Order requiring Dr. Gladden to within one year and three attempts complete the Medical Jurisprudence Examination (JP Exam); and within one year complete at least 24 hours of CME, divided as follows: 8 hours in risk management, 8 hours in supervision of midlevel providers, and 8 hours in ethics. The Board found Dr. Gladden was the subject of a peer review which found Dr. Gladden



failed to arrange coverage for his patients, failed to provide care to admitted hospital patients, failed to properly supervise his nurse practitioner, and had his hospital privileges suspended for 90 days as a result.

**Shah, Mrugeshkumar K., M.D., Lic. No. L6174, Carrollton**

On October 18, 2013, the Board and Mrugeshkumar K. Shah, M.D., entered into an Agreed Order requiring Dr. Shah to have his practice monitored by another physician for eight monitoring cycles; within one year complete at least 12 hours of CME, divided as follows: four hours in medical ethics, four hours in risk management, and four hours in medical recordkeeping. The Board found Dr. Shah had his privileges revoked due to his continued failure to timely complete his standard operating reports and failure to provide updated credentialing information.

**TXPHP VIOLATION**

**Whitt, Theresa Ann, M.D., Lic. No. J0360, Beeville**

On October 18, 2013, the Board and Theresa Ann Whitt, M.D., entered into an Agreed Order requiring Dr. Whitt to undergo an independent medical evaluation by a Board-designated psychiatrist and follow all recommendations for care and treatment and abstain from the consumption of prohibited substances. The Board found Dr. Whitt violated provisions of her 2012 Remedial Plan because she violated her contract to complete the Texas Physicians' Health Program (TXPHP).

**INADEQUATE MEDICAL RECORDS**

**Salameh, Raja Nicolas, M.D., Lic. No. G9654, McAllen**

On October 18, 2013, the Board and Raja Nicolas Salameh, M.D., entered into an Agreed Order requiring Dr. Salameh have his practice monitored by another physician for eight monitoring cycles; and within one year complete at least 8 hours of CME in the topic of risk management. The Board found Dr. Salameh maintained inadequate medical records for a patient to support his care and treatment of the patient.

**CEASE AND DESIST**

**Brooks, Amber, D.C., No Medical License, Dallas**

On September 25, 2013, the Board entered a Cease and Desist Order regarding chiropractor Amber Brooks, D.C., prohibiting her from engaging in the practice of medicine. The Board found Dr. Brooks engaged in the unlicensed practice of medicine by making offers on her website for treatments that exceed the scope of the practice of chiropractic.

**PAIN MANAGEMENT CLINIC ACTIONS**

**Dallas Medical Consultants, Cert. No. PMC00342, Dallas**

On October 18, 2013, the Board and and Robert John Koval, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Koval surrendered his Pain Management Clinic Certification for Dallas Medical Consultants in lieu of further disciplinary proceedings. The order requires Dr. Koval to immediately cease operating Dallas Medical Consultants as a pain clinic in Texas and withdraw any and all PMC applications, if any, currently pending before the Board.

###

*To view disciplinary orders, visit the TMB website, click on "Look Up A Doctor," accept the usage terms, then type in a doctor's name. Click on the name shown in the search results to view the doctor's full profile. Within that profile is a button that says "View Orders."*

## **Texas Medical Board Press Release**

### **FOR IMMEDIATE RELEASE**

December 12, 2013

Media contact: [Jarrett Schneider](#), 512-305-7018  
Customer service: 512-305-7030 or 800-248-4062

### **TMB restricts Laredo physician**

On December 11, 2013, a disciplinary panel of the Texas Medical Board temporarily restricted, with notice, the Texas medical license of Laredo physician Judson Jeffrey Somerville, M.D., after determining his continuation in the unrestricted practice of medicine poses a threat to public welfare. The restriction was effective immediately.

The restriction limits Dr. Somerville's pain management practice to interventional procedures performed in an outside surgical facility, prohibits him from performing office based procedures, and prohibits him from administering, dispensing, prescribing, or refilling a prescription for any controlled substance taken orally in Schedules II, III, IV or V identified in the Health and Safety Code, Chapter 481.

The temporary restriction was based on the panel's findings that Dr. Somerville violated the standard of care with respect to 36 patients, including nontherapeutic prescribing, operation of unregistered pain clinics, and failure to adequately supervise the activities of persons operating under his supervision by presigning prescriptions including prescription forms for Schedule II controlled substance medications.

The temporary restriction remains in place until the Board takes further action.

# # #

*To view disciplinary orders, visit the TMB website, click on "Look Up A Doctor," accept the usage terms, then type in a doctor's name. Click on the name shown in the search results to view the doctor's full profile. Within that profile is a button that says "View Orders."*

*All releases and publications are also available on the TMB website under the "News" heading.*