Texas Medical Board Press Release

FOR IMMEDIATE RELEASE
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TMB disciplines 78 physicians at June meeting, adopts rule changes

At its June 10, 2016 meeting, the Texas Medical Board disciplined 78 licensed physicians and issued one cease and desist order. The disciplinary actions included: eighteen orders related to quality of care violations, four orders related to unprofessional conduct, six revocations, nine voluntary surrenders/revocations, one restriction, three suspensions, five orders related to other states' actions, five orders related to peer review actions, one order related to criminal activity, seven orders related to nontherapeutic prescribing, two orders related to improper prescribing, six orders related to violation of Board rules, six orders related to violation of prior Board order, one order related to a Texas Physician Health Program violation, and four orders related to inadequate medical records. The Board also took an action against a Non-Certified Radiologic Technician and a Respiratory Care Practitioner.

The Board issued 127 physician licenses at the June meeting, bringing the total number of physician licenses issued in FY16 to 2,949.

RULE CHANGES ADOPTED

CHAPTER 160. MEDICAL PHYSICISTS
The adoption of **§§160.1 - 160.5** and **160.7 - 160.30** is intended to achieve consistency with the amended provisions of the Occupations Code transferring the primary responsibility for licensing and regulation of medical physicists to the Texas Medical Board and converting the Texas Board of Licensure for Professional Medical Physicists to an advisory committee to the Texas Medical Board. The rules align the policies and procedures related to licensing and regulation of medical physicists with the Board's current policies and procedures. The rules also serve to ensure the safe practice of properly trained and qualified medical physicists. Additionally, the rules provide an avenue for licensees to obtain treatment through the Texas Physician Health Program for health conditions that have the potential of impairing their practice of medical physics.

CHAPTER 161. GENERAL PROVISIONS
The Texas Medical Board adopted the rule review of 22 TAC Chapter 161, pursuant to Texas Government Code §2001.039.

CHAPTER 163. LICENSURE

§163.2, Full Texas Medical License
The amendment to §163.2, concerning Full Texas Medical License, corrects a citation in subsection (d)(3) related to a reference to an applicant's eligibility requirements for alternative license procedures for military service members, veterans, and spouses. The correction clarifies that the eligibility requirements are listed in additional numbered paragraphs of subsection (d).

§163.5, Licensure Documentation
The amendment to §163.5, concerning Licensure Documentation, changes language under subsection (d)(4) and (5) by eliminating an applicant's requirement to report having been treated on an in- or outpatient basis for certain mental or physical illnesses that "could" have impaired the applicant's ability to practice medicine, and replacing same with

language that requires an applicant to report those physical or mental illnesses that have impaired or currently impair the applicant's ability to practice medicine.

CHAPTER 164. PHYSICIAN ADVERTISING

The Texas Medical Board adopted the rule review of 22 TAC Chapter 164, pursuant to Texas Government Code §2001.039.

CHAPTER 168. CRIMINAL HISTORY EVALUATION LETTERS

The Texas Medical Board adopted the rule review of 22 TAC Chapter 168, pursuant to Texas Government Code §2001.039.

CHAPTER 170. PAIN MANAGEMENT

§170.3, Minimum Requirements for the Treatment of Chronic Pain

The amendments to §170.3, concerning Minimum Requirements for the Treatment of Chronic Pain, adds new language relating to limitations on the number of physicians who may prescribe to a patient dangerous and scheduled drugs for the treatment of chronic pain. The new language now allows a covering physician acting in compliance with Chapter 177, Subchapter E of this title (relating to Physician Call Coverage Medical Services) to prescribe dangerous and scheduled drugs for the treatment of chronic pain. New language also specifies that if a patient is treated for acute chronic pain by a physician other than the physician who is party to the pain management agreement or the covering physician, that the patient must notify the primary or covering physician, at the next date of service, about the prescription. The rule sets out specific requirements for the content of this notification.

The amendments to paragraph (4)(D) modify the exception to the one pharmacy requirement of pain management agreements by eliminating the requirement that the designated pharmacy be out of stock of the drug prescribed, and substituting broader language involving "circumstances for which the patient has no control or responsibility, that prevent the patient from obtaining prescribed medications at the designated pharmacy under the agreement." The amendment includes the requirement that if such circumstances apply and a prescription is filled at a pharmacy other than the designated pharmacy, the patient inform the primary or covering physician of the circumstances and the name of the pharmacy that dispensed the medication.

CHAPTER 171. POSTGRADUATE TRAINING PERMITS

§171.3, Physician-in-Training Permits

The amendments to §171.3, concerning Physician-in-Training Permits, change language under subsection (c)(2)(D) and (E) by eliminating an applicant's requirement to report having been treated on an in- or outpatient basis for certain mental or physical illnesses that "could" have impaired the applicant's ability to practice medicine, and replacing same with language that requires an applicant to report those physical or mental illnesses that have impaired or currently impair the applicant's ability to practice medicine.

CHAPTER 176. HEALTH CARE LIABILITY LAWSUITS AND SETTLEMENTS

The Texas Medical Board adopted the rule review of 22 TAC Chapter 176, pursuant to Texas Government Code §2001.039.

CHAPTER 181. CONTACT LENS PRESCRIPTIONS

The Texas Medical Board adopted the rule review of 22 TAC Chapter 181, pursuant to Texas Government Code §2001.039.

CHAPTER 183. ACUPUNCTURE

§183.2, Definitions

The amendment to §183.2, concerning Definitions, adds definitions for "Military service member," "Military spouse," "Military veteran," "Active duty," and "Armed forces of the United States." These amendments are in accordance with the passage of SB 1307 (84th Legislature, Regular Session) which amended Chapter 55 of the Texas Occupations Code.

§183.4, Licensure
The amendment to §183.4, concerning Licensure, adds language to subsection (a)(10), Alternative Licensing Procedure, expanding subsection (a)(10) to include military service members and military veterans. The amendment also includes language allowing the executive director to waive any prerequisite to obtaining a license for an applicant described in subsection (a)(10) after reviewing the applicant's credentials. These amendments are in accordance with the passage of SB 1307 (84th Legislature, Regular Session), which amended Chapter 55 of the Texas Occupations Code. Subsection (a)(10)(F) adds a provision for recognizing certain training for Applicants with military experience, based on the passage of SB 0162 (83rd Legislature, Regular Session). The change to subsection (c)(2)(A) deletes the word "either" to make the sentence grammatically correct.

§183.5, Annual Renewal of License
The amendment to §183.5, concerning Annual Renewal of License, adds new subsection (h) providing that military service members who hold a license to practice in Texas are entitled to two years of additional time to complete any other requirement related to the renewal of the military service member's license. This amendment is in accordance with the passage of SB 1307 (84th Legislature, Regular Session) which amended Chapter 55 of the Texas Occupations Code.

§183.18, Administrative Penalties
The amendment to §183.18, concerning Administrative Penalties, deletes subsection (g) due to redundancy, as Chapters 187 and 189 relating to Procedural Rules and Compliance already address Administrative Penalties.

§183.20, Continuing Acupuncture Education
The amendment to §183.20, concerning Continuing Acupuncture Education, adds new subsection (w) providing that an acupuncturist, who is a military service member, may request an extension of time, not to exceed two years, to complete any continuing education requirements. This amendment is in accordance with the passage of SB 1307 (84th Legislature, Regular Session) which amended Chapter 55 of the Texas Occupations Code.

CHAPTER 184. SURGICIAL ASSISTANTS

§184.4, Qualifications for Licensure
The amendment to §184.4, concerning Qualifications for Licensure, corrects a citation in subsection (c)(3) related to a reference to an applicant's eligibility requirements for alternative license procedures for military service members, veterans, and spouses. The correction clarifies that the eligibility requirements are listed in additional numbered paragraphs of subsection (c).

§184.5, Procedural Rules for Licensure Applicants
The amendment to §184.5, concerning Procedural Rules for Licensure Applicants, amends subsection (b), clarifying the determination of licensure eligibility process related to an application for surgical assistant licensure. The amendments further clarify that the procedures outlined under Chapter 187 of this title (relating to Procedural Rules) concerning determinations of licensure ineligibility apply to applications for surgical assistant licensure.

§184.6, Licensure Documentation
The amendment to §184.6, concerning Licensure Documentation, deletes the word "medical" to correct a reference to the category of surgical assistant licensure.

§184.8, License Renewal
The amendment to §184.8, concerning License Renewal, deletes the word "residence", as such information is not collected by the Medical Board in the process of renewing a surgical assistant's license.

§184.18, Administrative Penalties
The amendment to §184.18, concerning Administrative Penalties, eliminates subsection (f) due to the language's redundancy with Chapters 187 and 189 of this title (relating to Procedural Rules and Compliance Program) which sufficiently address the process related to imposition of administrative penalties.

§184.25, Continuing Education
The amendment to §184.25, concerning Continuing Education, deletes subsection (k), due to the language's redundancy with §184.18 of this title (relating to Administrative Penalties) and Chapter 187 of this title (relating to Procedural Rules) which sufficiently address the process related to imposition of administrative penalties.

CHAPTER 187. PROCEDURAL RULES

§187.16, Informal Show Compliance Proceedings (ISCs)
The amendment to §187.16, concerning Informal Show Compliance Proceedings (ISCs), adds clarifying language to the notice provision in order to clearly state that the notice provided to complainants differs from the notice provided to licensees, in that the latter contains the ISC evidence, which is confidential by statute and cannot legally be disclosed to the complainant.

§187.19, Resolution by Agreed Order
The amendment to §187.19, concerning Resolution by Agreed Order, eliminates subsection (e) relating to post-ISC negotiations, via telephone or in person, between panel members, Respondents and board staff, as this provision does not comport with our current process relating to post-ISC negotiations between board members and Respondents. Additionally, such negotiation between board members (directly) and Respondents is specifically reserved and provided for during the mediation process.

CHAPTER 188. PERFUSIONISTS
The adoption of **§§188.1 - 188.15, 188.17 - 188.24, 188.26, 188.28** and **188.29**, are adopted in accordance with the changes to Chapter 603 of the Texas Occupations Code, as enacted by S.B. 202, and are necessary to enable the Board to regulate the practice of perfusion and perform the various functions, including licensing, compliance, and enforcement relating the practice of perfusion.

CHAPTER 190. DISCIPLINARY GUIDELINES

§190.8, Violation Guidelines
The amendment to §190.8, concerning Violation Guidelines, adds the phrase "post-exposure prophylaxis" to language related to the type of treatment that may be provided by physicians for infectious diseases located under paragraph (1)(L)(iii)(II), so as to improve consistency and mirror other language under paragraph (1)(L)(iii)(I), pertaining to sexually transmitted diseases. The added phrase "post-exposure prophylaxis" (PEP) is intended to further clarify that the purpose of the exception is to potentially prevent infection and the furtherance of an outbreak. The amendments change the definition of a patient's "close contacts" so that the definition better reflects guidance published by the Centers for Disease Control and Prevention and local Texas health authority, so that the specific circumstances of a local communicable disease outbreak and possible drug shortages might be better addressed by physicians. Language under paragraph (1)(L)(iii)(II)(-a-), relating to Chicken Pox, and paragraph (1)(L)(iii)(II)(-f-), stating shingles, is deleted, and replaced with the addition of the term Varicella zoster, for the purpose of reorganizing the list and using scientific names. New language is added to paragraph (1)(L)(iii)(II) and (1)(L)(iii)(II)(-g-) providing language that would allow PEP to be administered by physicians providing public health medical services pursuant to a memorandum of understanding between the Department of State Health Services and the Texas Medical Board, and for any new or emergent communicable diseases not specifically listed under the rule that are determined to be a public health threat by state health authorities, thereby improving the state's ability to provide a quick public health response to communicable diseases affecting the health of Texans. The terms "infectious disease" and "communicable disease" are intended to be interchangeable.

CHAPTER 191. DISTRICT REVIEW COMMITTEES
The Texas Medical Board adopted the rule review of 22 TAC Chapter 191, pursuant to Texas Government Code §2001.039.

CHAPTER 196. VOLUNTARY RELINQUISHMENT OR SURRENDER OF MEDICAL LICENSE

§196.2, Surrender Associated with Disciplinary Action
The amendment to §196.2, concerning Surrender Associated with Disciplinary Action, corrects a citation to a Board rule.

DISCIPLINARY ACTIONS

QUALITY OF CARE
Ahmad, Salman, M.D., Lic. No. J8863, Lubbock
On June 10, 2016, the Board and Salman Ahmad, M.D., entered into an Agreed Order requiring Dr. Ahmad to submit to a Board-approved rheumatologist the records of all rheumatology and lupus patients currently under his care for review; have his practice monitored by another physician for eight monitoring cycles; and within one year complete at least 24 hours of CME, divided as follows: four hours in medical recordkeeping and 20 hours in rheumatology. The Board found Dr. Ahmad violated the standard of care by providing treatment in a number of cases that was inappropriate and nontherapeutic. Dr. Ahmed failed to perform adequate testing and document objective medical evidence to support his diagnosis for several patients.

Berndt, Peter Ulrich, M.D., Lic. No. F3408, Denver, CO
On June 10, 2016, the Board and Peter Ulrich Berndt, M.D., entered into an Agreed Order requiring Dr. Berndt to within one year complete at least 16 hours of CME, divided as follows: eight hours in physician-patient boundaries, if possible, in the area of physician patient boundaries in the psychiatric relationship, four hours in dealing with non-compliant patients and four hours in maintaining physician patient confidentiality, if possible in the topic of maintaining patient confidentiality in telemedicine. The Board found Dr. Berndt failed to follow established physician-patient boundaries, and employed unorthodox treatment methodologies that ultimately violated the standard of care.

Borissova, Irina Vitalyevna, M.D., Lic. No. N1268, San Antonio
On June 10, 2016, the Board and Irina Vitalyevna Borissova, M.D., entered into an Agreed Order requiring Dr. Borissova to have her practice monitored by another physician for eight consecutive monitoring cycles; within six months obtain Board approval for a board certified anesthesiologist to serve as her proctor and proctor her next 25 procedures; within one year complete at least 30 hours of CME in a comprehensive board review course for anesthesia certification; and within 60 days pay an administrative penalty of $3,000. The Board found Dr. Borissova failed to meet the standard of care with respect to her anesthesia care provided to three patients, failed to maintain adequate medical records and had her hospital privileges terminated due to concerns regarding the poor management and care for the three patients.

Braun, Patricia A.D., M.D., Lic. No. D3164, Emory
On June 10, 2016, the Board and Patricia A.D. Braun, M.D., entered into a Mediated Agreed Order requiring Dr. Braun to have her practice monitored by another physician for eight consecutive monitoring cycles; and within one year complete at least 12 hours of CME, divided as follows: four hours in treating critically ill patients, four hours in medical recordkeeping and four hours in risk management. The Board found Dr. Braun failed to meet the standard of care in the treatment of a patient by not properly assessing or diagnosing the patient's condition and recognizing the necessity for transfer of the patient to a higher level of care and Dr. Braun failed to maintain adequate medical records. This order resolves the formal complaint filed at the State Office of Administrative Hearings

Brookshire, Ralph Hamilton, D.O., Lic. No. L9113, Austin
On June 10, 2016, the Board and Ralph Hamilton Brookshire, D.O., entered into an Agreed Order on Formal Filing publicly reprimanding Dr. Brookshire and limiting his practice to a group or institutional setting. Additionally, Dr. Brookshire shall not possess, administer, dispense, or prescribe any controlled substance or dangerous drugs with addictive potential or potential for abuse, except as medically necessary for treatment of inpatients in a hospital or

institutional setting where he has privileges or practices; shall not treat or otherwise serve as a physician for his family, and shall not prescribe, dispense, administer, or authorize controlled substances or dangerous drugs with addictive potential or potential for abuse to himself or his immediate family; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 16 hours of CME, divided as follows: eight hours in physician-patient communication and eight hours in medical recordkeeping ; and within one year pay an administrative penalty of $5,000 or $2,500 within 60 days. The Board found Dr. Brookshire failed to meet the standard of care with regard to proper planning, communication with his back-up physician regarding follow-up in his absence, and communications with the patient. Dr. Brookshire admitted that he was using hydrocodone at the time of the incident however claims that did not affect his care and treatment of the patient. Dr. Brookshire is currently undergoing drug testing and has not had a positive test result since August, 2014. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Burleson, James Dewain, M.D., Lic. No. H1932, Lubbock
On June 10, 2016, the Board and James Dewain Burleson, M.D., entered into an Agreed Order requiring Dr. Burleson to within one year complete at least 12 hours of CME in risk management; and within 90 days pay an administrative penalty of $3,000. The Board found Dr. Burleson failed to notify and diagnose the patient after her Pap smear result was positive for trichomonas vaginalis.

Hong, Robert, M.D., Lic. No. P7465, Sweeny
On June 10, 2016, the Board and Robert Hong, M.D., entered into an Agreed Order requiring Dr. Hong to within one year complete at least eight hours in CME, divided as follows: four hours in diagnosis and treatment of pulmonary embolism and four hours in treating respiratory distress in an emergency room setting. The Board found Dr. Hong breached the standard of care when he failed to properly evaluate a patient by not ordering a D-Dimer test.

Ince, Christopher Werner, M.D., Lic. No. N4491, Willow Park
On June 10, 2016, the Board and Christopher Werner Ince, M.D., entered into an Agreed Order requiring Dr. Ince to within one year complete at least 16 hours of CME, divided as follows: eight hours in risk management and eight hours in assessing the risk of opioid dependence. The Board found Dr. Ince failed to adequately document a patient's history and potential for substance abuse, failed to adequately document the patient's past and current treatments for pain, and failed to adequately obtain prior medical records and consult with the patient's other treating physicians which would have disclosed the patient's history of opioid substance abuse.

Krusz, John Claude, M.D., Lic. No. G7076, Dallas
On June 10, 2016, the Board and John Claude Krusz, M.D., entered into an Agreed Order on Formal Filing requiring Dr. Krusz to within one year complete at least 12 hours of in-person CME, divided as follows: four hours in medical recordkeeping, four hours in identifying drug seeking behavior and four hours in treatment of chronic pain. The Board found Dr. Krusz's prescription of Adderall did not meet the standard of care. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Leeds-Richter, Shelly, M.D., Lic. No. L1642, Houston
On June 10, 2016, the Board and Shelly Leeds-Richter, M.D., entered into an Agreed Order requiring Dr. Leeds-Richter to within one year complete at least 16 hours of CME, divided as follows: eight hours in risk management and eight hours in fetal strip monitoring. The Board found Dr. Leeds-Richter's failure to review the entirety of the fetal health rate tracings caused her to miss late decelerations evident in the fetal strips.

Mego, Carlos David, M.D., Lic. No. K6147, McAllen
On June 10, 2016, the Board and Carlos David Mego, M.D., entered into an Agreed Order requiring Dr. Mego to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least eight hours of CME in medical recordkeeping; and within 60 days pay an administrative penalty of $5,000. The Board found Dr. Mego violated the standard of care with regard to four patients whose ultrasounds were based on inadequate documentation and were billed for the unnecessary diagnostic testing.

Mego, Pedro Antonio, M.D., Lic. No. M1925, McAllen
On June 10, 2016, the Board and Pedro Antonio Mego, M.D., entered into an Agreed Order requiring Dr. Mego to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in coronary angiography; and within 60 days pay an administrative penalty of $5,000. The Board found Dr. Mego violated the standard of care with regard to six patients. Three patient's carotid ultrasounds were based on inadequate documentation, and four patient's coronary computed tomographies were based on inadequate documentation, and therefore, were unnecessary. A coronary stent performed for one patient was also not indicated. Dr. Mego billed for these unnecessary procedures based on the inadequate documentation and failed to maintain adequate medical records for the patients.

Michaels, Wanda Jeanne, M.D., Lic. No. J4922, Lindale
On June 10, 2016, the Board and Wanda Jeanne Michaels, M.D., entered into an Agreed Order on Formal Filing prohibiting Dr. Michaels from treating or otherwise serving as a physician for her immediate family, and shall not prescribe, dispense, administer or authorize controlled substances or dangerous drugs with addictive potential or potential for abuse to herself or her immediate family; 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 at least 20 hours of CME, divided as follows: eight hours in medical recordkeeping, eight hours in ethics and four hours in risk management; and within 60 days pay an administrative penalty of $3,000. The Board found Dr. Michaels failed to obtain appropriate lab work and to rule out any other etiology of the patient's abdominal pain, failed to obtain appropriate diagnostic testing with regards to the patient's complaint of shoulder and arm pain following a severe fall before prescribing hydrocodone, failed to obtain testosterone levels before prescribing testosterone to the patient, failed to set firm boundaries with the patient during the course of her treatment by allowing the patient to ignore medical advice without consequences and self-prescribed various hormonal treatments without maintaining medical records.

Mitchell, Lylieth Paula-Ann, M.D., Lic. No. L9366, Orange
On June 10, 2016, the Board and Lylieth Paula-Ann Mitchell, M.D., entered into an Agreed Order requiring Dr. Mitchell to within one year complete at least eight hours of CME, divided as follows: four hours in risk management and four hours in patient and critical care assessment. The Board found Dr. Mitchell violated the acceptable standard of care with regard to an emergency department patient by failing to follow-up on unstable vital signs that had not improved after treatment.

Nguyen, Nathan Phuc, M.D., Lic. No. N0318, Wharton
On June 10, 2016, the Board and Nathan Phuc Nguyen, M.D., entered into an Agreed Order requiring Dr. Nguyen to within one year complete a Board Review Course in Internal Medicine; within one year complete at least 16 hours of CME, divided as follows: eight hours in medical record keeping and eight hours in risk management. The Board found Dr. Nguyen failed to adequately pursue the patient's neurological symptoms, adequately address the patient's high blood pressure, and properly investigate the edema and its potential causes. Dr. Nguyen also failed to maintain adequate medical records for the patient.

Trimble, Monty Vic, M.D., Lic. No. L4150, Fort Worth
On June 10, 2016, the Board and Monty Vic Trimble, M.D., entered into an Agreed Order requiring Dr. Trimble to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least four hours of CME in medical recordkeeping; and within 30 days pay an administrative penalty of $1,000. The Board found Dr. Trimble failed to diagnose a brain mass detected on a CT scan and therefore failed to refer the patient and failed to maintain adequate medical records.

Villarreal, Gustavo Enrique, M.D., Lic. No. G6038, Laredo
On June 10, 2016, the Board and Gustavo Enrique Villarreal, M.D., entered into an Agreed Order publicly reprimanding Dr. Villarreal and requiring him to have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete eight hours of in-person CME in endocrinology, with at least four hours addressing the treatment of diabetes; and within 120 days pay an administrative penalty of $3,000. The Board found Dr. Villarreal's

treatment for a patient's diabetes was inappropriate and violated the standard of care and that Dr. Villarreal's records lacked adequate information to justify prescribing multiple medications simultaneously.

Yarra, Subbarao, M.D., Lic. No. K3882, McAllen
On June 10, 2016, the Board and Subbarao Yarra, M.D., entered into an Agreed Order requiring Dr. Yarra to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in peripheral vascular intervention; and within 60 days pay an administrative penalty of $5,000. The Board found Dr. Yarra violated the standard of care with regard to eight patients by overestimating the true degree of stenosis on their angiographies and billed the patients for the procedures which lacked adequate documentation or justification.

UNPROFESSIONAL CONDUCT

Benson, Joseph Michael, M.D., Lic. No. E6230, Sherman
On June 10, 2016, the Board and Joseph Michael Benson, M.D., entered into an Agreed Order requiring Dr. Benson to within 60 days pay an administrative penalty of $500. The Board found Dr. Benson admitted to not providing an electronic death certification within the five day window required by statute.

Childers, Manon Eli, III, M.D., Lic. No. G4911, Perryton
On June 10, 2016, the Board and Manon Eli Childers, III, M.D., entered into an Agreed Order publicly reprimanding Dr. Childers and requiring him to have a chaperone present during physical exams of female patients; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete the boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and within one year complete at least four hours of CME in ethics. The Board found Dr. Childers admitted to engaging in a long term relationship with a patient.

Fontenot, James Thomas, M.D., Lic. No. E5518, Houston
On June 10, 2016, the Board and James Thomas Fontenot, M.D., entered into an Agreed Order requiring Dr. Fontenot to within seven days surrender his DEA/DPS controlled substances certificate if he has not already done so; and Dr. Fontenot shall not reregister or otherwise obtain controlled substances registrations until authorized. The Board found Dr. Fontenot pre-signed prescriptions for controlled substances for at least three patients, violating state and federal law.

Mays, Jeffrey Patrick, M.D., Lic. No. J7815, Brady
On June 10, 2016, the Board and Jeffrey Patrick Mays, M.D., entered into an Agreed Order requiring Dr. Mays to within one year complete at least eight hours of CME in medical recordkeeping; and within 60 days pay an administrative penalty of $500. The Board found Dr. Mays was repeatedly delinquent on completing medical charts.

REVOCATION

Greenwood, Denise Rochelle, M.D., Lic. No. J7977, Mayflower, AR
On June 10, 2016, the Board entered a Final Order against Denise Rochelle Greenwood, M.D., which revoked her Texas medical license. The Board found Dr. Greenwood has violated multiple Texas Medical Board and Arkansas Medical Board orders and has failed to prove that she has been rehabilitated. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Greenwood has 20 days from the service of the order to file a motion for rehearing.

Koval, Robert J., M.D., Lic. No. G1694, Dallas
On June 10, 2016, the Board entered a Default Order against Robert J. Koval, M.D., which revoked his Texas medical license. On July 27, 2015, the Board filed a Complaint with the State Office of Administrative Hearings (SOAH) Docket No. 503-15-4957.MD, alleging Dr. Koval failed to comply with his 2013 Order. Dr. Koval was served notice of the Complaint and subsequent hearing at SOAH and no answer or responsive pleading was ever filed by Dr. Koval. The Board granted a

Determination of Default and Dr. Koval's medical license was revoked by Default Order. This order resolves a formal complaint filed at SOAH. Dr. Koval has 20 days from the service of the order to file a motion for rehearing.

Muniz, Antonio Eugenio, M.D., Lic. No. M5844, Mesquite
On June 10, 2016, the Board entered a Default Order against Antonio Eugenio Muniz, M.D., which revoked his Texas medical license. On August 13, 2015, the Board filed a Complaint with the State Office of Administrative Hearings (SOAH) Docket No. 503-15-5320.MD, alleging Dr. Muniz was arrested for public intoxication. Dr. Muniz was served notice of the Complaint and subsequent hearing at SOAH. Dr. Muniz failed to appear at SOAH and no answer or responsive pleading was ever filed by Dr. Muniz. The Board granted a Determination of Default and Dr. Muniz's medical license was revoked by Default Order. This order resolves a formal complaint filed at SOAH. Dr. Muniz has 20 days from the service of the order to file a motion for rehearing.

Otey, Theodore Timothy, M.D., J1343, Houston
On June 10, 2016, the Board entered a Default Order against Theodore Timothy Otey, M.D., which revoked his Texas medical license. On February 5, 2015, the Board filed a Complaint with the State Office of Administrative Hearings alleging Dr. Otey illegally operated an unlicensed pain management clinic. Dr. Otey was served notice of the Complaint and subsequent hearing at SOAH. Dr. Otey failed to appear at the hearing and no answer or responsive pleading to the Notice of Adjudicative Hearing was ever filed. The Board granted a Determination of Default and Dr. Otey's medical license was revoked by Default Order. This order resolves a formal complaint filed at SOAH. Dr. Otey has 20 days from the service of the order to file a motion for rehearing.

Srivathanakul, Suraphandhu, M.D., Lic. No. E7288, Garland
On June 10, 2016, the Board entered a Final Order against Suraphandhu Srivathanakul, M.D., which revoked his Texas medical license. The Board found Dr. Srivathanakul failed to meet the standard of care with respect to multiple patients by nontherapeutically prescribing antibiotics without adequately determining if the patients had a bacterial infection, nontherapeutically prescribing codeine to patients with chronic bronchitis, by failing to consider differential diagnoses, failing to maintain adequate medical records and was in violation of his 2011 Board order. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Srivathanakul has 20 days from the service of the order to file a motion for rehearing.

Williams, Richard Pascal, Jr., M.D., Lic. No. D7887, Houston
On June 10, 2016, the Board entered a Default Order against Richard Pascal Williams, Jr., M.D., which revoked his Texas medical license. On August 28, 2015, the Board filed a Complaint with the State Office of Administrative Hearings (SOAH) alleging Dr. Williams' impairment from drugs and/or alcohol. Dr. Williams was served notice of the Complaint and subsequent hearing at SOAH. Dr. Williams failed to appear at SOAH and no answer or responsive pleading was ever filed by Dr. Williams. The Board granted a Determination of Default and Dr. Williams' medical license was revoked by Default Order. This order resolves a formal complaint filed at SOAH. Dr. Williams has 20 days from the service of the order to file a motion for rehearing.

VOLUNTARY SURRENDER/REVOCATION

Bentley, George Newell, M.D., Lic. No. AM00018, Tyler
On June 10, 2016, the Board and George Newell Bentley, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Bentley agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found that Dr. Bentley suffers from a medical condition that prevents him from practicing medicine.

Blanchette, Katherine Louise, M.D., Lic. No. H0188, Pearland
On June 10, 2016, the Board and Katherine Louise Blanchette, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Blanchette agreed to voluntarily surrender her Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Blanchette developed a medical condition which interferes with her ability to practice medicine and has indicated her desire to voluntarily surrender her medical license.

Cooke, Gregory Carrington, M.D., Lic. No. K1402, Angleton
On June 10, 2016, the Board and Gregory Carrington Cooke, M.D., entered into an Agreed Order of Voluntary Revocation in which Dr. Cooke agreed to the revocation of his Texas medical license in lieu of further disciplinary proceedings. Dr. Cooke's medical license had previously been temporarily restricted due to his failure to meet the standard of care with regard to multiple obstetrics patients. Dr. Cooke was also under investigation for boundary violations with a patient, unprofessional conduct of a sexual nature at work, and the resulting disciplinary action taken by a hospital.

Diaz, J. Jesus, M.D., Lic. No. E0882, Houston
On June 10, 2016, the Board and J. Jesus Diaz, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Diaz agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Diaz violated his 2015 Order by continuing to practice medicine and prescribe to patients while he was suspended and by failing to pay the administrative penalty.

Saunders, Aaron Truitt, M.D., Permit No. BP10048912, Houston
On June 10, 2016, the Board and Aaron Truitt Saunders, M.D., entered into an Agreed Order of Voluntary Revocation in which Dr. Saunders agreed to the revocation of his Physician in Training Permit in lieu of further disciplinary proceedings. Dr. Saunders was under investigation following his dismissal from his residency program due to diversion and abuse of a controlled substance, at which time his Permit was terminated.

Torres Santos, Juan Eduardo, M.D., Lic. No. P5242, Albuquerque, NM
On June 10, 2016, the Board and Juan Eduardo Torres Santos, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Torres Santos agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Torres Santos was convicted of sexual exploitation of children (possession) in New Mexico and is serving a term of 14 months at the New Mexico Department of Corrections.

Tuft, Daniel Stephen, M.D., Lic. No. J3640, Livingston
On June 10, 2016, the Board and Daniel Stephen Tuft, M.D., entered into an Agreed Order of Voluntary Surrender on Formal Filing in which Dr. Tuft agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board alleged Dr. Tuft failed to properly supervise a midlevel provider at his medical office. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Walker, Richard W., Jr., M.D., Lic. No. G0641, Rosharon
On June 10, 2016, the Board and Richard W. Walker, Jr., M.D., entered into an Agreed Order of Revocation in which Dr. Walker agreed to the revocation of his Texas medical license in lieu of further disciplinary proceedings. Dr. Walker was under investigation for allegations of operating an unregistered pain management clinic and nontherapeutically prescribing through his prescriptive delegate. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Williams, Michael Duane, M.D., Lic. No. E2943, Amarillo
On June 10, 2016, the Board and Michael Duane Williams, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Williams agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board alleged that Dr. Williams violated the terms of his December 4, 2015 Order.

RESTRICTION

Gregory, William Michael, M.D., Lic. No. N0064, Grapevine
On June 10, 2016, the Board entered a Final Order against William Michael Gregory, M.D., requiring Dr. Gregory to only prescribe controlled substances in the radiological suite and for use in the radiological suite; to not possess, administer or dispense any controlled substances; refrain from treating or otherwise serving as physician for himself or his family; within one year and three attempts pass the Medical Jurisprudence Exam; participate with the Texas Physician's Health Program for an additional two years; within one year complete at least 24 hours of CME, divided as follows: eight hours in risk management, eight hours in boundaries and eight hours in ethics; and Dr. Gregory shall not be permitted to

supervise or delegate prescriptive authority to a physician assistant or advanced practice nurse or supervise a surgical assistant. The Board found Dr. Gregory inappropriately prescribed controlled substances to family members and close friends and pleaded guilty to a Class A misdemeanor offense of Fraudulent Possession of a Controlled Substance or Prescription. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Gregory has 20 days from the service of the order to file a motion for rehearing.

SUSPENSION

Howie, David Ian, M.D., Lic. No. H2472, Cleveland

On June 10, 2016, the Board and David Ian Howie, M.D., entered into an Agreed Order of Suspension, suspending Dr. Howie's Texas medical license until such a time as he requests in writing to have the suspension stayed or lifted, appears before the Board and provides clear and convincing evidence that he is physically, mentally, and otherwise competent to safely practice medicine. Evidence shall include the complete and final resolution of any and all criminal charges and investigations that are currently ongoing or any charges that may be brought as a result of the investigation. The Board found Dr. Howie was arrested and charged with exhibiting a deadly weapon (a gun) during the commission of an assault. The criminal investigation is ongoing with no estimated time of completion.

Pena, Leandro III, M.D., Lic. No. J0186, Kerrville

On June 10, 2016, the Board and Leandro Pena, III, M.D., entered into an Agreed Order suspending Dr. Pena's license until such a time as he requests in writing to have the suspension stayed or lifted and appears before the Board to provide evidence that he is physically, mentally, and otherwise competent to safely practice medicine. The Board found Dr. Pena is unable to practice medicine with reasonable skill and safety because of a mental or physical condition.

Woody, Robert, M.D., Lic. No. E9031, Las Cruces, NM

On June 10, 2016, the Board and Robert Woody, M.D., entered into an Agreed Order of Suspension, suspending Dr. Woody's Texas medical license until such a time as he requests in writing to have the suspension stayed or lifted, appears before the Board and provides clear and convincing evidence that he is physically, mentally, and otherwise competent to safely practice medicine. Evidence shall include the complete and final resolution of any and all criminal charges and investigations currently pending, or any charges that may be brought as a result of the allegations. The Board found that on March 18, 2016, the New Mexico Medical Board summarily suspended Dr. Woody's medical license after finding he posed a clear and immediate danger to public health and safety. The Summary Suspension Order arose from criminal charges alleging Dr. Woody kidnapped and sexually assaulted two male patients.

OTHER STATES' ACTIONS

Fath, Steven Wade, M.D., Lic. No. K8144, Dallas

On June 10, 2016, the Board and Steven Wade Fath, M.D., entered into an Agreed Order restricting Dr. Fath's practice to a family practice setting; and requiring Dr. Fath to within 60 days contact the Texas A&M Health Science Center Rural and Community Health Institute (KSTAR) to schedule an assessment and comply with any recommendations. The Board found Dr. Fath was involved in a disciplinary proceeding initiated by the Medical Counsel of New Zealand which arose from allegations of substandard surgical care. Furthermore, the Board found Dr. Fath was involved in a motor vehicle accident which resulted in a traumatic brain injury affecting his ability to handle the practice of surgery.

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

On June 10, 2016, the Board and Carl W. Gossett, M.D., entered into an Agreed Order requiring Dr. Gossett to within 30 days submit to an evaluation by the Texas Physician Health Program and comply with any and all recommendations; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 16 hours of CME, divided as follows: eight hours in ethics and eight hours in risk management; and within 60 days pay an administrative penalty of $1,500. The Board found Dr. Gossett's license to practice medicine in Colorado was suspended due to his failure to comply with an order and that the Defense Health Agency suspended Dr. Gossett's payments for

present and future claims due to his writing of a significant amount of prescriptions to TRICARE beneficiaries outside the state of Colorado.

McGuckin, James Frederick, Jr., M.D., Lic. No. N1760, Philadelphia, PA
On June 10, 2016, the Board and James Frederick McGuckin, Jr., M.D., entered into an Agreed Order requiring Dr. McGuckin to comply with all terms as required by the Agreed Order issued by the Washington Medical Quality Assurance Commission. Dr. McGuckin shall not perform angioplasty and stenting procedures of the venous system for chronic cerebrospinal venous insufficiency (CCSVI) procedures or multiple sclerosis patients in the state of Texas. The Board found Dr. McGuckin entered into an Agreed Order with the Washington Medical Quality Assurance Commission which was based on the determination that Dr. McGuckin performed CCSVI procedures on patients without ensuring Bio-Med IRB obtained an approved Investigation Device Exemption (IDE) from the Food and Drug Administration.

Poling, Rodney Howard, M.D., Lic. No. F8617, Riverview, MI
On June 10, 2016, the Board and Rodney Howard Poling, M.D., entered into an Agreed Order requiring Dr. Poling to complete and comply with all terms as required by the Agreed Order issued by the Michigan Board of Osteopathic Medicine & Surgery. Dr. Poling shall not practice medicine in Texas until such a time as he requests and appears before the Board at an Informal Settlement Conference (ISC) Hearing. The Board found Dr. Poling was the subject of a disciplinary action by the Michigan Board of Osteopathic Medicine & Surgery.

Powell, Frank Curtis, M.D., Lic. No. J8721, Spring
On June 10, 2016, the Board and Frank Curtis Powell, M.D., entered into an Agreed Order on Formal Filing, which requires Dr. Powell to provide a copy of the Order to all medical facilities where he has privileges, seeks privileges, or otherwise practices medicine. The Board found that Dr. Powell was subject to disciplinary action from the Missouri State Board of Registration for the Healing Arts for violating the standard of care by failing to properly interpret and report radiological results.

PEER REVIEW ACTIONS

Freele, Robert Benson, Jr., M.D., Lic. No. M2953, Dallas
On June 10, 2016, the Board and Robert Benson Freele, Jr., M.D., entered into an Agreed Order publicly reprimanding Dr. Freele and requiring him to within 30 days obtain an independent medical evaluation by a Board-approved psychiatrist and follow any and all recommendations for care and treatment; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least eight hours in ethics; and within 60 days pay an administrative penalty of $5,000. The Board found Dr. Freele was the subject of a peer review action by his hospital due to boundaries violations with a patient.

Pecana, Manuel C., M.D., Lic. No. G7304, Irving
On June 10, 2016, the Board and Manuel C. Pecana, M.D., entered into an Agreed Order on Formal Filing publicly reprimanding Dr. Pecana and requiring him to within one year and three attempts pass the Medical Jurisprudence Exam and within 60 days pay an administrative penalty of $1,000. The Board found Dr. Pecana's hospital privileges were suspended and during the course of the investigation, Dr. Pecana resigned his clinical privileges at the hospital. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Saifee, Nafees Fatima, M.D., Lic. No. E3762, Fort Worth
On June 10, 2016, the Board and Nafees Fatima Saifee, M.D., entered into an Agreed Order requiring Dr. Saifee to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 24 hours of CME, divided as follows: eight hours in-person CME on medical recordkeeping, eight hours in ethics and eight hours in the Health Insurance Portability and Accountability Act (HIPAA); and within 60 days pay an administrative penalty of $1,500. The Board found Dr. Saifee's husband, who was her office manager, accessed a patient's electronic medical record without being deputized to do so and Dr. Saifee was the subject of peer review action by Baylor All Saints Medical Center after failing to timely provide confirmation of medical liability insurance coverage.

Swain, Timothy Whitzel, III, M.D., Lic. No. N7883, Corpus Christi
On June 10, 2016, the Board and Timothy Whitzel Swain, III, M.D., entered into an Agreed Order requiring Dr. Swain to within one year complete at least eight hours of CME in medical recordkeeping; and within 90 days pay an administrative penalty of $2,000. The Board found Dr. Swain allowed his privileges at Corpus Christi Medical Center to expire while under investigation for standard of care issues and disruptive behavior. The Board found Dr. Swain failed to maintain adequate medical records for one patient but did not find that Dr. Swain violated the standard of care.

Wilcox, Moses Edward, Sr., M.D., Lic. No. J7728, Nederland
On June 10, 2016, the Board and Moses Edward Wilcox, Sr., M.D., entered into an Agreed Order restricting Dr. Wilcox from performing radical prostatectomies. Dr. Wilcox may perform such procedures as a participant in a fellowship program approved in advance by the Board and shall remain restricted until he appears before the Board at an ISC and provides the ISC panel review documentation of his performance during the course of the fellowship. Further, Dr. Wilcox must undergo proctoring by a Board-approved proctor who is a board certified urologist on the first 10 radical nephrectomies he performs; within one year complete at least eight hours in CME, divided as follows: four hours in surgical management of renal cell carcinoma and four hours in surgical management of prostate cancer; and within 60 days pay an administrative penalty of $3,000. The Board found Dr. Wilcox was subject to peer review disciplinary action, and failed to meet the standard of care with respect to two patients.

CRIMINAL ACTIVITY

Hayes, Leo Michael, D.O., Lic. No. K2486, Houston
On June 10, 2016, the Board and Leo Michael Hayes, D.O., entered into an Agreed Order requiring Dr. Hayes to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least eight hours of CME in risk management; and within 60 days pay an administrative penalty of $1,500. The Board found Dr. Hayes pleaded guilty to a misdemeanor, entering an Order of Defered Adjudication for criminal possession of one pill of Cialis, a controlled substance.

NONTHERAPEUTIC PRESCRIBING

Ellison, Nicole Michelle, M.D., Lic. No. N2485, Cedar Hill
On June 10, 2016, the Board and Nicole Michelle Ellison, M.D., entered into an Agreed Order restricting Dr. Ellison under the following terms: limiting Dr. Ellison's prescribing of controlled substances for patients' immediate needs as defined; within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in risk management; and shall not be permitted to supervise and delegate prescriptive authority to physician assistants or advanced practice nurses. The Board found Dr. Ellison's practice, prescribing, and documentation fell below the standard of care as she failed to obtain prior medical records, substantiate diagnoses with adequate assessments and diagnostics, and failed to document her rationale for her prescriptions of controlled substances such as alprazolam and hydrocodone to 11 patients.

Hill, Welton Ellis, M.D., Lic. No. F6746, Bellville
On June 10, 2016, the Board and Welton Ellis Hill, M.D., entered into an Agreed Order prohibiting Dr. Hill from treating patients for chronic pain and requiring Dr. Hill to maintain a logbook of all prescriptions written by himself or his delegates for controlled substances or dangerous drugs. The Board found Dr. Hill failed to meet the standard of care for 15 chronic pain patients by failing to evaluate the effectiveness of the therapy, failing to monitor the patients for abuse or diversion, failing to refer the patients to specialists, failing to properly evaluate, diagnose, treat, and monitor patients suffering from anxiety and increasing medication dosage without medical reasoning or justification.

Hutcheson, Fred Atkinson, Jr., M.D., Lic. No. E1341, Texarkana
On June 10, 2016, the Board and Fred Atkinson Hutcheson, Jr., M.D., entered into an Agreed Order requiring Dr. Hutcheson to within seven days request modification of his DEA/DPS controlled substances registration certificates to eliminate Schedule II and III; and within one year complete at least 24 hours of CME, divided as follows: eight hours in medical recordkeeping, eight hours in drug seeking behavior and eight hours in ethics. The Board found Dr. Hutcheson

failed to meet the standard of care by nontherapeutically prescribing controlled substances and/or dangerous drugs to 15 patients.

Kiss, George, M.D., Lic. No. L8398, Spring
On June 10, 2016, the Board and George Kiss, M.D., entered into an Agreed Order restricting Dr. Kiss to an emergency room or emergency medical services (pre-hospital emergency) setting; Dr. Kiss shall not treat chronic pain and shall not prescribe any scheduled controlled substances for a period of lasting longer than 72 hours nor provide refills of any scheduled controlled substance to a patient; and shall not supervise or delegate prescriptive authority to a physician assistant or advanced practice nurse or supervise a surgical assistant. Further, within one year Dr. Kiss shall complete the prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in risk management; and within 90 days pay an administrative penalty of $5,000. The Board found Dr. Kiss violated the standard of care, including nontherapeutic prescribing of controlled substances, and failed to properly supervise his delegates.

Odulaja, Kolawole A., M.D., Lic. No. N2694, San Antonio
On June 10, 2016, the Board and Kolawole A. Odulaja, M.D., entered into an Agreed Order publicly reprimanding Dr. Odulaja and requiring him to have his practice monitored by another physician for 16 consecutive monitoring cycles; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 48 hours of CME, divided as follows: eight hours in identifying drug-seeking behavior, eight hours in medical recordkeeping, eight hours in risk management, eight hours in diagnosis and treatment of asthma, eight hours in diagnosis and treatment of back pain, and eight hours in prescribing controlled substances; develop a pain management contract with specific provisions requesting drug screening and termination of the physician-patient relationship; and within 90 days pay an administrative penalty of $5,000. The Board found Dr. Odulaja prescribed controlled substances nontherapeutically to a patient and that he failed to adhere to the Board rules relating to the treatment of pain.

Wade, Randall William, M.D., Lic. No. G7117, McKinney
On June 10, 2016, the Board and Randall William Wade, M.D., entered into an Agreed Order requiring Dr. Wade to refer any and all chronic pain patients to other appropriate practitioners and shall not engage in the treatment of any chronic pain for any new patients; have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year and three attempts pass the Medical Jurisprudence Exam; within in one year complete the medical recordkeeping course offered by the University of San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete at least 24 hours of CME, divided as follows: eight hours in pain management, eight hours in drug seeking behavior and eight hours in risk management; and within 90 days pay an administrative penalty of $3,000. The Board found Dr. Wade operated an unregistered pain management clinic, routinely prescribed controlled substances to 17 chronic pain patients without stating a clear medical rationale, treatment goals, or therapeutic benefit, if any, to the patients, failed to monitor and evaluate patients he was prescribing to for pain and failed to maintain adequate medical records.

Wilson, Pamela Doylene, M.D., Lic. No. J8842, Spring
On June 10, 2016, the Board and Pamela Doylene Wilson, M.D., entered into an Agreed Order prohibiting Dr. Wilson from treating or otherwise serving as a physician for her immediate family, and shall not prescribe, dispense, administer or authorize controlled substances or dangerous drugs with addictive potential or potential for abuse to herself, immediate family or friends; requiring Dr. Wilson to within a year complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and within one year complete at least eight hours of CME in medical recordkeeping. The Board found Dr. Wilson failed to order necessary diagnostic testing prior to prescribing testosterone to a patient with whom she had a close relationship, failed to properly evaluate and monitor her boyfriend prior to prescribing him Adderall with no justification for the prescribing in the medical record, assumed the role of primary care physician for several close family members and failed to order the necessary testing to confirm her diagnoses prior to prescribing and failed to maintain adequate medical records related to her treatment.

IMPROPER PRESCRIBING

DeWitte, David M., M.D., Lic. No. N9039, Austin

On June 10, 2016, the Board and David M. DeWitte, M.D., entered into an Agreed Order requiring Dr. DeWitte to within one year and three attempts pass the Medial Jurisprudence Exam; and within one year complete at least 16 hours of CME, divided as follows: four hours in medical recordkeeping, four hours in risk management and eight hours in appropriate prescribing of controlled substances. The Board found Dr. DeWitte prescribed both controlled substances and dangerous drugs to a close family member without maintaining an adequate medical record, has a history of prescribing to close family members without maintaining adequate medical records and has self-prescribed on one occasion while residing and practicing in the state of Texas.

Hermann, Heinz, M.D., Lic. No. E2611, Pasadena

On June 10, 2016, the Board and Heinz Hermann, M.D., entered into an Agreed Order requiring Dr. Hermann to within one year and three attempts pass the Medical Jurisprudence Exam; and within one year complete at least 16 hours of CME, divided as follows: eight hours in risk management and eight hours in appropriate prescribing of controlled substances. The Board found Dr. Hermann admitted to prescribing Fiorinal to a family member in amounts beyond the period of immediate need and without maintaining a medical record for the treatment.

VIOLATION OF BOARD RULES

Beaty, Barry Lee, D.O., Lic. No. F3746, Fort Worth

On June 10, 2016, the Board and Barry Lee Beaty, D.O., entered into an Agreed Order on Formal Filing requiring Dr. Beaty to within one year complete at least 4 hours of CME in physician-patient communication. The Board found Dr. Beaty did not follow Board rules in his attempted discharge of a patient. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Bixby, Raymond Richard, M.D., Lic. No. K0420, Anson

On June 10, 2016, the Board and Raymond Richard Bixby, M.D., entered into an Agreed Order on Formal Filing requiring Dr. Bixby to within seven days surrender his DEA/DPS controlled substances certificates if he has not already done so; within one year and three attempts pass the Medical Jurisprudence Exam; within one year 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 complete the medical recordkeeping course offered by the PACE program; within one year complete at least 16 hours of CME in risk management; and within 60 days pay an administrative penalty of $3,000. The Board found Dr. Bixby failed to meet the standard of care with respect to his care and prescribing for treatment of chronic pain, failed to keep adequate medical records, and failed to respond to Board subpoena. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

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

On June 10, 2016, the Board and Dennis David Cantu, M.D., entered into an Agreed Order requiring Dr. Cantu to within one year complete at least eight hours of CME in risk management and within 60 days pay an administrative penalty of $500. The Board found Dr. Cantu was the subject of a federal charge of prescribing methadone to patients without the proper DEA registration. The charge was eventually dismissed with no admission of guilt and a $50,000 fine assessed to Dr. Cantu.

Gore, Thomas O., M.D., Lic. No. F6682, Lubbock

On June 10, 2016, the Board and Thomas O. Gore, M.D., entered into an Agreed Order prohibiting Dr. Gore from treating patients for chronic pain or engaging in the practice of pain management; and requiring Dr. Gore to within one year complete at least 24 hours of CME, divided as follows: eight hours in risk management, eight hours in prescribing benzodiazepines (or similar topic) and eight hours in identifying his risk patients, including those exhibiting drug-seeking behavior. The Board found Dr. Gore lacked attention to detail in his treatment of a patient in regards to the pain medications the patient was taking and authorization of early refills that he prescribed.

Karim, Shahnaz Amin, M.D., Lic. No. K8774, Houston

On June 10, 2016, the Board and Shahnaz Amin Karim, M.D., entered into an Agreed Order requiring Dr. Karim to within one year complete at least 28 hours of CME, divided as follows: eight hours in medical recordkeeping and 20 hours in pain management; and have his practice monitored by another physician for 8 consecutive monitoring cycles. The Board found Dr. Karim violated the standard of care by failing to properly evaluate and monitor a patient while prescribing narcotics despite signs that the patient was non-compliant in treatment recommendations and the physician-patient agreement for pain management.

Thomas, Flavia La Nell, D.O., Lic. No. K8520, Sugar Land
On June 10, 2016, the Board and Flavia La Nell Thomas, D.O., entered into an Agreed Order requiring Dr. Thomas to have her practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete at least eight hours of CME in medical recordkeeping; and within 90 days pay an administrative penalty of $3,000. The Board found Dr. Thomas violated the standard of care for 15 patients and failed to comply with Board rules related to the treatment of pain and supervision.

VIOLATION OF PRIOR BOARD ORDER

Battle, Clinton Charles, M.D., Lic. No. F1368, Fort Worth
On June 10, 2016, the Board and Clinton Charles Battle, M.D., entered into a Mediated Agreed Order Modifying Prior Order modifying Dr. Battle's 2013 Order. The modification requires Dr. Battle to within six months complete the Clinical Competence Assessment, including Phase I and II, offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete any and all retraining, remedial measures, and/or other recommendations made by PACE; have his practice monitored by another physician for six consecutive monitoring cycles; and within one year complete at least four hours of CME in billing/coding. The Board found Dr. Battle is not in compliance with his 2013 Order and did not implement the chart monitor recommendations globally across all his patients. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

Ferguson, Donald William, II, M.D., Lic. No. L6039, Arlington
On June 10, 2016, the Board and Donald William Ferguson, II, M.D., entered into an Agreed Order publicly reprimanding Dr. Ferguson and restricting his practice to Administrative Medicine; and requiring him to within 60 days pay an administrative penalty of $2,000. The Board found Dr. Ferguson violated the terms of his Order of Temporary Restriction by having indirect contact with patients. Specifically, Dr. Ferguson was acting as a scribe and communicating with patients by sending text messages to the Executive Director of Meadow View Assisted Living Center regarding patients' medical care.

Giacona, Jewel Annette, M.D., Lic. No. H8073, Baytown
On June 10, 2016, the Board and Jewel Annette Giacona, M.D., entered into an Agreed Order publicly reprimanding Dr. Giacona and requiring her to within seven days surrender her DEA/DPS controlled substances certificates. Dr. Giacona shall not possess, administer, dispense, prescribe, or order the administration, dispensing, or prescribing, of any controlled substance to any patient under any circumstances; shall not supervise or delegate prescriptive authority to a physician assistant or advanced practice nurse or supervise a surgical assistant; and within 30 days obtain an independent medical evaluation by a board certified psychiatrist and follow all recommendations for care and treatment. The Board found Dr. Giacona violated her 2015 and 2016 Orders by failing to comply with Board subpoena and not submitting medical records she kept for herself, failing to timely pay her administrative penalty and prescribing controlled substances beyond 72 hours.

Pittard, Carlton Duwain, M.D., Lic. No. C6476, Bedford
On June 10, 2016, the Board and Carlton Duwain Pittard, M.D., entered into an Agreed Order Modifying Prior Order modifying Dr. Pittard's June 2012 Order. The modification prohibits Dr. Pittard from prescribing, or authorizing approval or refills of any medication, including dangerous drugs and controlled substances. The Board found Dr. Pittard refilled his wife's Tramadol; twice authorized testosterone refills for a friend; and twice refilled testosterone for himself; did not maintain adequate medical records; failed to document immediate need to prescribe the medication. Dr. Pittard voluntarily surrendered his DEA/DPS controlled substances certification during the investigation.

Sacks, Steven Michael, M.D., Lic. No. J0658, Beaumont
On June 10, 2016, the Board and Steven Michael Sacks, M.D., entered into an Agreed Order Modifying Prior Order. The modification requires Dr. Sacks to tender payment for all monitoring costs and provide proof of payment to the Board by no later than June 30, 2016. The Board found Dr. Sacks violated his 2012 Order by failing to pay the physician monitoring fees for Cycle 5 in a timely manner. All other terms of the order remain in full force.

Wyder, Holly Jo, M.D., Lic. No. M8441, San Antonio
On June 10, 2016, the Board and Holly Jo Wyder, M.D., entered into an Agreed Order requiring Dr. Wyder to within one year complete at least eight hours of CME in ethics. The Board found Dr. Wyder violated the April 2015 Order because she called in late for testing on two separate occasions and provided one negative dilute specimen for testing.

TEXAS PHYSICIAN HEALTH PROGRAM VIOLATION

Pirinelli, Jeffrey John, M.D., Lic. No. K6241, Irving
On June 10, 2016, the Board and Jeffrey John Pirinelli, M.D., entered into an Agreed Order requiring Dr. Pirinelli for a period of three years: abstain from the consumption of prohibited substances as defined in the order; participate in the Board's drug testing program; obtain a Board approved psychiatrist and follow all recommendations for care and treatment; participate in a county or state medical society committee on physician health and rehabilitation, including meetings, no less than three times per month; and participate in Narcotics Anonymous no less than three times per week. The Board found Dr. Pirinelli failed to comply with the terms of his Texas Physician's Health Program agreement.

INADEQUATE MEDICAL RECORDS

Lewis, Adolphus Ray, D.O., Lic. No. H2532, Fort Worth
On June 10, 2016, the Board and Adolphus Ray Lewis, D.O., entered into an Agreed Order After Formal Filing publicly reprimanding Dr. Lewis and requiring Dr. Lewis to have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in proper billing practices and eight hours in ethics; and within six months pay an administrative penalty of $6,000. The Board found the evidence indicated a pattern of poor billing practices on the part of Dr. Lewis and that Dr. Lewis failed to document a minimal history for all patients at issue. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

McGonagle, Martin Eugene, M.D., Lic. No. G6563, Brownwood
On June 22, 2016, the Board entered a Final Order against Dr. Martin Eugene McGonagle, M.D., requiring Dr. McGonagle to have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least eight hours of CME in medical recordkeeping; and within 60 days pay an administrative penalty of $2,000. The Board found Dr. McGonagle failed to maintain adequate medical records. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. McGonagle has 20 days from the service of the order to file a motion for rehearing.

Philips, Robert J., D.O., Lic. No. E8110, Pampa
On June 10, 2016, the Board and Robert J. Philips, D.O., entered into an Agreed Order requiring Dr. Philips to within one year complete at least four hours in medical recordkeeping; and within 60 days pay an administrative penalty of $500. The Board found Dr. Philips failed to keep adequate medical records for one patient.

Thomas, Daniele D., M.D., Lic. No. G2123, Spring
On June 10, 2016, the Board and Daniele D. Thomas, M.D., entered into a Mediated Agreed Order requiring Dr. Thomas to within 60 days pay an administrative penalty of $500. The Board found Dr. Thomas did not maintain adequate medical records because some of her handwriting was illegible. This order resolves the formal complaint filed at the State Office of Administrative Hearings.

NON-CERTIFIED RADIOLOGIC TECHNICIAN

Tafolla, Gloria E., NCT, Permit No. NC01574, Fort Worth

On June 10, 2016, the Board and Gloria E. Tafolla, NCT, entered into an Agreed Order publicly reprimanding Ms. Tafolla and requiring her to provide quarterly reports from her court appointed Probation Officer to the Compliance Officer of the Board addressing her compliance with her sentence imposed by her conviction of DWI; participate in AA no less than 90 meetings in the first 90 days of the effective date of her order, and no less than three times a week thereafter. The Board found Ms. Tafolla pleaded guilty to DWI repeat offender, a misdemeanor, in Arlington, Texas.

RESPIRATORY CARE PRACTIONER

Poore, Laquanna, RCP, Permit No. 69698, Lancaster

On June 10, 2016, the Board and Laquanna Poore, RCP, entered into an Agreed Order requiring her to within 30 days have her current supervisor assign licensed respiratory therapists to serve as Ms. Poore's work-site monitor and monitor Ms. Poore for four consecutive quarters/cycles; and within one year complete at least six hours of CE, divided as follows: four hours in respiratory care and two hours in ethics. The Board found Ms. Poore documented treatment that was not actually provided.

CEASE AND DESIST

Botts, Trevor, D.C., No License, Austin

On June 10, 2016, the Board and Trevor Botts, D.C., entered into an Agreed Cease and Desist Order prohibiting Mr. Botts from acting as, or holding himself out to be, a licensed physician in the state of Texas. The Board found Mr. Botts' website and other promotional materials did not make it clear that he does not treat thyroid disease, diabetes, Hashimoto's disease, fatigue, digestive issues, and autoimmune disorders. Mr. Botts' website and other promotional materials state he is licensed by the Pastoral Medical Association. This entity does not confer any authority upon Mr. Botts to practice medicine in the state of Texas under the Medical Practice Act.

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

All releases and bulletins are also available on the TMB website under the "Newsroom" heading.