

## Texas Medical Board Press Release

### FOR IMMEDIATE RELEASE

September 11, 2014

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

### **TMB disciplines 41 physicians at August meeting, adopts rule changes**

At its August 29, 2014 meeting, the Texas Medical Board disciplined 41 licensed physicians and issued three cease and desist orders. The disciplinary actions included seven orders related to quality of care violations, three orders related to unprofessional conduct, three revocations, seven voluntary surrenders, four suspensions, one order related to peer review actions, two orders related to other states' actions, two orders related to nontherapeutic prescribing, three orders related to inappropriate prescribing, four orders related to violation of prior board order, one order related to violation of Board rules, one order related to Texas Physician Health Program violations, and three orders related to inadequate medical records. The Board also took disciplinary action against two pain management clinics and a surgical assistant.

The Board issued 244 physician licenses at the August meeting, bringing the total number of physician licenses issued in FY14 to 3,994.

### **RULE CHANGES ADOPTED**

#### **CHAPTER 163. LICENSURE**

##### **§163.6, Examinations Accepted for Licensure**

The amendment to rule 163.6, related to Examinations Accepted for Licensure, eliminates an incorrect reference in (f) to another part of the rule.

#### **CHAPTER 182. USE OF EXPERTS**

##### **§182.8, Expert Physician Reviewers**

The amendments to rule 182.8, related to Expert Physician Reviewers, adds language to subsection (c), relating to Expert Reviewers' Report, in the form of a new paragraph (3), requiring that an expert report must include notice to the respondent stating that the report is investigative information and is privileged and confidential under §164.007(c) of the Medical Practice Act, preventing its use or dissemination outside the informal settlement conference process and making the report inadmissible in civil, judicial, or administrative proceedings, and that release of the report to the respondent shall not constitute a waiver of the privileged and confidential status of the report, in accordance with §§164.003 and 164.007 of the Medical Practice Act and Board Rule 179. The amendments also add new subsection (d), providing that such reports are investigative information and privileged and confidential, in accordance with §164.007(c), Texas Occupations Code; and investigative reports by a consulting expert as defined by Texas Rules of Civil Procedure 192.7(d).

#### **CHAPTER 185. PHYSICIAN ASSISTANTS**

##### **§185.7, Temporary License**

The amendments to rule 185.7, related to Temporary License, adds language requiring that in order to be eligible for a temporary license, an applicant must be supervised by a physician who holds an active, unrestricted license as a physician in Texas; has not been the subject of a disciplinary order, unless the order was administrative in nature; and is not a relative or family member of the applicant. The amendment further requires that the applicant present written verification from the supervising physician that the physician will supervise the physician assistant according to rules adopted by the board; and retain professional and legal responsibility for the care rendered by the physician assistant.

#### **§185.28, Retired License**

The amendments to rule 185.28, related to Retired License, adds language providing an emeritus status for retired physician assistants who meet specific criteria.

### **CHAPTER 187. PROCEDURAL RULES**

#### **§187.5, National Practitioner Databank**

The amendment to rule 187.5, related to National Practitioner Databank, deletes language specifying the types of actions that are reportable and adds language that provides that the board will report according to NPDB guidelines and applicable federal law.

### **CHAPTER 195. PAIN MANAGEMENT CLINICS**

#### **§195.2, Certification of Pain Management Clinics**

The amendment to rule 195.2, related to Certification of Pain Management Clinics, corrects the citation to provisions under the Texas Occupations Code related to the regulation of pain management clinics.

## **DISCIPLINARY ACTIONS**

### **QUALITY OF CARE**

#### **Amine, Maged A., M.D., Lic. No. K1340, Houston**

On August 29, 2014, the Board and Maged A. Amine, M.D., entered into an Agreed Order requiring Dr. Amine to within one year complete at least 12 hours of CME, divided as follows: six hours in medical recordkeeping, three hours in risk management and three hours in complex coronary intervention/complications. The Board found Dr. Amine failed to adequately document and communicate that he recognized a patient's problem with coronary flow was due to dissection in both the circumflex and left anterior descending artery (LAD) and Dr. Amine acknowledged that his documentation did not clearly demonstrate his recognizing of significant disease in the LAD, and this was a complex bifurcation angioplasty and not a simple percutaneous coronary intervention (PCI).

#### **Boone, Heliodoro, M.D., Lic. No. D9364, San Antonio**

On August 29, 2014, the Board and Heliodoro Boone, M.D., entered into an Agreed Order requiring Dr. Boone to within one year complete at least 22 hours of CME, divided as follows: 10 hours in pancreatic-hepatic-biliary disease diagnosis and treatment and 12 hours in medical recordkeeping; and have his practice monitored by another physician for four consecutive monitoring cycles. The Board found Dr. Boone failed to meet the standard of care when he left the hospital to perform another surgery while the patient was post-operatively experiencing coagulopathic bleeding; failed to meet the standard of care by failing to confer and consult preoperatively; failed to perform a total splenectomy on the patient under the circumstances of suspected malignancy; failed to meet the standard of care for the patient due to his failure to perform a total splenectomy under those circumstances; and failed to maintain adequate medical records with respect to several patients.

#### **Bowers, Robert Martin, M.D., Lic. No. H9808, Texarkana**

On August 29, 2014 the Board and Robert Martin Bowers, M.D., entered into an Agreed Order requiring Dr. Bowers to within one year complete at least 12 hours of CME, divided as follows: eight hours in the treatment of medical sepsis and four hours in risk management. The Board found Dr. Bowers should have admitted a patient based on the subsequent development of worsening presenting clinical symptoms.

**Jackson, James Don, Jr., M.D., Lic. No. J3124, Palestine**

On August 29, 2014, the Board and James Don Jackson, Jr., M.D., entered into a Mediated Agreed Order publicly reprimanding Dr. Jackson and requiring Dr. Jackson to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 24 hours of CME, divided as follows: eight hours in medical recordkeeping, eight hours in prescribing and eight hours in ethics; within one year and three attempts pass the Medical Jurisprudence Exam; and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Jackson's medical records were inadequate, and the lack of objective findings indicating the treatment constituted nontherapeutic prescribing; failed to properly supervise a registered nurse who was working under his direction; and failed to cooperate with Board staff by failing to appear at ISCs on April 19, 2013 and June 17, 2013 and by failing to timely respond to Board subpoena.

**Khan, Muhammad Akram, M.D., Lic. No. J4878, McKinney**

On August 29, 2014, the Board and Muhammad Akram Khan, M.D., entered into an Agreed Order requiring Dr. Khan to within one year complete at least 12 hours of CME, divided as follows: four hours in risk management, four hours in ethics and four hours in patient communications. The Board found Dr. Khan admitted there was a system error which resulted in failing to do the time-out which led to the mistake in using a drug eluting stent in a patient.

**Quiring, Mark Edmond, M.D., Lic. No. J2263, Mount Pleasant**

On August 29, 2014, the Board and Mark Edmond Quiring, M.D., entered into an Agreed Order requiring Dr. Quiring to not possess, administer, dispense, or prescribe any Schedule II controlled substances, except as is medically necessary for treatment of inpatients in a hospital setting where Dr. Quiring has privileges or practices medicine. Any prescription of Schedule II controlled substances outside of the hospital setting shall result in the immediate suspension of Dr. Quiring's license to practice medicine; further requiring Dr. Quiring to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete the medical recordkeeping course and the physician 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; and pay an administrative penalty of \$10,000 within 60 days. The Board found Dr. Quiring pre-signed controlled substance prescription forms prior to leaving for vacation for specific patients coming in for refills on Schedule II drugs. Dr. Quiring stated that despite the covering physician using his own DEA number and signature on the prescription pad, the EMR carried Dr. Quiring's embedded name, causing the pharmacy to fill the prescriptions under Dr. Quiring's DEA number due to mistake on part of the pharmacy. Furthermore, Dr. Quiring failed to meet the standard of care with respect to several patients by failing to maintain adequate medical records to justify his prescribing.

**Thompson, Douglas Edward, M.D., Lic. No. L4149, Texarkana**

On August 29, 2014, the Board and Douglas Edward Thompson, M.D., entered into an Agreed Order requiring Dr. Thompson to within one year complete at least eight hours of CME in treatment of medical sepsis; and have his practice monitored by another physician for eight consecutive monitoring cycles. The Board found Dr. Thompson failed to meet the standard of care regarding his failure to diagnose the total infected knee and in his lack of knowledge regarding sepsis; and failed to meet the standard of care in his failure to admit the patient.

**UNPROFESSIONAL CONDUCT**

**Cunningham, Laurence W., D.O., Lic. No. G8685, Jacksonville**

On August 29, 2014, the Board and Laurence W. Cunningham, D.O, entered into an Agreed Order requiring Dr. Cunningham to submit to an evaluation by the Physician Health Program (PHP) and comply with any and all recommendations made by PHP. The Board found Dr. Cunningham admitted his unprofessional conduct and

intemperance with alcohol, his summary suspension and subsequent resignation from the hospital, and his arrest for disruptive behavior.

**Stoufflet, Paul Eric, M.D., Lic. No. H8440, Austin**

On August 29, 2014, the Board and Paul Eric Stoufflet, M.D., entered into an Agreed Order requiring Dr. Stoufflet to within one year complete at least 40 hours of CME, divided as follows: eight hours in medical ethics, eight hours in risk management, eight hours in recordkeeping, eight hours in informed consent and eight hours in patient communication; and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Stoufflet failed to clearly indicate his relationship with Gulf Coast Neurology (Gulf Coast) to his patients, failed to obtain consent to conduct a test performed by his office by an outside company; and failed to provide a copy of test results to the patient at issue until eight months after the initial request.

**Washington, Donald, Jr., M.D., Lic. No. H8886, Bedford**

On August 29, 2014, the Board and Donald Washington, Jr., M.D., entered into an Agreed Order publicly reprimanding Dr. Washington and requiring Dr. Washington to within one year complete at least four hours of CME in physician communication and four hours in risk management; and pay an administrative penalty of \$1,500 within 60 days. The Board found Dr. Washington exhibited unprofessional conduct in his communications towards a patient and his family who was undergoing treatment for mesothelioma and experiencing shortness of breath and pain; and Dr. Washington admitted to failing to report to the Board that in 2006 he was arrested for domestic violence and was ordered to take a 24 week batterer's prevention and intervention program in Dallas County.

**REVOCATION**

**Lee, Shayna Patrice, M.D., Lic. No. H0554, Houston**

On August 29, 2014, the Board entered a Final Order revoking Shayna Patrice Lee, M.D.'s Texas medical license. The Board found Dr. Lee pleaded guilty to the second-degree felony offense of engaging in organized criminal activity regarding the aggregate theft of Medicaid/Medicare funds on July 23, 2012. Dr. Lee also failed to comply with a prior 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. Lee has 20 days from the service of the order to file a motion for rehearing.

**Parker, Donald, M.D., Lic. No. N6563, Houston**

On August 29, 2014, the Board approved a Final Order revoking Donald Parker, M.D.'s Texas medical license. The Board found Dr. Parker voluntarily surrendered his Louisiana medical license in light of a pending investigation by the Louisiana State Board of Medical Examiners for unprofessional conduct involving inappropriate behavior with a patient. Notice of the hearing before the State Office of Administrative Hearings was served to Dr. Parker. Dr. Parker did not appear and was not represented at the scheduled hearing, therefore staff moved for a default, which was granted by the Administrative Law Judge. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Parker has 20 days from the service of the order to file a motion for rehearing.

**Smith, Ralph Arnold, Jr., M.D., Lic. No. J3618, Greenwood, MS**

On August 29, 2014, the Board entered a Final Order revoking Ralph Arnold Smith, Jr., M.D.'s Texas medical license. The Board found Dr. Smith was charged in 2012 with capital murder and conspiring to commit murder in the State of Mississippi. On July 9, 2012, the Mississippi State Board of Medical Licensing (MSBML) issued an order taking disciplinary against Dr. Smith's Mississippi medical license. The order required him to undergo an independent medical examination and prohibited him from practicing medicine until such a time as he had submitted to the necessary medical examination and the MSBML has determined his fitness to practice medicine. On January 14, 2014, the Circuit Court of Leflore County, Mississippi, issued an order finding Dr. Smith to be mentally incompetent to stand trial for the criminal charges against him in Mississippi. Dr. Smith is currently being held in a state hospital facility in Mississippi until such a time as he is found competent to stand trial for the criminal charges against him. Accordingly, he is currently of unsound mind. As a result, on March 24, 2014, Board staff filed a motion for summary judgment in this case. 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. Smith has 20 days from the service of the order to file a motion for rehearing.

### **VOLUNTARY SURRENDER**

#### **De Leon, Oscar, M.D., Lic. No. P1287, Grand Prairie**

On August 29, 2014, the Board and Oscar De Leon, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. De Leon agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings and requiring Dr. De Leon to immediately cease practice in Texas. Dr. De Leon was currently suspended from practicing medicine in the state of Texas, after the Board entered an Order of Temporary Suspension on June 12, 2014, related to Dr. De Leon's pending criminal charges alleging he engaged in inappropriate sexual contact with a minor.

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

On August 29, 2014, the Board and Philip Martinez Cantu, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Cantu agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings and requiring Dr. Cantu to immediately cease practice in Texas. Dr. Cantu was under investigation for allegations related to his care and treatment of several patients. Dr. Cantu has reported to the Board that he has a medical condition which precludes him from practicing medicine with reasonable skill and safety to patients.

#### **Fisher, Stephen Neal, M.D., Lic. No. H9635, Pittsburgh, PA**

On August 29, 2014, the Board and Stephen Neal Fisher, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Fisher agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Fisher was under investigation for allegations that he surrendered his California Medical License while under investigation for violations of laws in the state of California.

#### **Gustafson, Klemens Elden, M.D., Lic. No. G4300, Roanoke**

On August 29, 2014, the Board and Klemens Elden Gustafson, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Gustafson agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Gustafson was under investigation by Board staff related to an alleged violation of §164.053(a)(8), failure to supervise adequately the activities of those acting under the supervision of the physician.

#### **Hohn, Joyce Tolles, M.D., Lic. No. J1096, Dallas**

On August 29, 2014, the Board and Joyce Tolles Hohn, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Hohn agreed to voluntarily surrender her Texas medical license in lieu of further disciplinary proceedings. Dr. Hohn has indicated her desire to voluntarily surrender her medical license in lieu of fulfilling the terms of her agreement with the Texas Physician Health Program (PHP), entered April 26, 2013.

#### **Hughes, Jason, M.D., Lic. No. H3893, Topeka, KS**

On August 29, 2014, the Board and Jason Hughes, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Hughes agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Hughes was under investigation for allegations related to a Stipulation and Final Agency Order, issued by the Colorado Medical Board on August 15, 2013. Dr. Hughes has reported to the Board that he has a medical condition which precludes him from practicing medicine with reasonable skill and safety to patients.

#### **West, William Watkins, Jr., M.D., Lic. No. D0345, Austin**

On August 29, 2014, the Board and William Watkins West, Jr., M.D., entered into an Agreed Voluntary Surrender Order in which Dr. West agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. West was under investigation for allegations of unprofessional conduct in his care and treatment of one patient.

## **SUSPENSION**

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

On August 11, 2014, the Board entered an Automatic Suspension Order regarding Forrest Carroll Brown, M.D., requiring Dr. Brown to immediately cease practicing as a physician in Texas until he requests in writing to have the suspension stayed or lifted, personally appears before the Board and provides sufficient evidence which, in the discretion of the Board, is adequate to show he possesses the skills and knowledge to safely practice in Texas and is otherwise physically and mental competent to resume practice in this state. The Board found Dr. Brown violated the terms of the June 2013 Order by failing to take and pass the Jurisprudence Exam within the required time frame.

### **Mahmood, Tariq, M.D., Lic. No. F2338, Cameron**

On August 29, 2014, the Board and Tariq Mahmood, M.D., entered into an Agreed Order of Voluntary Suspension, suspending Dr. Mahmood'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. Such evidence and information shall include at minimum, but shall not be limited to the following: the complete and final resolution of any and all criminal charges and investigations that are currently pending, or any charges that may be brought as a result of the allegations. The Board found Dr. Mahmood has indicated his desire to voluntarily suspend his medical license in lieu of further disciplinary proceedings due to his initial conviction of conspiracy, identity theft and health care fraud stemming from fraudulent Medicare and Medicaid claims.

### **Torres Santos, Juan, M.D., Lic. No. P5242, Albuquerque, NM**

On August 29, 2014, the Board and Juan Torres Santos, M.D., entered into an Agreed Order of Voluntary Suspension, suspending Dr. Torres Santos' 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. Such evidence and information shall include at minimum, but shall not be limited to the following: evidence addressing any and all pending investigations, allegations and/or disciplinary matters before the Board; evidence addressing any and all pending or resolved investigations, allegations and/or disciplinary matters in the State of New Mexico; and evidence that any criminal matter regarding the alleged activities has been completely and finally resolved. The Board found Dr. Torres Santos is currently being investigated by the State of New Mexico after being arrested for possession of child pornography. In view of the ongoing investigation by the State of New Mexico, Dr. Torres Santos agreed to the voluntary suspension of his license to practice medicine in the state of Texas.

### **Ramirez, Roque Joel, M.D., Lic. No. K4201, Corpus Christi**

On August 15, 2014, the Board entered an Order of Suspension By Operation of Law, suspending Roque Joel Ramirez, M.D.'s Texas medical license. The Board found that on May 25, 2014, Dr. Ramirez entered a guilty plea to Federal charges of mail fraud, and was ordered to do the following: serve 37 months in Federal prison; upon release from prison, serve three years on supervised release; pay a \$10,000 fine; and pay restitution of \$370,638.28 to Medicare and Medicaid. Dr. Ramirez was ordered to surrender to the Bureau of Prisons on July 3, 2014, and is scheduled to be released March 8, 2017. The Order remains in effect until superseded by a subsequent Order of the Board.

## **PEER REVIEW ACTIONS**

### **Poteet, Charles Leamon, Jr., M.D., Lic. No. J5868, Owensboro, KY**

On August 29, 2014, the Board and Charles Leamon Poteet, Jr., M.D., entered into an Agreed Order requiring Dr. Poteet to within 30 days contact with Colorado Physicians Education Program (CPEP) or University of California San Diego Physician Assessment and Clinical Education (PACE) Program for a competency evaluation. The Board found Dr. Poteet submitted a competency evaluation based on his actions at a facility that resulted in a patient death; subsequently, an administrative decision was made to remove him from the Emergency Department schedule at the hospital.

## **OTHER STATES' ACTIONS**

### **Gansert, Gary, M.D., Lic. No. E4344, Reno, NV**

On August 29, 2014, the Board and Gary Gansert, M.D., entered into an Agreed Order prohibiting Dr. Gansert from practicing in Texas until such a time as he personally appears before the Board and provides clear and convincing evidence that he is physically, mentally, and otherwise competent to safely practice medicine. Such evidence and information shall include at minimum, but shall not be limited to the following: evidence of full compliance with the terms and conditions of the Nevada State Board of Medical Examiners' Settlement Order, entered against Dr. Gansert on March 7, 2014. The Board found Dr. Gansert was disciplined by the Nevada State Board of Medical Examiners following allegations that he violated the standard of care and kept inadequate medical records in relation to one patient.

### **Tu, Gene Chang, M.D., Lic. No. J9562, Rowland Heights, CA**

On August 29, 2014, the Board and Gene Chang Tu, M.D., entered into an Agreed Order revoking Dr. Tu's Texas license; staying the revocation and placing Dr. Tu on probation under the following terms for 5 years: shall not practice until such a time as he requests in writing to resume practice of medicine in Texas, 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. Tu was disciplined by the California Medical Board in 2013 for failure to maintain adequate medical records for his treatment of multiple patients. The California Medical Board revoked Dr. Tu's medical license and stayed the revocation, placing him on probation for five years under various terms.

## **NONTHERAPEUTIC PRESCRIBING**

### **Joselevitz, Joel, M.D., Lic. No. J1703, Houston**

On August 29, 2014, the Board and Joel Joselevitz, M.D., entered into an Agreed Order on Formal Filing restricting Dr. Joselevitz from prescribing Schedules II – V and prohibiting Dr. Joselevitz from treating patients for chronic pain. The Board found Dr. Joselevitz obtained inadequate histories, performed insufficient physical examinations, and failed to meet the standard of care for these patients. Dr. Joselevitz non-therapeutically prescribed controlled substances and continued to prescribe controlled substances as long-term treatment and without adequately documenting and justifying changes in medication and/or indications of therapeutic benefits; and failed to properly monitor these patients for aberrant drug-taking behavior and/or failed to properly respond to the indications of aberrant drug use. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

### **Quintanilla, Mario, M.D., Lic. No. G5506, Houston**

On August 29, 2014, the Board and Mario Quintanilla, M.D., entered into an Agreed Order requiring Dr. Quintanilla to within one year complete the physician 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 eight hours of CME in ethics; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Quintanilla failed to obtain objective evidence confirming that the patient had the diagnosis of metastatic melanoma as the patient had claimed, and, as a result, Dr. Quintanilla's continued treatment with prescriptions for narcotics was nontherapeutic. Dr. Quintanilla failed to confirm the cause of the patient's chronic pain and continued prescription of narcotics in the face of repeat signs that the patient was drug-seeking.

## **INAPPROPRIATE PRESCRIBING**

### **Casey, David London, M.D., Lic. No. J3292, Lewisville**

On August 29, 2014, the Board and David London Casey, M.D., entered into an Agreed Order requiring Dr. Casey 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 pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Casey improperly prescribed controlled substances to his mother and to a second individual to whom he had a close personal relationship. The prescriptions covered a period of time beyond the 72 hour period of immediate need.

### **Crandall, Paul Stuart, M.D., Lic. No. G4938, San Antonio**

On August 29, 2014, the Board and Paul Stuart Crandall, M.D., entered into an Agreed Order requiring Dr. Crandall to within one year complete at least eight hours of CME in risk management; and pay an administrative penalty of \$1,500 within 60 days. The Board found Dr. Crandall inappropriately entered into a personal relationship with a former patient, inappropriately prescribed to himself and a close friend or family member and personally used an antibiotic he prescribed in the name of a close friend or family member.

**Porras, Jose L., M.D., Lic. No. H3143, El Paso**

On August 29, 2014, the Board and Jose L. Porras, M.D., entered into an Agreed Order requiring Dr. Porras to within one year complete at least 12 hours of CME, divided as follows: four hours in medical recordkeeping, four hours in prescribing controlled substances and four hours in risk management; and within one year and three attempts pass the Medical Jurisprudence Exam. The Board found Dr. Porras acknowledged that he provided medical treatment to his close family members which included prescribing quantities of controlled substances that lasted beyond the 72 hours of immediate need.

**VIOLATION OF PRIOR ORDER**

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

On August 29, 2014, 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 consecutive monitoring cycles. The Board found Dr. Butka violated terms of his 2013 Order by failing to implement chart monitor recommendations as required. Specifically, he failed to implement the chart monitor's recommendation to utilize pain management agreements and urine drug screens.

**Messner, Gregory N., D.O., Lic. No. K5159, Dallas**

On August 29, 2014, the Board and Gregory N. Messner, D.O., entered into an Agreed Order requiring Dr. Messner to within one year complete either the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, Vanderbilt University, University of Texas and the Santé Institute of Professional Education and Research, or equivalent approved in advance; complete at least 16 hours of CME, divided as follows: eight hours in ethics, four hours in risk management and four hours in medical records; and pay an administrative penalty of \$1,500 within 60 days. The Board found Dr. Messner did not maintain adequate medical records for friends and family members whom he provided medical treatment and obtained a \$50,000 loan from a patient who was related to another employee/patient of Dr. Messner.

**Mills, Virginia M., M.D., Lic. No. J2210, Houston**

On August 29, 2014, the Board entered a Modified Agreed Order, modifying Virginia M. Mills, M.D.'s February 2012 Order. The modification removes the requirement that Dr. Mills limits her practice to a group setting, removes the chart monitoring requirement, and adds a repayment plan paragraph for the fee owed under the deleted chart monitoring provision. The Board found that although Dr. Mills has made good faith efforts to comply, she has not complied with the fee requirement of her 2012 Order. All other provisions of the Order, as modified, remain in full force.

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

On August 29, 2014, the Board and William Edward Skiba, M.D., entered into an Agreed Order Modifying Prior Order publicly reprimanding Dr. Skiba and requiring him to within 45 days comply with the terms of his 2013 Order, including compliance with any recommendations from the evaluating psychiatrist regarding recommended sessions of psychotherapy. The Board found Dr. Skiba is not in compliance with his October 2013 Order. Specifically, Dr. Skiba failed to obtain the recommended six sessions of psychotherapy as recommended by the evaluating psychiatrist and Dr. Skiba has also failed to cooperate with Board staff.

**VIOLATION OF BOARD RULES**

**Robles, Jose Antonio, M.D., Lic. No. G0527, Houston**



On August 29, 2014, the Board and Jose Antonio Robles, M.D., entered into an Agreed Order publicly reprimanding Dr. Robles and requiring him to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 20 hours of CME, divided as follows: 12 hours in risk management and eight hours in ethics; and pay an administrative penalty of \$2,000 within 180 days. The Board found Dr. Robles failed to exercise diligence and violated rules relating to pain management clinic registration by applying for a Pain Management Certificate (PCM) on March 2, 2011 for Wilcrest Family Practice and Wellness Center and indicated on the application that he was the owner, despite the clinic being owned by Dario Juarez. Furthermore, Dr. Robles failed to exercise professionalism and diligence in his practice by failing to secure prescription pads which, in turn were used by Juarez to prescribe controlled substances to people out of Juarez's home.

## **TEXAS PHYSICIANS HEALTH PROGRAM (PHP) VIOLATION**

### **Smith, Jack Coldwell, III, M.D., Lic. No. L3131, Pampa**

On August 29, 2014, the Board and Jack Coldwell Smith, III, M.D., entered into an Agreed Order requiring Dr. Smith to abstain from the consumption of prohibited substances, as defined in the Order, except as prescribed by another physician to Dr. Smith for legitimate and documented therapeutic purposes; participate in the Board's drug testing program for a period of ten years; attend at least five Alcoholics Anonymous meetings per week; meet with his treating psychiatrist at least once every six weeks; Dr. Smith shall not prescribe any medication to himself or his family; and shall only use his DEA and DPS controlled substances registration certificates for prescriptions written in connection with his practice within a hospital facility. The Board found Dr. Smith failed to comply with the Texas Physician Health Program and relapsed by using hydrocodone.

## **INADEQUATE MEDICAL RECORDS**

### **Francis, William Raleigh, Jr., M.D., Lic. No. E0920, The Woodlands**

On August 29, 2014, the Board and William Raleigh Francis, Jr., M.D., entered into an Agreed Order requiring Dr. Francis to within a 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. Francis failed to adequately document in the medical records as to his medical reasoning for prescribing of narcotics to one patient.

### **Hey, Wayne Albert, D.O., Lic. No. F5943, Fort Worth**

On August 29, 2014, the Board and Wayne Albert Hey, D.O., entered into an Agreed Order on Formal Filing requiring Dr. Hey to within one year complete at least eight hours of in-person CME in medical recordkeeping. The Board found Dr. Hey failed to maintain adequate medical records in his treatment of one patient in the placement of a surgical stent on the patient's right ureter. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

### **Okechuku, Theodore Emeka, M.D., Lic. No. L0888, Dallas**

On August 29, 2014, the Board and Theodore Emeka Okechuku, M.D., entered into an Agreed Order requiring Dr. Okechuku to within one year and three attempts to pass the Medical Jurisprudence Exam; 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 medical recordkeeping and eight hours in risk management; and pay an administrative penalty of \$5,000 paid in five monthly installments of \$1,000, with the first payment due within 30 days. The Board found Dr. Okechuku failed to maintain adequate medical records. Specifically, Dr. Okechuku's medical records did not provide sufficient document rationale for the choice of prescriptions used to treat the patients reviewed.

## **PAIN MANAGEMENT CLINIC ACTIONS**

### **Holland Medical Clinic (Cert. No. PMC00250) and Normandy Medical, PA (Cert. No. PMC00251)**

On August 29, 2014, the Board and Carl Davis Jr., M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Davis surrendered his Pain Management Clinic certificates for Holland Medical Clinic and Normandy Medical, PA in lieu of further disciplinary proceedings. The Order requires Dr. Davis to immediately cease operating Holland Medical

Clinic and Normandy Medical, PA as pain clinics in Texas and withdraw any and all pain management clinic applications, if any, currently pending before the Board. The Board found Dr. Davis is no longer qualified to be an owner or operator of the clinics because he has been subject to a disciplinary order by the Board related to inappropriate prescribing of controlled substances.

## **SURGICAL ASSISTANT**

### **Reyes-Aguero, Maria Del Pilar, S.A., Lic. No. SA00404, Pharr**

On August 29, 2014, the Board and Maria Del Pilar Reyes-Aguero, S.A., entered into an Agreed Order requiring Ms. Reyes-Aguero to correct all print and web-based advertisements so that Ms. Reyes-Aguero is no longer referred to as "Dr." without the required disclosures related to the basis of the title and statement that indicates she is "not licensed to practice in Texas," have her practice monitored by a physician for eight consecutive monitoring cycles; within one year complete at least four hours of CME in ethics; and pay an administrative penalty of \$5,000 within 60 days. The Board found Ms. Reyes-Aguero disseminated false and misleading statements, through web-based and print advertisements, representing that she was a physician.

## **CEASE AND DESIST**

### **Hasse, Bryan C., D.C., No License, Houston**

On August 29, 2014, the Board and Bryan C. Hasse, D.C., entered into an Agreed Cease and Desist Order prohibiting Mr. Hasse from practicing medicine in Texas. The Board found Mr. Hasse, a licensed chiropractor and Advanced Registered Nurse, performed a needle electromyogram (EMG) and nerve conduction study on a patient without delegation or adequate supervision. Mr. Hasse also performed an EMG on a second patient. Furthermore, Mr. Hasse signed the medical records using "Dr." without delineating language to show that he was a chiropractor and not a physician. Corrections have been made to clarify Mr. Hasse's credentials.

### **Jimenez, Dulce, No License, Houston**

On August 29, 2014, the Board and Dulce Jimenez entered into an Agreed Cease and Desist Order requiring Ms. Jimenez to only advertise and offer to the public those services that she is licensed or otherwise lawfully authorized to provide to the public, including services and skin treatments that she is authorized to provide under her cosmetology license and the cosmetology license of her salon, and shall not otherwise engage in the unlicensed practice of medicine in the state of Texas. The Board found Ms. Jimenez subleased a room in her salon to Denise Lorenzen for \$600 per month for Lorenzen's business, which included multiple "body sculpting" services, such as cavitation and cellulite and spot weight loss. In Lorenzen's subleased space at Ms. Jimenez's hair salon, Yokaty Mencia Wilson allegedly administered "mesotherapy" weight loss injections that resulted in suspected injury to four individuals. Ms. Jimenez's hair salon and facial business was a separate business from Lorenzen's body sculpting business and Wilson's mesotherapy business. Ms. Jimenez denies, and there is no evidence to show, that Ms. Jimenez advertised, sold, or administered mesotherapy injections in her hair salon and facial business, but agrees to the entry of this Agreed Order, and to comply with the terms and conditions of the Order.

### **Lorenzen, Denise, No License, Houston**

On August 29, 2014, the Board and Denise Lorenzen entered into an Agreed Cease and Desist Order requiring Ms. Lorenzen prohibiting Ms. Lorenzen from practicing medicine in Texas, including but not limited to: the diagnosing, treating or offering to treat skin and or other diseases, or using letters, words, or terms, affixed on stationary and advertisements, indicating Ms. Lorenzen is entitled to treat skin and other diseases. The Board found Ms. Lorenzen diagnosed, treated or offered to treat skin and or other diseases at 726 Wilcrest Drive, Houston, Texas 77042. Ms. Lorenzen denies that she engaged in the practice of medicine, but agrees to the entry of this Agreed Order, and to comply with the terms and conditions of the Order.

###

*To view disciplinary orders, visit the TMB website, click on "Look Up A License," 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 Board Actions."*

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