Texas Medical Board
News Release
FOR IMMEDIATE RELEASE
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Medical Board Disciplines 71 Doctors and Issues 526 Licenses

Since its April board meeting, the Texas Medical Board has taken disciplinary action against 71 licensed physicians.
The actions included 15 violations based on quality of care; 11 actions based on unprofessional conduct; two nontherapeutic prescribing violations; six agreed orders based on inadequate medical records violations; one action based on impairment due to alcohol or drugs or mental/physical condition; four actions based on other states' or entity's actions; one action based on failure to properly supervise or delegate; two actions based on peer review actions; two actions based on violation of probation or prior order; one agreed order modifying a prior order; and five voluntary surrenders. Twenty-one physicians entered into administrative orders for minor statutory violations.

At its May 28-29 meeting, the board issued **526** physician licenses.

RULE CHANGES ADOPTED

The board adopted the following rule changes that were published in the *Texas Register:*
Chapter 162, Supervision of Medical School and Physician Assistant Students: §162.1, Supervision of Medical School Students.
Chapter 165, Medical Records: §165.3, Patient Access to Diagnostic Imaging Studies in Physician's Office.
Chapter 173, Physician Profiles: §173.1 Profile Contents.
Chapter 190, Disciplinary Guidelines: §190.8(1)(L) relating to the prescribing of controlled substances/dangerous drugs for the partners of patients that have been diagnosed with sexually transmitted diseases.

PROPOSED RULE CHANGE WITHDRAWN

Chapter 174, Telemedicine: §§174.1-174.6, rule review and proposed amendments, were withdrawn for further review and will be republished for comment.

PROPOSED RULE CHANGES

The following proposed rule changes will be published in the *Texas Register* for public comment.
Chapter 163, Licensure: §163.4, Procedural Rules for Licensure Applicants.

Chapter 175, Fees, Penalties, and Forms: §175.1, Application Fees; §175.5, Payment of Fees or Penalties.

DISCIPLINARY ACTIONS

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

QUALITY OF CARE VIOLATIONS

Aggarwal, Ajay, M.D., Lic. #J7879, Bay City TX
On May 1, 2009, the Board and Dr. Aggarwal entered into a five-year Agreed Order of public reprimand requiring that, for each year of the order, Dr. Aggarwal obtain 50 hours of continuing medical education in assessing, diagnosing and treating substance abuse; that he have a practice monitor; that he request modification of his DEA and DPS controlled substance registration to eliminate Schedule II, limiting his prescribing of controlled substances to the remaining schedules, and that he not obtain controlled substance registration without board approval. The action was based on Dr. Aggarwal's failure to meet the standard of care in his prescribing, monitoring, follow-up care, treatment plan and management of a pain patient and failing to heed multiple red flags for nontherapeutic controlled substance abuse by the patient, who died of acute Methadone intoxication.

Cantu, David A., M.D., Lic. #J1073, Fredericksburg TX
On May 29, 2009, the board and Dr. Cantu entered into an agreed order requiring that he complete 10 hours of continuing medical education in risk management. The action was based on Dr. Cantu's prescribing an adult-strength dose of Ambien for a seven-year-old patient; neglecting to eliminate 11 refills for the drug that his electronic system provided; and failing to follow up or monitor the effectiveness of the drug on the patient and her 13-year-old sister, to whom he had also prescribed Ambien.

Carrasco-Santiago, Manuel, M.D., Lic. #J5275, Big Spring TX
On May 29, 2009, the board and Dr. Carrasco-Santiago entered into a mediated agreed order requiring that he obtain 10 hours each of continuing medical education in pre-operative evaluation of patients and general cardiology and that he pay an administrative penalty of $1,500 within 90 days. The action was based on Dr. Carrasco-Santiago's failure to make appropriate efforts to follow up on an EKG and further evaluate a patient's cardiovascular status prior to clearing the patient for knee surgery, after which the patient suffered an acute myocardial infarction complicated by pulmonary edema and died.

Findley, Michael S., M.D., Lic. #H1279, Waco TX
On May 29, 2009, the board and Dr. Findley entered into an agreed order requiring that he complete 10 hours of continuing medical education in prescribing for pain management. The action was based on Dr. Findley's failure to properly document neurological and physical examinations; his prescribing excessive amounts of narcotics; and his failure to recognize narcotics abuse in one patient.

Haney, Peter M., M.D., Lic. #K4911, Houston TX
On May 29, 2009, the board and Dr. Haney entered into an agreed order requiring that, within two years, Dr. Haney obtain 30 hours of continuing medical education of at least 10 hours each in medical recordkeeping, pediatric GI diseases and physician-patient communication and that he

pay an administrative penalty of $2,000 within 30 days. The action was based on Dr. Haney's failure to communicate with an infant's parents to their satisfaction; failure to explicitly document his concerns regarding a possible diagnosis of malrotation; and failure to order an upper GI study to rule out malrotation in a timely manner.

Hill, Welton E., M.D., Lic. #F6746, Bellville TX

On May 29, 2009, the board and Dr. Hill entered into a two-year agreed order requiring that he have a practice monitor; that he obtain 10 hours of continuing medical education in medical recordkeeping for each year of the order; and that he pay an administrative penalty of $1,000 within 90 days. The action was based on Dr. Hill's inadequate documentation in treatment of multiple patients with dementia, ADD and depression.

Malone, Timothy F., D.O., Lic. #K1540, Dallas TX

On May 29, 2009, the board and Dr. Malone entered into an agreed order of public reprimand suspending Dr. Malone's licensing, staying the suspension, placing him on probation for 10 years and requiring the following: Dr. Malone may not delegate prescribing of Schedule II and III drugs to physician assistants or advanced practice nurses; he must surrender his DEA and DPS prescribing certificates for Schedule II and III drugs; he may not prescribe controlled substances until he receives authorization from the Board; he must have a female chaperone present when examining female patients; he must have a practice monitor for the first three years of the order; within one year he must take and pass the Texas Medical Jurisprudence Examination; within one year he must complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program or the Vanderbilt Center for Professional Health; and he must receive care and treatment from a psychiatrist. The action was based on Dr. Malone's failure to meet the standard of care in prescribing of controlled substances and dangerous drugs and narcotics and his having an inappropriate sexual relationship with a patient.

Patel, Vikramkumar D., M.D., Lic. #G6987, Houston TX

On May 29, 2009, the board and Dr. Patel entered into an agreed order of public reprimand requiring that he have a practice monitor or, within two years, obtain recertification from the American Board of Obstetrics and Gynecology; that, within two years, he obtain 10 hours each of continuing medical education in medical recordkeeping and risk management; and that he pay an administrative penalty of $5,000 within 90 days. The action was based on Dr. Patel's failure to properly manage the care and treatment of a patient on hormone replacement therapy who required a hysterectomy after developing endometrial adenocarcinoma.

Pickrell, Michael B., M.D., Lic. #H7807, Austin TX

On May 29, 2009, the board and Dr. Pickrell entered into a 15-year agreed order requiring that he abstain from consuming prohibited substances; participate in the board's drug-testing program; submit to an independent medical examination by a psychiatrist; participate in AA; have a practice monitor; and, within one year, obtain 15 hours of continuing medical education in chronic pain. The action was based on Dr. Pickrell's prescribing narcotics and other drugs to multiple patients without adequate documentation or laboratory work and on his abuse of alcohol, steroids and other drugs.

Rainey, Dennis C., M.D., Lic. #J3583, Beaumont TX

On May 29, 2009, the board and Dr. Rainey entered into an agreed order requiring that, within one year, he complete 10 hours of continuing medical education in the pharmacology of emergency medicine. The action was based on his failure to meet the standard of care by transferring a medically unstable patient to a psychiatric facility rather than have her monitored.

Salas, David S., M.D., Lic. #H6944, Paris TX
On May 29, 2009, the board and Dr. Salas entered into an agreed order requiring that, within one year, he obtain at least four hours of continuing medical education in risk management and pay an administrative penalty of $1,000 within 60 days. The action was based on his prescribing an excessive dose of Bactrim-DS to an 11-year-old patient who suffered edema, conjunctival hemorrhage, rash, nausea and vomiting as a result of the excessive dose.
Sands, Larry R., M.D., Lic. #G0884, Zapata TX
On May 29, 2009, the board and Dr. Sands entered into an agreed order requiring that he complete five hours of continuing medical education in medical recordkeeping. The action was based on Dr. Sands' failure to properly document informing an 82-year-old patient of the sedative effects of an injection and to determine whether the patient had someone to drive her home.
Schnider, Geoffrey, M.D., Lic. #E8887, Houston TX
On May 29, 2009, the board and Dr. Schnider entered into an agreed order of public reprimand. The action was based on Dr. Schnider's performing a tubal ligation on a surgical patient, subsequent to emergency surgery for abdominal bleeding, without her informed consent.
Smith, George N., D.O., Lic. #E5251, West TX
On May 29, 2009, the board and Dr. Smith entered into a two-year agreed order requiring that he complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; that he have a practice monitor for the duration of the order; that, within one year, he obtain 10 hours of continuing medical education in medical recordkeeping and 10 hours in addiction medicine; that he obtain 15 hours per year of CME in pain management; and prohibiting him from prescribing narcotic schedule II or III drugs except as provided in the order. The action was based on Dr. Smith's failure to meet the standard of care in prescribing IM morphine and Demerol to two chronic pain patients.
Tressler, Samuel D. III, M.D., Lic. #E8978, San Antonio TX
On May 29, 2009, the board and Dr. Tressler entered into an agreed order requiring that he pay an administrative penalty of $1,000 within 60 days. The action was based on Dr. Tressler's failure to meet the standard of care in prescribing Auralgan for a 16-month-old patient with tympanostomy tubes (PE tubes), which is contraindicated for patients with PE tubes. The patient did not exhibit any adverse effects from the Auralgan.

UNPROFESSIONAL CONDUCT VIOLATIONS

Blackwell, Michael, M.D., Lic. # J3695, Tomball TX
On May 29, 2009, the board and Dr. Blackwell entered into an agreed order requiring that he pay an administrative penalty of $1,000 within 90 days. The action was based on Dr. Blackwell's yelling at hospital staff in the presence of a patient, family members and staff when he was informed his scheduled surgical case would be delayed because of an emergency.
Campbell, Odette L., M.D., Lic. #H9609, Denton TX
On May 29, 2009, the board and Dr. Campbell entered into an agreed order requiring that, within 180 days, she pay a $3,000 administrative penalty. The action was based on her failure to respond to a board subpoena and her violation of a 2007 agreed order.
Chumak, Bogdan A., M.D., Lic. #H1053, La Grange TX
On April 3, 2009, the board and Dr. Chumak entered into an agreed order requiring that, within one year, he obtain 40 hours of continuing medical education, with at least eight hours each in

the following areas: risk management, boundary violations, medical recordkeeping, and identifying drug-seeking behavior; and that he pay an administrative penalty of $2,500 within 90 days. The action was based on Dr. Chumak's prescribing large quantities of medications, including controlled substances, to a patient with whom he had a romantic relationship, and prescribing over-the-counter medications to her children.

Holt, Janie E., M.D., Lic. #H7429, College Station TX

On May 29, 2009, the board and Dr. Holt entered into an agreed order requiring that, within one year, she complete 100 hours of community service with one or more nonprofit charitable organizations. The action was based on Dr. Holt's failure to provide medical records to four patients in a timely manner after the closing of her practice and her failure to report her address change to the board in 30 days as required by law.

Kilianski, Joseph R., M.D., Lic. #H4463, Keller TX

On May 29, 2009, the board and Dr. Kilianski entered into an agreed order prohibiting him from authorizing ultrasound exams without a physician's order; mandating that he comply with state and federal laws regarding ultrasounds; and imposing an administrative penalty of $2,000 to be paid within 90 days. The action was based on Dr. Kilianski's allowing staff at a prenatal obstetric ultrasound center to perform ultrasounds on five patients without a physician's order, in violation of federal and state regulations.

McDonald, Deward D., M.D., Lic. #C5174, Longview TX

On May 29, 2009, the board and Dr. McDonald entered into an agreed order of public reprimand requiring that, within one year, Dr. McDonald obtain five hours each of continuing medical education in ethics and boundary violations; and that he pay an administrative penalty of $1,000 within 90 days. The action was based on Dr. McDonald's having an inappropriate sexual relationship with a patient on whom he performed a breast biopsy.

Messer, Dale L., M.D., Lic. #D2740, Alvin TX

On May 29, 2009, the board and Dr. Messer entered into an agreed order requiring that he complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The action was based on Dr. Messer's making a sexually inappropriate remark to a patient.

Pearce, Jay, D.O., Lic. #H4608, Fulton TX

On May 29, 2009, the board and Dr. Pearce entered into an agreed order requiring that, within one year, he take and pass the Texas Medical Jurisprudence Examination. The action was based on Dr. Pearce's inappropriate behavior toward a hospital staff member.

Salinas, Fulgencio P., M.D., Lic. #G7325, Edinburg TX

On May 29, 2009, the board and Dr. Salinas entered into an agreed order requiring that he submit billing records to the board's compliance division; that he submit a written protocol for charges for medical records; and that he pay an administrative penalty of $2,000 within 90 days. The action was based on excessive charges for an autopsy report and failure to comply with a board subpoena.

Saran, Nisha M., D.O., Lic. #L5894, Arlington TX

On May 29, 2009, the board and Dr. Saran entered into an agreed order of public reprimand. The action was based on suspension of her DEA certificate because of its unauthorized use by a member of her family.

Young, James R., M.D., Lic. #K4616, Nacogdoches TX

On May 29, 2009, the board and Dr. Young entered into a mediated agreed order of public reprimand requiring that he pay an administrative penalty of $5,000 within 30 days. The action

was based on his abusive behavior toward other physicians and staff during an effort to stabilize a post-operative patient at Nacogdoches Memorial Hospital and the suspension of his privileges from that hospital.

NONTHERAPEUTIC PRESCRIBING VIOLATIONS

Emejulu, Herbert M., M.D., Lic. #E4320, Port Arthur TX

On May 29, 2009, the board and Dr. Emejulu entered into a three-year agreed order requiring that his practice be monitored; that, within one year and for each year of the order he obtain 20 hours of continuing medical education in pain management and 10 hours in medical recordkeeping; and within one year take and complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program or an equivalent course. The action was based on Dr. Emejulu's poor recordkeeping and prescribing practices.

King, Charles F., M.D., Lic. #K6628, Commerce TX

On May 29, 2009, the board and Dr. King entered into a three-year agreed order requiring that his practice be monitored and that, within one year, he take and complete the physician prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The action was based on his nontherapeutically prescribing Xanax and Soma to one patient.

INADEQUATE MEDICAL RECORDS

Horndeski, Gary M.D., Lic. #G2390, Sugar Land TX

On May 29, 2009, the board and Dr. Horndeski entered into an agreed order requiring that, within one year, he obtain 10 hours of continuing medical education in medical recordkeeping and that he pay an administrative penalty of $2,000 within 90 days. The action was based on Dr. Horndeski's failure to properly document a patient assessment and physical examination, patient expectations for surgery, an operative plan for initial surgery and for a revision, and, for the revision, a reason for the change in the proposed procedure on the day of the surgery, for a liposuction patient.

Louis, Edward E., M.D., Lic. #D0953, Dickinson TX

On May 29, 2009, the board and Dr. Louis entered into an order requiring that he have a practice monitor for two years. The action was based on concerns over documentation of five patients' charts that led to a temporary restriction on Dr. Louis' practice in June, 2008.

Roach, Dee A., M. D., Lic. #G5542, Colorado City TX

On May 29, 2009, the board and Dr. Roach entered into an agreed order requiring that, within one year, he take and complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The action was based on Dr. Roach's failure to maintain adequate medical records on one patient.

Smith, Theodore D., D.O., Lic. #L1465, Austin TX

On May 29, 2009, the board and Dr. Smith entered into an agreed order requiring that, within one year, he obtain 10 hours of continuing medical education in medical recordkeeping; and, within one year, he organize and present to his practice group a seminar discussing the treatment and diagnosis of depression and how to properly document treatment of depression. The action was based on Dr. Smith's failure to properly document discussion of treatment options and whether there was suicidal ideation in a patient for whom he prescribed Prozac who committed suicide.

Walker, Jonathan E., M.D., Lic. #D2622, Dallas TX
On May 29, 2009, the board and Dr. Walker entered into an agreed order requiring that, within one year, he complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program and pay an administrative penalty of $1,000 within 90 days. The action was based on Dr. Walker's failure to properly document his clinical testing and evaluation to show justification for his diagnostic conclusions and recommended treatment for two patients in his neurology practice.
Walker, McDonald H., M.D., Lic. #F7658, Plano TX
On May 29, 2009, the board and Dr. Walker entered into an agreed order requiring that, within one year, he complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program and pay an administrative penalty of $2,000 within 90 days. The action was based on Dr. Walker's failure to adequately document the medical record of a three-year-old emergency room patient with regard to the wound, the prescribed antibiotics, his observations of the patient, and complete discharge instructions for a possible snakebite.
IMPAIRMENT DUE TO ALCOHOL OR DRUGS
Goen, Tracy H., M.D., Lic. #K3579, College Station TX
On May 29, 2009, the board and Dr. Goen entered into an agreed order suspending his license until such time as the board finds clear evidence that Dr. Goen is able to safely practice medicine. The action was based on Dr. Goen's inability to practice because of addiction to prescription medicine.

ACTIONS BASED ON ACTION BY ANOTHER STATE OR ENTITY

Hurley, Regina S., M.D., Lic. #L4454, Clearwater FL
On May 29, 2009, the board and Dr. Hurley entered into an agreed order requiring that she pay an administrative penalty of $2,000 within 90 days. The action was based on action by the Florida Department of Health after Dr. Hurley left a guide wire in a patient after the insertion of a central line catheter.
McCarthy, James M., M.D., Lic. #H3118, Lafayette LA
On May 29, 2009, the board and Dr. McCarthy entered into an agreed order requiring that he comply with his consent order with the Louisiana State Board of Medical Examiners; that he ask the Louisiana Board to provide reports to the Texas board; and that within 60 days he pay an administrative penalty of $500. The action was based on Dr. McCarthy's five-year consent order with the Louisiana Board requiring that he participate in the Louisiana Physician's Health Program and its drug-testing program, maintain abstinence and notify employers of the order.
Meharry, Leroy I., M.D., Lic. #F4955, Umatilla OR
On May 29, 2009, the board and Dr. Meharry entered into an agreed order in which Dr. Meharry voluntarily surrendered his license. The action was based on Dr. Meharry's health problems and his desire to surrender his Texas medical license in lieu of further disciplinary proceedings regarding allegations he violated a 2006 order of the Oregon Medical Board.
Woodward, Robert A., M.D., Lic. #G8518, Plano TX
On May 29, 2009, the board and Dr. Woodward entered into a 10-year agreed order of public reprimand requiring that he not treat himself or his family; that he abstain from the consumption of prohibited substances; that he attend AA or a similar program at least three times a week; that within 90 days he get an independent evaluation from a psychiatrist; and that within one year he

take and pass the Texas Medical Jurisprudence Examination. The action was based on Dr. Woodward's failure to report the suspension of his Louisiana medical license to the board and on his writing prescriptions for his wife and diverting them for his own use.

FAILURE TO PROPERLY SUPERVISE OR DELEGATE

Muñoz, Jesus A., M.D., Lic. #J6184, Humble TX

On May 29, 2009, the board and Dr. Muñoz entered into an agreed order requiring that, within one year, he obtain 10 hours of continuing medical education in supervising delegates or, if he is unable to find such a course, in risk management, and pay an administrative penalty of $3,000 within 60 days. The action was based on Dr. Muñoz's allowing nursing staff to diagnose, order tests, and write prescriptions for his patients without appropriate qualifications.

PEER REVIEW ACTIONS

Bourgeois, Sebastian, M.D., Lic. #BP30027420, Houston TX

On May 29, 2009, the board and Dr. Bourgeois entered into a mediated agreed order of public reprimand. The action was based on Dr. Bourgeois' suspension from a general surgery residency program at Baylor Medical School for making an inappropriate sexual remark to a female surgery resident.

Grant, Paul A., M.D., Lic. #E7608, Fort Worth TX

On May 29, 2009, the board and Dr. Grant entered into an agreed order requiring that, within one year, he obtain 10 hours of continuing medical education in risk management or ethics and that he successfully complete the professional boundaries course offered by the Vanderbilt Center for Professional Health. The action was based on Dr. Grant's giving up privileges at Baylor Surgical Hospital after an investigation into his making inappropriate sexual remarks and contact with staff members at the hospital.

VIOLATION OF PROBATION OR PRIOR ORDER

Patt, Richard B., M.D., Lic. #J5440, Pasadena TX

On May 29, 2009, the board and Dr. Patt entered into an agreed order requiring that he pay an administrative penalty of $250 within 30 days. The action was based on Dr. Patt's failure to submit specimens for drug-testing as required by a 2007 board order.

Zimmerman, Erica I., M.D., Lic. # J6829, Austin TX

On May 29, 2009, the board and Dr. Zimmerman entered into an agreed order requiring that, within 180 days, she obtain at least five hours of continuing medical education in either psychopharmacology or the treatment of depression. The action was based on Dr. Zimmerman's failure to obtain sufficient CME required by a previous order.

ORDER MODIFYING PRIOR ORDER

Head, Philip A., M.D., Lic. #J5097, Houston TX

On May 29, 2009, the board and Dr. Head entered into an agreed order modifying prior order requiring that within six months he obtain a position in a residency/fellowship program of not less than one year; that he continue with AA attendance; and that he submit reports from the TMA drug-testing program prior to starting the board's drug-testing program, which will occur when he enters a residency program. The action was based on Dr. Head's difficulty in finding a mini-residency as required by the 2008 order.

VOLUNTARY SURRENDERS/REVOCATIONS

Aurignac, Fabian, M.D., Lic. #K3977, Miami FL

On May 29, 2009, the board and Dr. Aurignac entered into an agreed order of voluntary revocation of Dr. Aurignac's license. The action was based on Dr. Aurignac's desire to avoid further investigations and hearings on pending cases before the board.

Cohn, Cal K., M.D., Lic. #E4819, Houston TX
On May 29, 2009, the board and Dr. Cohn entered into an agreed order in which Dr. Cohn voluntarily surrendered his license because of his medical condition.
Roberts, Gary F., M.D., Lic. #J1371, Mesquite TX
On May 29, 2009, the board and Dr. Roberts entered into an agreed order in which he voluntarily surrendered his license. The action was based on allegations that Dr. Roberts made inappropriate sexual comments and touched a patient inappropriately.
Womack, James. C., M.D., Lic. #C7834, San Angelo TX
On May 29, 2009, the board and Dr. Womack entered into a mediated agreed order requiring that, within 180 days, Dr. Womack permanently surrender his Texas medical license. The action was based on his desire to retire from practice.
Wood, Robert F., M.D., Lic. #E2948, Wichita Falls TX
On May 29, 2009, the board and Dr. Wood entered into an agreed order in which he voluntarily surrendered his license. The action was based on Dr. Wood's desire to cease practicing medicine because of a physical disability and his desire to avoid further litigation.

MINOR ADMINISTRATIVE VIOLATIONS

Twenty-one physicians entered into administrative agreed orders with the board for minor statutory violations.
CORRECTIONS
In the April 10, 2009, news release the summary for Victor Pallares, M.D., Lic. #J3867, should have been listed under Inadequate Medical Records.

The following summary should have been included in the April 10 release under Quality of Care Violations:
Ybarra, Benjamin, D.O., Lic. #K3883, Mansfield TX
On March 2, 2009, the Board and Dr. Ybarra entered into a three-year agreed order requiring that he have a practice monitor, and that, within the first year of the order, he obtain eight hours of continuing medical education in medical recordkeeping and eight hours of CME in pain management. The action was based on Dr. Ybarra's failure to meet the standard of care for one patient by failing to fully and properly assess the patient's medical condition prior to initiating treatment; failing to adequately document prescriptions and the rationale for prescribing decisions in the patient's treatment; failing to thoroughly review relevant patient records during the course of the patient's treatment; and by continuing to prescribe high dose narcotics to the patient after the patient's hospitalization for an overdose.