

**Texas Medical Board
News Release
FOR IMMEDIATE RELEASE
Friday, August 28, 2009**

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Medical Board Disciplines 131 Doctors and Issues 829 Licenses

Since its May 28-29 board meeting, the Texas Medical Board has taken disciplinary action against 131 licensed physicians. This exceeds the record of 99 actions set in August 2006. The actions included 40 violations based on quality of care; 12 actions based on unprofessional conduct; 10 nontherapeutic prescribing violations; 13 actions based on inadequate medical records violations; two actions based on impairment due to alcohol or drugs; four actions based on peer review actions; two actions based on failure to properly supervise or delegate; one advertising violation; five orders based on criminal convictions; two actions based on violation of probation or prior order; two orders modifying a prior order; five voluntary surrenders; and two revocations. The board issued 31 orders for minor statutory violations. At its July 17 meeting, the Texas Physician Assistant Board took actions against seven physician assistants.

At its August 20-21 meeting, the board issued **829** physician licenses.

RULE CHANGES ADOPTED

The board adopted the following rule changes that were published in the *Texas Register*:

Chapter 175, Fees, Penalties, and Forms: §175.1, Application Fees; §175.2, Registration and Renewal Fees; §175.5, Payment of Fees or Penalties, increasing certain application and renewal fees, establishing fees for the approval of continuing acupuncture courses, and providing circumstances under which application and renewal fees may be refunded.

Chapter 163, Licensure: §163.4, Procedural Rules for Licensure Applicants, establishing criteria for granting licensure application extensions.

Chapter 180, Physician Health Rehabilitation Program: repeal of §180.1. Rehabilitation Orders;

new §§180.1-180.7 establishing the Texas Physician Health Program for the purpose encouraging the wellness of licensees and applicants pursuant to the Medical Practice Act ("Act"), Tex. Occ. Code Ann. §§167.001-.011 (emergency adoption).

Chapter 183, Acupuncture: §183.14, Acudetox Specialists, removing duplicative language regarding fees for acudetox certification.

PROPOSED RULE CHANGES

The following proposed rule changes will be published in the *Texas Register* for public comment.

Chapter 163, Licensure: proposed amendments to §163.1 Definitions; §163.2 Full Texas

Medical License; §163.4 Procedural Rules for Licensure Applicants; §163.5 Licensure Documentation; §163.6 Examinations Accepted for Licensure; §163.7 Ten Year Rule; §22 TAC 163.11 Active Practice of Medicine.

Chapter 166, Physician Registration: Proposed amendments to §166.1, Physician Registration; §166.2, Continuing Medical Education; §166.3, Retired Physician Exception; §166.4, Expired Registration Permits; §166.6, Exemption From Registration Fee for Retired Physician Providing Voluntary Charity Care.

Chapter 168, Criminal History Evaluation Letters: Proposed new §168.1-168.2, Criminal History Evaluation Letters.

Chapter 171, Postgraduate Training Permits: Proposed amendments to §171.3, Physician-in-Training Permits; §171.4, Board-Approved Fellowships; §171.5, Duties of PIT Holders to Report.

Chapter 172, Temporary and Limited Licenses: Proposed amendments to §172.8, Faculty Temporary License; new §172.12, Provisional Licenses for Medically Underserved Areas.

Chapter 173, Physician Profiles: Proposed amendments to §173.1, Profile Contents; §174.4, Use of the Internet in Medical Practice.

Chapter 174, Telemedicine: Rule review and proposed amendments to chapter.

Chapter 175, Applications forms: Repeal of §175.4, Application Forms; §175.1, Registration Fees; §175.2, Registration and Renewal Fees.

Chapter 179, Investigations: Proposed amendments to §179.4, Request for Information and Records from Physicians.

Chapter 187, Procedural Rules: Proposed amendments to §187.25, Notice of Adjudicative Hearing; §187.26, Service in SOAH Proceeding; §187.27, Written Answers in SOAH Proceedings and Default Orders; and §187.37, Final Decisions and Order.

Chapter 190, Disciplinary Guidelines: Proposed amendments to §190.2, Board's Role; and §190.14, Disciplinary Sanction Guidelines.

Chapter 192, Office Based Anesthesia Services and Pain Management Clinics: Proposed amendments to §192.1, Definitions; §192.4, Registration; §192.5, Inspections; §192.6, Requests for Inspection and Advisory Opinion; new §192.7, Operation of Pain Management Clinics.

Chapter 193, Standing Delegation Orders: Proposed amendments to §193.6, Delegation of the Carrying Out or Signing of Prescription Drug Orders to Physician Assistants and Advanced Practice Nurses; and §193.7, Delegated Drug Therapy Management.

Chapter 194, Non-Certified Radiologic Technicians: Proposed amendments to §194.2, Definitions; §194.3, Registration; §194.5, Non-Certified Technician's Scope of Practice.

Board Approves Tanning Advisory Statement

In accordance with HB 1310 enacted by the 81st Legislature, the Texas Medical Board approved the following statement:

Both indoor and outdoor tanning expose a person to ultraviolet radiation. The U.S. Department of Health and Human Services has declared ultraviolet radiation to be a cancer causing substance (carcinogen). UV radiation can come from the sun and artificial sources, such as tanning beds and sun lamps. People who tan greatly increase their risk of developing skin cancer. The number of skin cancers has been rising over the past several years due to increasing exposure to UV radiation from the sun, tanning beds, and sun lamps. The amount of UV radiation received during indoor tanning is similar to the amount received from the sun, and in some cases may be stronger. Several studies have shown that exposure to UV radiation from indoor tanning devices

is associated with an increased risk of skin cancer, especially when the user is exposed during their twenties, teens, or even younger. Exposure to UV radiation from indoor tanning devices can also lead to premature skin aging, eye damage, and damage to the immune system. These effects are delayed and show up several years after the exposure.

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. Orders are posted on the TMB web site at http://reg.tmb.state.tx.us/OnLineVerif/Phys_NoticeVerif.asp about 10 days after the board meeting.

QUALITY OF CARE VIOLATIONS

Babcock, Chad, M.D., Lic. #L8269, Austin TX

On August 21, 2009, the Board and Dr. Babcock entered into an agreed order requiring that within one year he obtain five hours of continuing medical education in ethics; that within one year he complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and that within 90 days he pay an administrative penalty of \$2,000. The action was based on Dr. Babcock's prescribing several medications, x-rays and tests to a friend without maintaining medical records or written justification and neglecting to secure written informed consent or advise the friend of foreseeable side effects.

Bang, Richard, M.D., Lic. #L6280, Rockwall TX

On August 21, 2009, the Board and Dr. Bang entered into an agreed order requiring that he have a practice monitor for three years; that within one year he obtain 10 hours of continuing medical education in risk management and 10 hours of CME in medical recordkeeping; that he complete the physician prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and that within 60 days he pay an administrative penalty of \$5,000. The action was based on Dr. Bang's prescribing excessive amounts of medications to a known drug abuser, who died of a drug overdose.

Berwind, Robert T., M. D., Lic. #E5481, Kingwood TX

On August 21, 2009, the Board and Dr. Berwind entered into an agreed order requiring that within one year he obtain 30 hours of continuing medical education, including 20 hours in urogynecology and 10 hours in medical recordkeeping; and that within 90 days he pay an administrative penalty of \$1,000. The action was based on Dr. Berwind's failure to properly evaluate and properly perform surgery on a patient with a vaginal prolapse, requiring the patient to undergo a second surgical procedure.

Black, James Nelson, M.D., Lic. #G1282, Temple TX

On August 21, 2009, the Board and Dr. Black entered into an agreed order of public reprimand requiring that within three years he take and pass the examination promulgated by the International Board of Heart Rhythm Examiners and that within 90 days he pay an administrative penalty of \$3,000. The action was based on Dr. Black's improper placement of a lead when implanting a pacemaker in a patient.

Branch, Rudolph E., M.D., Lic. #D6378, Dallas TX

On August 21, 2009, the Board and Dr. Branch entered into an agreed order of public reprimand

suspending his license and staying the suspension under the following conditions: that within one year he obtain 10 hours of continuing medical education in ethics and 10 hours in medical recordkeeping; that within 90 days he pay an administrative penalty of \$2,500; and that he become familiar with state and federal regulations regarding prescribing dangerous drugs and controlled substances, as well as Texas Medical Board Rule 174.4; and that he make patient records available for inspection by the Board. The action was based on Dr. Branch's prescribing weight-loss medications to two patients via the Internet.

Crawford, Debbie A., D.O., Lic. #J8973, Brownwood TX

On August 21, 2009, the Board and Dr. Crawford entered into an agreed order requiring that within one year she obtain 10 hours of continuing medical education in medical recordkeeping and 10 hours in ethics; the order also requires that she submit a written statement of corrective action taken. The action was based on Dr. Crawford utilizing a Florida company for administration and interpretation of Electromyography (EMG) and Nerve Conduction Velocity Studies, and that employees who administered and interpreted the studies were not licensed Texas health care providers as required.

Dake, Theodore Jr., M.D., Lic. #E9594, San Marcos TX

On August 21, 2009, the Board and Dr. Dake entered into an agreed order requiring that within one year Dr. Dake obtain 10 hours of continuing medical education in medical recordkeeping. The action was based on Dr. Dake's failure to adequately document his testing and workup in the process of evaluating and diagnosing a patient.

Daugherty, Brian, M.D., Lic. #K2325, Huffman TX

On August 21, 2009, the Board and Dr. Daugherty entered into an agreed order requiring that he have a practice monitor for one year; that within one year he obtain 10 hours of continuing medical education in medical recordkeeping and 10 hours of CME in prescribing for pain management; and that within 180 days he pay an administrative penalty of \$1,000. The action was based on Dr. Daugherty's failure to do a thorough evaluation and examination of a patient he treated for pain, relying on the patient's statements, and his failure to request the patient's medical records to verify the patient's statements.

Granado, Elma Gonzales, M.D., Lic. #G9744, Fort Worth TX

On August 7, 2009, the Board and Dr. Granado entered into an agreed order requiring that within one year Dr. Granado obtain 10 hours of continuing medical education in risk management, 10 hours in pharmacology, and 10 hours in medical recordkeeping. The action was based on Dr. Granado's failure to use reasonable diligence regarding a patient's prior documented allergies when she administered Haldol to a patient who was allergic to Haldol, and her failure to properly document her concerns about possible contraindicated medications administered to the patient.

Grant, James S., M.D., Lic. #E7096, Texarkana TX

On August 21, 2009, the Board and Dr. Grant entered into a three-year agreed order prohibiting him from engaging in the practice of pain management; limiting his practice to a group or institutional setting; requiring that within one year he take and pass the Texas Medical Jurisprudence Examination; that within 180 days he take the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and that he have a practice monitor. The action was based on Dr. Grant's failure to appropriately treat seven patients for health issues including diabetes, hypertension, and chronic pain. Additionally, Dr. Grant failed to appropriately document care provided to the patients.

Hinshaw, Luke, M.D., Lic. #L8077. Great Falls MT

On August 21, 2009, the Board and Dr. Hinshaw entered into an agreed order requiring that within one year Dr. Hinshaw obtain 10 hours each of continuing medical education in pharmacology, with emphasis on the use of antibiotics, and in management of hospital acquired infections. The action was based on Dr. Hinshaw's prescribing gentamicin to a hospitalized patient in excessive quantities.

Kendall, Kevin, M.D., Lic. #J8620, Katy TX

On August 21, 2009, the Board and Dr. Kendall entered into an agreed order requiring that he have a practice monitor for one year; that within one year he obtain 10 hours of continuing medical education in each of the following areas: pain management, medical recordkeeping and pediatric ambulatory care; and that he pay an administrative penalty of \$2,500 within 60 days. The action was based on Dr. Kendall's failure to notify hospital staff of his transfer of a patient to the patient's primary physician, and his prescribing nontherapeutic doses of controlled substances in treating chronic pain in three patients.

Key, James D. Sr., M.D., Lic. #E3339, Brownsville TX

On August 21, 2009, the Board and Dr. Key entered into a five-year agreed order requiring that he obtain a second opinion from a board certified orthopedic surgeon with a spine specialty or neurosurgeon prior to performing any spinal surgeries or procedures; that he have a practice monitor; and that within 30 days he contact the Texas A&M Health Science Center Rural and Community Health Institute (K-STAR) or the University of California San Diego Physician Assessment and Clinical Education (PACE) program to schedule an assessment of his practice. The action was based on Dr. Key's failure to meet the standard of care in treating a surgical patient because of inadequate follow-up on a post-operative complication, and his inadequate documentation in the medical record of that patient.

Khan, Muhammad A., M.D., Lic. #J4878, McKinney TX

On August 21, 2009, the Board and Dr. Khan entered into a one-year agreed order requiring that he have a practice monitor; that within one year he obtain 30 hours of continuing medical education in the following areas: 10 hours in medical recordkeeping; 10 hours in interventional cardiology related to cardiology; and 10 hours in interventional cardiology, non-cardiac specific; and that he obtain a written consultation from a licensed Texas physician who is board certified in vascular surgery or interventional neuro-radiology prior to performing carotid arteriograms, vertebral arteriograms, and/or any endovascular interventions. The action was based on Dr. Khan's failure to meet the standard of care in performing cardiac procedures on 29 patients and his failure perform and/or document a history or physical examination in these patients, who did not meet the criteria for such invasive and risky procedures.

Klein, Amy W., D.O., Lic. #K7781, Gainesville TX

On August 21, 2009, the Board and Dr. Klein entered into an agreed order requiring that within one year she obtain eight to 10 hours of continuing medical education in obstetric ultrasound or fetal monitoring; 10 hours in high-risk obstetrics and 10 hours in medical recordkeeping. The action was based on Dr. Klein's failure to meeting the standard of care of a patient and her baby during final stages of labor in not recognizing the severity of fetal distress and not timely addressing fetal strip abnormalities.

Le, David E., M.D., Lic. #F6356, Houston TX

On August 21, 2009, the Board and Dr. Le entered into an agreed order requiring that he have a practice monitor for one year; that within 30 days he obtain 10 hours of continuing medical education in medical recordkeeping; and that within 30 days he pay an administrative penalty of \$500. The action was based on Dr. Le's failure to meet the standard of care and/or properly

document care and treatment of two patients, and on his failure to notify the board of his change of address within 30 days as required.

Liggett, Scott, M.D., Lic. #F8766, Marble Falls TX

On August 21, 2009, the Board and Dr. Liggett entered into an agreed order requiring that within one year Dr. Liggett obtain eight hours each of continuing medical education in medical recordkeeping, diagnosis and treatment of diabetes and physician-patient communication. The action was based on Dr. Liggett's failure to adequately document in the medical record of a new-onset type 2 diabetic: hydration status; any fingerstick results; and a plan for follow-up and monitoring. Although Dr. Liggett obtained a urinalysis indicating an abnormal urine glucose level, performed a physical exam, prescribed Glipizide, a glucometer and diabetic supplies, ordered a consult for diabetes and nutrition counseling, instructed the patient to check her blood sugar twice daily and record the results, and ordered a laboratory workup, which would be available the next morning, to confirm the patient's elevated blood sugar, Dr. Liggett did not remember whether he obtained a fingerstick blood sugar test on the patient in his office.

Luna, Sergio, M.D., Lic. #J7058, Austin TX

On August 21, 2009, the Board and Dr. Luna entered into an agreed order requiring that he have a practice monitor for one year and that within one year he obtain 10 hours of continuing medical education in medical recordkeeping, 10 hours in child and adolescent psychiatry, and 10 hours in child and adolescent psychopharmacology. The action was based on Dr. Luna's failure to meet the standard of care in the treatment of an eight-year-old boy with bipolar disorder to whom Dr. Luna prescribed multiple psychotropic drugs.

McGonagle, Martin, M.D., Lic. #G6563, Brownwood TX

On August 21, 2009, the Board and Dr. McGonagle entered into a 2½ year mediated agreed order requiring his invasive cosmetic surgery practice be monitored; 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; that within one year he complete the "maintaining proper boundaries" course offered by Santé Center for Healing; that he attend the 26th Annual Scientific Meeting of the American Academy of Cosmetic Surgery in Orlando, Florida, January 27-31, 2010; that within two years Dr. McGonagle obtain 20 hours of continuing medical education offered by Audio-Digest Foundation in wound care, infectious disease, and antibiotic therapy; and that he pay an administrative penalty of \$2,000 within 180 days. The action was based on Dr. McGonagle's failure to meet the standard of care in treatment of several patients who received cosmetic procedures, including lip implant, face lift, breast augmentation and blepharoplasty, as it related to the treatment of postoperative wound infections and the use of antibiotic therapy, and his entering into an inappropriate financial relationship with an employee.

Muza, Hugo, M.D., Lic. #D4239, San Antonio TX

On August 21, 2009, the Board and Dr. Muza entered into an agreed order requiring that within one year Dr. Muza obtain 12 hours of continuing medical education offered by the American Academy of Disability Evaluating Physicians that includes evaluating workers' compensation cases and four hours CME in peripheral vs. radiculopathy workups. The action was based on Dr. Muza's failure to meet the standard of care regarding appropriate documentation, diagnoses, treatment plan, and medical advice for a patient for whom he ordered nerve conduction velocity studies, and his failure to document medical reasoning and rationale for the NCV testing.

Olive, Trevelyn J., M.D., Lic. #M1992, Arlington TX

On August 21, 2009, the Board and Dr. Olive entered into an agreed order requiring that within

one year Dr. Olive obtain 10 hours of continuing medical education in medical recordkeeping; 10 hours CME in high-risk obstetrics; and 10 hours in gynecological and obstetrical emergencies. The action was based on Dr. Olive's improper diagnosis of an ectopic pregnancy, her failure to document a pelvic examination, and her injecting Methotrexate into a patient whose later sonogram showed viable embryos, which the patient subsequently miscarried, in her uterus.

Parikh, Navinchandra C., M.D., Lic. #E1697, Grand Prairie TX

On August 21, 2009, the Board and Dr. Parikh entered into an agreed order of public reprimand requiring that he limit his practice to a group or institutional setting; that he have a practice monitor; that within seven days he eliminate from his DEA and DPS permits Schedule II prescribing; that within one year he take and pass the Special Purpose Examination (SPEX); and that within one year he take 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. Parikh's failure to maintain even minimally adequate medical documentation, failure to adequately examine or document a patient who suffered a deep vein thrombosis; failure to perform any diligent steps regarding continuing management of Warfarin prescribed for the patient after he was diagnosed with a DVT and a pulmonary embolism, and nontherapeutically prescribing Vicodin.

Restrepo, Margo K., M.D., Lic. #E2815, Houston TX

On August 21, 2009, the Board and Dr. Restrepo entered a two-year agreed order requiring that, for each year of the order, she obtain 12 hours of continuing medical education in suicide risk management, and that within 60 days she pay an administrative penalty of \$5,000. The action was based on Dr. Restrepo's admitting and discharging a psychiatric patient without conducting a face-to-face evaluation, mental status examination, or risk assessment. The patient committed suicide within 24 hours of being discharged from the psychiatric unit at St. Joseph's Medical Center.

Schmiege, Gustav R. Jr., M.D., Lic. #F5036, Pasadena TX

On August 21, 2009, the Board and Dr. Schmiege entered into an agreed order requiring that Dr. Schmiege limit his practice to a group or institutional setting; that for one year he have a practice monitor; and that within one year he obtain 10 hours of continuing medical education in medical recordkeeping. The action was based on his failure to adequately document the basis of his diagnoses and justification for the use of the medications prescribed to two patients.

Sharp, Thomas L., D.O., Lic. #L2003, Greenville TX

On August 21, 2009, the Board and Dr. Sharp entered into an agreed order requiring that within 90 days Dr. Sharp pay an administrative penalty of \$1,000. The action was based on Dr. Sharp's failure to adequately inform a patient's family or other providers that a patient had been advised to transfer to another hospital or that the seriousness and risks of the situation had been explained to the patient, and his failure to accurately document the patient's refusal to transfer with an appropriate "against medical advice" form.

Singstad, Charles P., M.D., Lic. #K4251, San Antonio TX

On August 21, 2009, the Board and Dr. Singstad entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in risk management and within 60 days he pay an administrative penalty of \$500. The action was based on Dr. Singstad's failure to adequately document a discharge medication treatment plan and his failure to contact a patient's primary care physician and ensure agreement on a treatment plan to be followed upon the patient's transfer to a nursing home.

Smith, Howard B., M.D., Lic. #J2341, Dallas TX

On August 21, 2009, the Board and Dr. Smith entered into an agreed order requiring that within one year Dr. Smith take the medical recordkeeping and physician prescribing courses offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The action was based on Dr. Smith's failure to properly follow up and document treatment of a patient with complaints of alcohol dependency, generalized anxiety disorder and Attention Deficit Hyperactivity Disorder whom he treated with Levitra, which is not consistent with FDA guidelines.

Spencer, James B., M.D., Lic. #D4315, Jasper TX

On August 21, 2009, the Board and Dr. Spencer entered into an agreed order requiring that within one year Dr. Spencer obtain 10 hours of continuing medical education in risk management and within 180 days he pay an administrative penalty of \$2,000. The action was based on Dr. Spencer's failure to diagnose a gangrenous gall bladder in a patient who presented to the emergency room.

Sreshta, Dominic G., M.D., Lic. #L0617, Houston TX

On August 21, 2009, the Board and Dr. Sreshta entered into an agreed order requiring that within one year Dr. Sreshta obtain 10 hours in each of continuing medical education in risk management and medical recordkeeping. The action was based on Dr. Sreshta's improperly transferring a 94-year-old patient to a nursing home and inadequately documenting his reasons for doing so and communicating to the patient's family.

Standefer, John, M.D., Lic. #F2038, Dallas TX

On August 21, 2009, the Board and Dr. Standefer entered into a three-year mediated agreed order of public reprimand requiring that Dr. Standefer have a practice monitor; that within one year he obtain 10 hours each of continuing medical education in medical recordkeeping, ethics, and physician-patient communications and, for each year of the order thereafter, 15 hours of ethics; that he comply with Chapter 192 of the board rule on office-based anesthesia; that he monitor his practice's web site annually to assure it doesn't contain false or misleading statements; that he document that he has explained procedures to patients; that he see each patient before surgery and receive written consent; that he indicate which surgeon will perform procedures; and that within 90 days he pay an administrative penalty of \$20,000. The action was based on Dr. Standefer's failure to see patients prior to cosmetic procedures; misleading advertising; failure to meet the standard of care in obtaining informed consent from cosmetic procedure patients; and his purchase and use of unapproved botox.

Thakkar, Harish N., M.D., Lic. #K1096, Houston TX

On June 29, 2009, the Board and Dr. Thakkar entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in the treatment of high-risk patients. The action was based on Dr. Thakkar's failure to order appropriate diagnostic studies, to recognize the gravity of the patient's condition, or to advise emergency room evaluation or hospital admission for a patient with respiratory symptoms who suffered a cardiopulmonary arrest and subsequently died.

Taveau, H. Sprague IV., D.O., Lic. #J0696, Killeen TX

On July 2, 2009, the Board and Dr. Taveau entered into an agreed order requiring that his practice be monitored; that he notify the board within 20 days if he is not seeing patients; that within one year he obtain 10 hours of continuing medical education in endocrinology; and that he pay an administrative penalty of \$1,000 within 60 days. The action was based on his ordering extensive lab tests for a patient without discussing them with her; his pursuing secondary and

tertiary testing before primary tests were done; and his prescribing medications such as thyroid and B12 that were not warranted.

Tomaszek, David E., M.D., Lic. #K9191, Conroe TX

On August 21, 2009, the Board and Dr. Tomaszek entered into an agreed order requiring that within one year Dr. Tomaszek obtain eight hours of continuing medical education in medical recordkeeping and 16 hours in minimally invasive spine surgery; and that within 180 days he pay an administrative penalty of \$2,000. The action was based on Dr. Tomaszek's failure to get an updated MRI and failure to document why he did not think it was necessary to get an updated MRI for a patient on whom he performed a cervical discectomy.

Williams, Embry W. III, M.D., Lic. #F4689, Richardson TX

On August 21, 2009, the Board and Dr. Williams entered into an agreed order requiring that he have an independent psychiatric evaluation and that he pay an administrative penalty of \$500 within 90 days. The action was based on Dr. Williams' failure to respond to calls and pages from nursing and hospital staff when his patients needed his attention. In two instances, other physicians were required to deliver his patients' babies.

Williams, Lucia, M.D., Lic. #G9013, Jacksonville TX

On August 21, 2009, the Board and Dr. Williams entered into a mediated agreed order requiring that within one year Dr. Williams obtain 16 hours of continuing medical education in operative laparoscopic surgery and that she pay an administrative penalty of \$5,000 within 90 days. The action was based on Dr. Williams' failure to meet the standard of care in the management of a surgical patient.

Wills, Matthew J., M.D., Lic. #K8576, Topeka KS

On August 21, 2009, the Board and Dr. Wills entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in medical errors. The action was based on Dr. Wills' performing four wrong-site surgeries between 1999 and 2006.

Wilson, Hugh H. Jr., M.D., Lic. #D6212, Lubbock TX

On August 21, 2009, the Board and Dr. Wilson entered into an agreed order of public reprimand requiring that Dr. Wilson have a practice monitor for one year; that within one year he take and pass the Special Purpose Examination (SPEX); that within one year he obtain 20 hours of continuing medical education in the following areas: five hours in medical recordkeeping, five hours in risk management, five hours in general prescribing practices, and five hours in the diagnosis and evaluation of kidney diseases; and that within 90 days he pay an administrative penalty of \$1,000. The action was based on Dr. Wilson's failure to recognize acute renal failure and refer a patient to a nephrologist or admit the patient to the intensive care unit.

Winton, Kenneth R., D.O., Lic. #H0955, Kermit TX

On August 21, 2009, the Board and Dr. Winton entered into an agreed order requiring that for three years he have a practice monitor; that within one year he obtain 10 hours of continuing medical education in medical recordkeeping and 10 hours in emergency room medicine; and that within 60 days he pay an administrative penalty of \$500. The action was based on Dr. Winton's failure to do adequate ER workups prior to discharging five patients; failure to correct a billing discrepancy for one patient; and failure to update his TMB physician profile.

Yueh, Hwai C., M.D., Lic. #J8175, Bedford TX

On August 21, 2009, the Board and Dr. Yueh entered into an agreed order requiring that within one year Dr. Yueh obtain 10 hours of continuing medical education in management of internal medicine emergencies and the course entitled "Annual High Risk Emergency Medicine" offered by the Center for Emergency Medicine Education. The action was based on Dr. Yueh's failure

consult an emergency room patient's primary care physician to verify her baseline renal function, and on his discharging the patient although laboratory tests indicated a possible state of infection or stress.

Zegarrundo, Rolando, M.D., Lic. #E8244, Houston TX

On August 21, 2009, the Board and Dr. Zegarrundo entered into an agreed order of public reprimand requiring that within one year Dr. Zegarrundo take and pass the Texas Medical Jurisprudence Examination; that within one year he obtain 10 hours of continuing medical education in ethics; and that within 60 days he pay an administrative penalty of \$5,000. The action was based on Dr. Zegarrundo's failure to properly supervise physician assistants in a weight-loss clinic; his applying incorrect protocols in the treatment of patients in the clinic; and his inadequate documentation of the evaluation, treatment, and follow-up care provided to the patients.

UNPROFESSIONAL CONDUCT VIOLATIONS

Alvear, Joel, M.D., Lic. #L1514, Katy TX

On August 21, 2009, the Board and Dr. Alvear entered into a three-year mediated agreed order requiring that Dr. Alvea have a practice monitor; that within six months he complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and that he complete 50 hours of continuing medical education as follows: 10 hours in pain management for each of the three years of the order, and 10 hours in medical recordkeeping and 10 hour in ethics to be completed by the end of the second year of the order. The action was based on Dr. Alvear's having a sexual relationship with a subordinate in a clinic whom he had also seen as a patient, and on Dr. Alvear's lack of documentation and pain contracts in the treatment of multiple patients.

Bracamontes, Francisco I., M.D., Lic. #J5264, McAllen TX

On August 21, 2009, the Board and Dr. Bracamontes entered into an agreed order requiring that within one year Dr. Bracamontes successfully complete the anger management course at the Anger Management Institute of Texas and that within 90 days he pay an administrative penalty of \$1,000. The action was based on Dr. Bracamontes' yelling and cursing at nurses and ICU staff after an incident in which he was not notified about a patient's deteriorating condition in a timely manner.

Chen, Eugene Y., M.D., Lic. #H4231, Las Vegas NV

On August 21, 2009, the Board and Dr. Chen entered into an agreed order requiring that within one year Dr. Chen obtain eight hours of continuing medical education in CPT coding. The action was based on Dr. Chen being found guilty of violation of the False Claims Act in U.S. District court for double-billing Medicare.

Benson, Royal H. III, M.D., Lic. #H0175, Bryan TX

On August 21, 2009, the Board and Dr. Benson entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in physician-patient relationships and within 180 days he pay an administrative penalty of \$2,500. The action was based on Dr. Benson's verbal communications in a restaurant to a former patient in reaction to a complaint she filed; the comments appeared to be for the purpose of intimidation.

Fenton, Barry, M.D., Lic. #G1005, Dallas TX

On August 21, 2009, the Board and Dr. Fenton entered into an agreed order of public reprimand requiring that within one year he complete the Vanderbilt University Medical Center for

Professional Health's professional boundaries course; that he have a chaperone when treating female patients until he has completed the Vanderbilt course; and that within 180 days pay an administrative penalty of \$5,000. The action was based on Dr. Fenton's having a personal romantic relationship with a psychiatric patient.

Gibson, Donald II, M.D., Lic. #H5209, Houston TX

On August 21, 2009, the Board and Dr. Gibson entered into an agreed order requiring that within one year Dr. Gibson take and pass the Texas Medical Jurisprudence Examination and within 90 days he pay an administrative penalty of \$1,000. The action was based on Dr. Gibson's writing prescriptions for Adderall, a controlled substance, for a family member in the absence of immediate need, without taking a history or physical and without creating or maintaining any medical records

House, Janelle K., D.O., Lic. #K9083, Rockdale TX

On August 21, 2009, the Board and Dr. House entered into an agreed order requiring that within one year she obtain 15 hours of continuing medical education, including at least 12 hours in prescribing for pain and three hours of ethics. The action was based on Dr. House's failure to recognize drug-seeking behavior in a patient.

Rappe, Brian D., D.O., Lic. #J4981, Carlsbad TX

On August 21, 2009, the Board and Dr. Rappe entered into a five-year agreed order of public reprimand, suspending his license, staying the suspension and placing him on probation for five years under the following terms and conditions: within 90 days he undergo an independent psychiatric exam; within one year he take and pass the Texas Medical Jurisprudence Examination; that he have a practice monitor; and that he not treat or prescribe to members of his family. The action was based on Dr. Rappe's failure to properly notify patients of closing his practice; failure to undergo a psychiatric evaluation requested by the board, and failure to appear at hearings requested by the board.

Scaff, Bruce E., M.D., Lic. #G0065, Athens TX

On August 21, 2009, the Board and Dr. Scaff entered into an agreed order requiring that within 60 days he pay an administrative penalty of \$500. The action was based on Dr. Scaff's striking his hand on a toddler's forehead when the child was flailing during an exam. The patient was not harmed.

Shah, Zille H., M.D., Lic. #BP10022448, Irving TX

On August 21, 2009, the Board and Dr. Shah entered into an agreed order requiring that within 90 days Dr. Shah pay an administrative penalty of \$3,000. The action was based on Dr. Shah's working as medical director for a company that provided a variety of medical services, which was beyond the scope of her physician-in-training permit.

Warren, Kelly J., M.D., Lic. #K8565, Dallas TX

On August 21, 2009, the Board and Dr. Warren entered into an agreed order requiring Dr. Warren to pay an administrative penalty of \$8,000 within 45 days. The action was based on Dr. Warren's failure to respond to a board subpoena for records.

Smith, Barlow, M.D., Lic. #F9026, Marble Falls TX

On June 29, 2009, the Board and Dr. Smith entered into an agreed order of public reprimand requiring that, within one year, he 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 that he pay an administrative penalty of \$3,000 within 180 days. The action was based on Dr. Smith's repeated sexual contact

with a psychiatric patient who had a history of being sexually abused, and on his telling his fiancée, who called the patient and insulted her.

NONTHERAPEUTIC PRESCRIBING VIOLATIONS

Avila, Fernando T., M.D., Lic. #G2899, San Antonio TX

On August 21, 2009, the Board and Dr. Avila entered into an agreed order requiring that within two years he obtain 20 hours of continuing medical education in pain management and that within one year Dr. Avila 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. Avila's nontherapeutic prescribing of pain medications and other drugs to two patients and his failure to properly document his prescribing.

Burgin, William W. Jr., M.D., Lic. #E1998, Corpus Christi TX

On August 21, 2009, the Board and Dr. Burgin entered into an agreed order requiring that within one year he obtain 20 hours of continuing medical education in the following areas: 10 hours in medical recordkeeping; five hours in physician/patient relationships; and five hours in risk management; and that within 60 days he pay an administrative penalty of \$2,000. The action was based on Dr. Burgin's inappropriate prescribing practices with patients with whom he had personal relationships.

Burleson, James D., M.D., Lic. #H1932, Gatesville TX

On August 21, 2009, the Board and Dr. Burleson entered into a five-year agreed order of public reprimand requiring that he limit his practice to a group or institutional setting; that he eliminate Schedule II and III drugs from his DEA and DPS controlled substance registrations; that he have a practice monitor for the term of the order; that within one year he take and pass the Special Purpose Examination (SPEX) and the Texas Medical Jurisprudence Examination; and for each of the five years he obtain 10 hours of continuing medical education in pain management and 10 hours in medical recordkeeping. The action was based on Dr. Burleson's prescribing high doses of narcotics to 17 patients without adequate documentation; prescribing high doses of methadone in violation of FDA restrictions; and other documentation and prescribing issues for multiple patients.

Harris, Sabrina D., M.D., Lic. #J2057, San Antonio TX

On August 21, 2009, the Board and Dr. Harris entered into an agreed order requiring that within one year she take and pass the Texas Medical Jurisprudence Examination; that within one year she obtain 10 hours of continuing medical education in risk management, five hours of CME in physician-patient relationships, and five hours of CME in ethics. The action was based on nontherapeutically prescribing to patients of a weight-loss clinic and failing to respond to initial board subpoenas and requests for documents.

Lugo-Miro, Victor I., M.D., Lic. #H6890, Kingwood TX

On August 21, 2009, the Board and Dr. Lugo-Miro entered into an agreed order requiring that within one year he obtain 30 hours of continuing medical education, including 10 hours in medical recordkeeping and 20 hours in chronic pain and pain management. The action was based on Dr. Lugo-Miro's failure to properly evaluate, diagnose, and treat a patient for a chronic pain condition.

Polasek, Jerry W., M.D., Lic. #M5885, Houston TX

On August 21, 2009, the Board and Dr. Polasek entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in risk management and 10

hours in endocrinology. The action was based on Dr. Polasek's prescribing potentially dangerous medications to five weight-loss patients.

Roy, Lisa Marie, M.D., Lic. #M0892, San Angelo TX

On August 21, 2009, the Board and Dr. Roy entered into an agreed order requiring that within one year Dr. Roy take and pass the Texas Medical Jurisprudence Examination and that within one year she obtain 10 hours of continuing medical education in medical recordkeeping and 10 hours of CME in common psychiatric conditions. The action was based on Dr. Roy's failure to properly treat, prescribe to, and document her treatment and prescribing to a patient who was also a friend.

Simmons, Donald R., M.D., Lic. #L2010, Linden TX

On August 21, 2009, the Board and Dr. Simmons entered into an agreed order requiring that he have a practice monitor for two years; that within one year he obtain 10 hours of continuing medical education in medical recordkeeping and 15 hours in prescribing for and treating chronic pain. The action was based on Dr. Simmons' prescribing methadone, baclofen, Klonopin and other medications to a patient who previously had been hospitalized for overdoses.

Soumahoro, Zainab H., M.D., Lic. #M2231, Humble TX

On August 21, 2009, the Board and Dr. Soumahoro entered into an agreed order requiring that within one year Dr. Soumahoro take and pass the Texas Medical Jurisprudence Examination and within one year she obtain five hours of continuing medical education in ethics. The action was based on her prescribing nontherapeutically to four patients in a weight-loss clinic.

Ybarra, Benjamin, D.O., Lic. #K3883, Mansfield TX

On August 21, 2009, the Board and Dr. Ybarra entered into an agreed order of public reprimand requiring that within 180 days Dr. Ybarra pay an administrative penalty of \$5,000. The action was based on Dr. Ybarra's prescribing multiple opioids to a family member without performing necessary physical examinations, documenting a medical history or maintaining contemporaneous medical records.

INADEQUATE MEDICAL RECORDS

Bertino, Michael, M.D., Lic. #D4928, San Antonio TX

On August 21, 2009, the Board and Dr. Bertino entered into a two-year mediated agreed order requiring that Dr. Bertino have a practice monitor and that within six months he obtain 10 hours of continuing medical education in medical recordkeeping. The action was based on Dr. Bertino's failure to adequately document an appropriate indication for sinus surgery before performing invasive procedures on multiple pediatric patients, and his records did not adequately document the patients' medical histories or whether an appropriate trial of maximal medical therapy, evaluation or antibiotic therapy was first conducted to resolve the patients' symptoms before proceeding to surgery.

Fontanier, Charles E., D.O., Lic. #F3960, Houston TX

On August 21, 2009, the Board and Dr. Fontanier entered into an agreed order requiring that within one year Dr. Fontanier obtain 10 hours of continuing medical education in medical recordkeeping and that within 180 days he submit a plan indicating how he intends to improve coordination of care methods, including methods of external and internal communication, including how he will communicate his assessments, treatment plans, and concerns with his colleagues who are also involved in the care of his patients. The action was based on Dr. Fontanier's medical records that failed to provide a clear and coherent overview of the care

provided to a patient from multiple providers and that failed to clearly indicate whether medications were filled or changed by Dr. Fontanier or other providers.

Khan, Zohra R., M.D., Lic. #H0074, Euless TX

On August 21, 2009, the Board and Dr. Khan entered into an agreed order requiring that within one year she obtain eight hours of continuing medical education in medical recordkeeping. The action was based on Dr. Khan's failure to properly document care and treatment of nine psychiatric patients.

Phipps, Wendy D., M.D., Lic. #L4648, El Paso TX

On August 21, 2009, the Board and Dr. Phipps entered into an agreed order requiring that within one year she obtain five hours of continuing medical education in medical recordkeeping. The action was based on Dr. Phipps' failure to properly document and communicate lab results to a patient.

Schmidt, Rebecca S., M.D., Lic. #K2118

On August 21, 2009, the Board and Dr. Schmidt entered into an agreed order requiring that within 90 days Dr. Schmidt pay an administrative penalty of \$500. The action was based on Dr. Schmidt's failure to properly document the treatment of a patient receiving Mesotherapy, a fat reduction technique.

Serna, Samuel, M.D., Lic. #M0562, Edinburg TX

On August 21, 2009, the Board and Dr. Serna entered into an agreed order requiring that within one year Dr. Serna obtain eight hours of continuing medical education in medical recordkeeping. The action was based on Dr. Serna's prescribing thyroid medication to a colleague without keeping any prescription or any other medical records.

Shah, Pankaj K., M.D., Lic. #H9712, Houston TX

On August 21, 2009, the Board and Dr. Shah entered into an agreed order requiring that Dr. Shah obtain 30 hours of continuing medical education in each of the following areas: 10 hours in medical recordkeeping; 10 hours of ethics; and 10 hours of physician-patient communication. The action was based on Dr. Shah's poor records and poor communications relating to scheduling pre-operative tests for a patient on whom elective surgery was performed prior to some of the tests and without Dr. Shah's clearance for the surgery.

Sirinek, Kenneth R., M.D., Lic. #F5377, San Antonio TX

On August 21, 2009, the Board and Dr. Sirinek entered into an agreed order requiring that within 90 days Dr. Sirinek pay an administrative penalty of \$1,000. The action was based on Dr. Sirinek's writing prescriptions for Vicodin and Darvocet for a family member who suffered from migraine headaches without maintaining any documentation.

Tano, Benoit D., M.D., Lic. #M4963, Tyler TX

On August 21, 2009, the Board and Dr. Tano entered into an agreed order requiring that within one year Dr. Tano obtain 10 hours of continuing medical education in treatment of thyroid diseases and 10 hours of CME in risk management. The action was based on Dr. Tano's use of standard records for thyroid workups that were inadequate.

Webster, A. Ross, M.D., Lic. #F1301, Houston TX

On August 21, 2009, the Board and Dr. Webster entered into an agreed order requiring that within one year Dr. Webster obtain 10 hours of continuing medical education in medical recordkeeping and within 90 days pay an administrative penalty of \$1,000. The action was based on Dr. Webster's illegible medical records for a patient who had undergone a hemorrhoidectomy and his inadequate documentation regarding effective communication with the patient.

Wong, Ronald E., M.D., Lic. #J5950, San Antonio TX

On August 21, 2009, the Board and Dr. Wong entered into an agreed order requiring that within one year he complete 10 hours of continuing medical education in medical recordkeeping. The action was based on medical record documentation that was illegible and incomplete for a patient he treated in the emergency room.

Yudovich, Martin, M.D., Lic. #E3806, Houston TX

On August 21, 2009, the Board and Dr. Yudovich entered into a two-year agreed order of public reprimand requiring that Dr. Yudovich's practice be monitored; that within one year he take the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and that for each year of the order he obtain five hours of continuing medical education in medical billing. The action was based on Dr. Yudovich's failure to adequately and fully document his treatment, examinations and rationale for diagnoses for multiple pediatric patients and on his failure to meet the minimum requirements set by a state program for adequate records to support the charges for medical services billed to the state program.

Weeks, David, M.D., Lic. #L4165, Austin TX

On August 21, 2009, the Board and Dr. Weeks 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. The action was based on Dr. Weeks' failure to document justifications for tests he provided.

IMPAIRMENT DUE TO ALCOHOL OR DRUGS

Mullen, John B., M.D., Lic. #G1123, Mount Pleasant TX

On August 21, 2009, the Board and Dr. Mullen entered into a five-year agreed order requiring that he abstain from prohibited substances; that he establish a physician-patient relationship and undergo a complete examination by both a board-certified internal medicine physician and board-certified cardiologist approved by the Executive Director, and if continuing care is recommended Dr. Mullen shall undergo continuing care and treatment by either or both of the physicians for the treatment of any condition that, without adequate treatment, could adversely affect his ability to safely practice medicine; that he obtain an independent medical evaluation from an evaluating psychiatrist; that he continue seeing his counselor; and that he participate in AA at least six times a month. The action was based on Dr. Mullen's treatment of an emergency room patient while he was intoxicated, resulting in his inability to intubate a patient in respiratory distress. After three unsuccessful attempts the patient died. In addition, Dr. Mullen has serious cardiac issues he has been treating himself.

Turner, Richard T., M.D., Lic. #G9237, Valley Mills TX

On August 21, 2009, the Board and Dr. Turner entered into an agreed order of restriction by which Dr. Turner agrees not to resume the practice of medicine until he appears before the board and presents evidence that he is competent to practice medicine. The action was based on his inability to practice because of a physical condition and his abuse of alcohol.

PEER REVIEW ACTIONS

Lauer, Scott D., D.O., Lic. #K9102, Grapevine TX

On August 21, 2009, the Board and Dr. Lauer entered into an agreed order requiring that within one year he obtain 15 hours of continuing medical education in medical recordkeeping. The

action was based on Dr. Lauer's being subject to peer action at North Hills Hospital for issues regarding inadequate/poor communication and delinquent prenatal records.

Ross, H. Dudley, M.D., Lic. #F7120, Houston TX

On August 21, 2009, the Board and Dr. Ross entered into an agreed order of public reprimand requiring that within one year he take and pass the Texas Medical Jurisprudence Examination and that within 180 days he pay an administrative penalty of \$5,000. The action was based on the suspension of Dr. Ross' privileges at Mesquite Community Hospital for submitting a falsified medical malpractice insurance certificate.

Sadana Amit, M.D., Lic. #L9880, Portland OR

On August 21, 2009, the Board and Dr. Sadana entered into an agreed order requiring that he pay an administrative penalty of \$2,000 within 90 days. The action was based on the suspension of Dr. Sadana's privileges until he completed all delinquent medical records at Trinity Clinic in Tyler, and his failure to notify the board of his address change when he moved to Oregon.

Wade, Andrew L., M.D., Lic. #H8962, Sherman TX

On August 21, 2009, the Board and Dr. Wade entered into an agreed order requiring that within one year he obtain 10 hours of continuing medical education in medical recordkeeping and within 180 days he pay an administrative penalty of \$500. The action was based on Dr. Wade's being the subject of peer review action by Wilson N. Jones Medical Center in Sherman because of problems with his documentation of patient care.

SUPERVISION OR DELEGATION VIOLATIONS

Gressler, Volker, M.D., Lic. #J5775, Richardsn TX

On August 21, 2009, the Board and Dr. Gressler entered into a three-year agreed order requiring that he employ a registered nurse or midlevel practitioner certified in chemotherapy administration; that all chemotherapy patients in his office be seen by a physician, nurse or midlevel practitioner certified in chemotherapy administration; that his practice be monitored; and that within one year he obtain 10 hours of continuing medical education in prevention of medication errors. The action was based on the administration of an overdose of Taxol to a prostate cancer patient that contributed to the patient's death.

To, Brandon Nghia, M.D., Lic. #L5929, Katy TX

On August 21, 2009, the Board and Dr. To entered into an agreed order requiring him to pay an administrative penalty of \$1,000 within 90 days. The action was based on Dr. To's failure to be present at an alternate practice site at least 20 per cent of the time and his failure to adequately supervise providers practicing under his supervision.

ADVERTISING VIOLATION

Manrique de Lara, Carlos, M.D., Lic. #K3794, Edinburg TX

On August 21, 2009, the Board and Dr. Manrique de Lara entered into a one-year agreed order under which his advertisements will be monitored by the board's compliance division; requiring that within one year Dr. Manrique de Lara obtain eight hours of continuing medical education in ethics; and that within 60 days he pay an administrative penalty of \$5,000. The action was based on Dr. Manrique de Lara's false, misleading or deceptive advertising of his LASIK surgery procedures.

CRIMINAL CONVICTIONS

Berry, Jennifer Y., M.D., Lic. #L3920, Bay City TX

On August 21, 2009, the Board and Dr. Berry entered into an agreed order of public reprimand revoking Dr. Berry's license, staying the revocation and placing her on probation for 10 years; requiring that within one year she obtain 20 hours of continuing medical education in ethics or risk management; that she comply with all terms and conditions of her federal probation; that within two years she take and pass the Texas Medical Jurisprudence Examination; and that within 30 days she retain the services of a professional billing/auditing services and follow its recommendations. The action was based on Dr. Berry's conviction on one count of Medicare fraud in Mississippi.

Gunn, John Christian, M.D., Lic. #L9039, San Antonio TX

On July 7, 2009, the Board entered an Order of Suspension of Dr. Gunn's Texas medical license. The action was based on Dr. Gunn's incarceration in a federal correctional institution.

Hoang, Thu Anh, M.D., Lic. #K2925, Houston TX

On August 21, 2009, the Board and Dr. Hoang entered into an agreed order requiring that within one year Dr. Hoang take and pass the Texas Medical Jurisprudence Examination and that within one year she obtain 22 hours of continuing medical education, including 10 hours each in risk management and medical recordkeeping and two hours in ethics. The action was based on Dr. Hoang's pleading guilty to a federal class A misdemeanor for one count of misbranding drugs while working for a company that distributed controlled substances via the Internet.

Klem, Jeffrey, M.D., Lic. #L2379, Beaumont TX

On August 21, 2009, the Board and Dr. Klem entered a 15-year agreed order of public reprimand in which Dr. Klem's license was suspended, the suspension was stayed and Dr. Klem was placed under the following conditions: Dr. Klem may not have direct or indirect contact with patients under the age of 21; when treating patients 21 and older, Dr. Klem must have a chaperone present; he must practice in a group or institutional setting; within 30 days he must submit names of treating psychiatrists to be approved for care and treatment, and within 30 days of approval must begin care and treatment with a psychiatrist and follow the psychiatrist's recommendations; 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 Vanderbilt Medical Center for Professional Health or the similar course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE); he must present copies of the order to his probation officers in Harris and Jefferson Counties and present his probation orders to his TMB compliance officer; and within 90 days he must pay an administrative penalty of \$5,000. The action was based on Dr. Klem's guilty plea in Beaumont to injury to a child based on three allegations of unwanted sexual contact with a minor child, for which he served six months in Jefferson County Jail, and his guilty plea of injury to a child, a third-degree felony, in 176th District Court in Harris County.

Olmsted, William R., M.D., Lic. #J1550, Georgetown TX

On August 21, 2009, the Board and Dr. Olmsted entered into an agreed order of public reprimand revoking his license, staying the revocation and placing him on probation for 10 years under the following terms and conditions: that he have an independent psychiatric evaluation; that he limit his practice to a group or institutional setting; that within one year he complete the professional boundaries courses offered by Vanderbilt University Medical Center for Professional Health or the University of California San Diego Physician Assessment and Clinical

Education (PACE) program; that within 180 days he pay an administrative penalty of \$5,000; and that he comply with the terms of his plea agreement in Criminal District Court in Dallas County, including paying a fine, registering as a sex offender, obtaining counseling, performing community service and ceasing contact with children except his own. The action was based on Dr. Olmsted's *nolo contendere* plea of indecency with a child by contact, a second degree felony.

VIOLATION OF PROBATION OR PRIOR ORDER

Cantu, Phillip M., M.D., Lic. #K2865, Orange TX

On August 21, 2009, the Board and Dr. Cantu entered into an agreed order of public reprimand extending his 2006 agreed order by three years and requiring that within 180 days he pay an administrative penalty of \$3,000. The action was based on Dr. Cantu's failure to comply with provisions of the 2006 agreed order.

Green, Demetris, M.D., Lic. #J4168, Houston TX

On August 21, 2009, the Board and Dr. Green entered into an agreed order modifying his required payments to a drug testing company. The action was based on his lack of progress in paying down his debt to the drug testing company.

ORDERS MODIFYING PRIOR ORDERS

Lorentz, Rick G., M.D., Lic. #J2169, Spring TX

On August 21, 2009, the Board and Dr. Lorentz entered into an agreed order modifying a prior order by extending Dr. Lorentz's February 8, 2006, order by six months; requiring that his choice of treating psychiatrists be limited to the Harris County area; and requiring that he begin treatment within 30 days of approval of a treating psychiatrist and follow the psychiatrist's recommendations. The action was based on Dr. Lorentz's noncompliance with provisions of his 2006 order and his difficulty in finding a treating psychiatrist.

Sarkar, Ankur, M.D., Lic. #K3450, Houston TX

On August 21, 2009, the Board and Dr. Sarkar entered into an agreed order modifying his April 11, 2008, order to state that if he receives two consecutive favorable chart monitor reports that do not include findings that Respondent has failed to follow the recommendations of the chart monitor, he may submit a request to terminate the order. The action was based on Dr. Sarkar's inability to comply with previous requirements because of loss of employment and patients.

VOLUNTARY SURRENDERS/SUSPENSIONS

Anderson, Robert Michael, M.D., Lic. #K6799, Lake Charles LA

On August 21, 2009, the Board and Dr. Anderson entered into an agreed order of voluntary surrender of his license in lieu of further disciplinary proceedings.

Garza, Raul, M.D., Lic. #F3134, San Benito TX

On August 21, 2009, the Board and Dr. Garza entered into an agreed order of voluntary surrender of his license in lieu of further disciplinary proceedings within 90 days, during which time he may not prescribe any Schedule II, III or IV controlled substances. Dr. Garza has decided to retire and asserts that he committed no violation of the Medical Practice Act.

Glinkowski, Tadeusz, M.D., Lic. #E5090, Houston TX

On August 21, 2009, the Board and Dr. Glinkowski entered into an agreed order of voluntary

surrender of his license in lieu of further disciplinary proceedings.

Taylor, Judy G., M.D., Lic. #G5680, Irving TX

On August 21, 2009, the Board and Dr. Taylor entered into an agreed order of voluntary surrender of her Texas medical license. The action was based on Dr. Taylor's inability to practice medicine due to a physical condition.

Wesson, Mae E., M.D., Lic. #F2103, Beaumont TX

On August 21, 2009, the Board and Dr. Wesson entered into an agreed order by which her license is suspended. The action was based on Dr. Wesson's desire to suspend her practice of medicine until she is both mentally and physically able to practice in a manner consistent with public health and safety.

REVOCATIONS

Daniel A. Crain, D.O., Lic. #J4063, Bridge City TX

On August 21, 2009, the Board entered a Default Order against Daniel A. Crain, D.O, revoking his Texas medical license. On March 17, 2009, the Board filed a Complaint with the State Office of Administrative Hearings (SOAH) in case no. 503-09-3212 which alleging Dr. Crain closed his practice in December 2007 without advising his patients he was terminating their care; failed to follow-up with numerous patient requests for medical records; failed to notify the Board of an address change; and abandoned hazardous waste at his former practice site. After responding to an initial contact by the Board, Dr. Crain subsequently failed to reply to any contact by the Board; failed to supply necessary information and records to the Board; and failed to respond to Board subpoenas. After filing of the SOAH Complaint, all notices were perfected and the Board issued a Determination of Default, and all other required deadlines passed without any response from Dr. Crain. As a result, all facts alleged in the Complaint were therefore deemed admitted, and Dr. Crain's Texas medical license was revoked by Default Order.

William Donald Littlejohn, M.D., Lic. #D4203, Fort Worth TX

On August 21, 2009, the Board entered a Default Order against William Donald Littlejohn, M.D., revoking his Texas medical license. On February 24, 2009, the Board filed a Complaint with the State Office of Administrative Hearings (SOAH) in case no. 503-09-2794 which alleged that Dr. Littlejohn is unable to practice safely due to a mental or physical condition; that he became personally or financially involved with a patient in an inappropriate manner; that he failed to maintain adequate medical records; and that failed to treat a patient according to the recognized standard of care. After filing of the SOAH Complaint, all notices were perfected and the Board issued a Determination of Default, and all other required deadlines passed without any response from Dr. Littlejohn. As a result, all facts alleged in the Complaint were therefore deemed admitted, and Dr. Littlejohn's Texas medical license was revoked by Default Order.

MINOR STATUTORY VIOLATIONS

The board took actions against 31 physicians for minor statutory violations ("fast-track orders").

PHYSICIAN ASSISTANTS

Fields, John P., Lic. # PA03606, San Antonio TX

On July 17, 2009, the Board and Mr. Fields entered into an Agreed Voluntary Surrender order.

The action was based on claims that Mr. Fields issued false or fictitious prescriptions for a schedule IV drug for his personal use using his supervising physician's prescriptive privileges and DEA number. Mr. Fields neither admits nor denies the allegations.

Shrout, Anita Dawn, Lic. # PA03854, Houston TX

On July 17, 2009, the Board and Ms. Shrout entered into an Agreed Order requiring that she have on-site physician supervision; that within one year she complete the Professional/Problem Based Ethics (PROBE) course offered by the Center for Personalized Education for Physicians; that she take and pass the Texas Physician Assistant Jurisprudence Examination; and that she pay an administrative penalty of \$5,000. The action was based on Ms. Shrout's prescribing scheduled drugs after her DEA license had lapsed; using the DEA number of a physician who was not listed on her profile or on the physician's profile as her supervising physician; and nontherapeutic prescribing of Lortab and Xanax.

Polasek, Adriana, Lic. #PA04738, Sugar Land TX

On July 17, 2009, the Board and Ms. Polasek entered into an Agreed Order requiring that within one year she obtain 10 hours each of continuing medical education in medical recordkeeping and endocrinology; and that within one year she take and pass the Texas Physician Assistant Jurisprudence Examination. The action was based on Dr. Polasek's prescribing potentially dangerous medications without adequate justification to five weight-loss patients.

Kolman, Arnold Drew, Lic. #PA001185, Houston TX

On July 17, 2009, the Board and Mr. Kolman entered into an Agreed Order requiring that within 90 days he pay an administrative penalty of \$2,000 and that within one year he take and pass the Texas Physician Assistant Jurisprudence Examination. The action was based on Mr. Kolman's failure to meet the standard of care in prescribing medication to weight-loss patients and for inadequate medical records in the treatment of weight-loss patients.

Hopson, Lewis Bernard, Lic. #PA00835, Houston TX

On July 17, 2009, the Board and Mr. Hopson entered into an Agreed Order of public reprimand requiring that within one year he take and pass the Texas Physician Assistant Jurisprudence Examination; that within one year he obtain at least 10 hours each of continuing medical education in medical recordkeeping, endocrinology and ethics; and that within 180 days he pay an administrative penalty of \$5,000. The action was based on Mr. Hopson's failure to meet the standard of care in treating multiple patients, including inadequate examinations, diagnostic imaging and lab tests, and prescribing thyroid medication for patients who did not have hypothyroidism.

Custodio, Israel David, Lic. #PA01549, San Antonio TX

On July 17, 2009, the Board and Mr. Custodio entered into an Agreed Order of public reprimand requiring that within one year he take and pass the Texas Physician Assistant Jurisprudence Examination; that within one year he obtain at least 10 hours of continuing medical education in ethics; and that within 180 days he pay an administrative penalty of \$5,000. The action was based on Mr. Custodio's failure to meet the standard of care in treating and prescribing medications to weight-loss patients, including failure to order appropriate lab tests, and prescribing thyroid medication for patients who did not have hypothyroidism.

In addition, the Texas Physician Assistant Board took one action based on a minimal statutory violation.

Document updated 9-9-09 to correct the placement of Dr. Michael Bertino's summary; 9-17-09 to add "public reprimand" to Dr. Phillip Cantu's summary; and 10-12-09 to change Dr. Debbie Crawford's listing from Unprofessional Conduct to Quality of Care.