### Texas Medical Board

**News Release** 

### FOR IMMEDIATE RELEASE

Wednesday, December 13, 2006

Media contact: Public Information Officer Jill Wiggins at jill.wiggins@tmb.state.tx.us or (512) 305-7018.

Non-media contact: (512) 305-7030 or (800) 248-4062.

# Medical Board Disciplines 39 Doctors

At its December 7-8 meeting, the Texas Medical Board took disciplinary action against 38 licensed physicians.

Actions included 13 violations based on quality of care; four actions based on unprofessional conduct; one action based on inappropriate conduct involving physician-patient relationships; four actions based on inadequate medical records; two actions based on impairment due to alcohol or drugs; one action based on nontherapeutic prescribing; two actions based on other states' actions; three actions based on inadequate supervision; three voluntary surrenders; and six minimal statutory violations. Administrative penalties totaling \$48,750 were assessed.

### **New Licenses Issued**

The board issued 628 licenses at the December 7-8 meeting. This was the largest number of licenses ever approved at a single board meeting. TMB is endeavoring to reduce the backlog of pending physician licensure applications. The board has approved rule changes to formalize these efforts (see below), simplifying and streamlining the process for uncomplicated applications.

### **Rule Changes**

The Board adopted the following proposed rule changes that were published in the Texas Register:

Chapter 163, **Licensure**, to amend §163.2, <u>Definitions</u>, to correct a reference; §163.5, <u>Licensure</u> <u>Documentation</u> to eliminate the requirement for all applicants to present certain documents to the Board, and §163.6, <u>Examinations Accepted to Licensure</u> regarding the Jurisprudence Examinations.

Repeal of Chapter 170, Authority of Physician to Prescribe for the Treatment of Pain.

New Chapter 170, **Pain Management**, to substantially rewrite the current rule. The revised rule sets forth appropriate standards for good medical practice in the treatment of pain.

Chapter 183, **Acupuncture**, to amend §183.2 <u>Definitions</u>, to allow licensing of an applicant who graduated from an acupuncture school that was in candidacy status at the time of graduation; §183.4 <u>Licensure</u>, to allow a showing of English proficiency by attending an acceptable approved school of acupuncture in the United State or Canada; §183.5 <u>Annual Renewal of License</u>, to provide for the automatic cancellation of a license that has been expired for more than one year; §183.15, <u>Use of Professional Titles</u>, to delete the requirement to include "Texas" in the title; and §183.20, <u>Continuing Acupuncture Education</u>, to delete references to "informal" CAE.

Chapter 187, **Procedural Rules**, to amend §187.28, <u>Discovery</u>, to set forth a procedure for the identification of expert witnesses who may testify in cases before the State Office of Administrative Hearings.

#### Withdrawn

**Proposed amendments to** Chapter 172, **Temporary and Limited Licenses**, to add a new § 172.14, <u>Limited License for the Practice of Administrative Medicine</u>, to provide a new, limited license for the practice of administrative medicine, as required by the Legislature in SB 419 and Chapter 190, **Disciplinary Guidelines**, to amend § 190.8, <u>Violation Guidelines</u>, regarding standard procedures necessary to make a reasoned decision in the assessment and/or determination of the medical necessity of treatment, were withdrawn and sent back to board staff for additional information.

### **Proposed Rule Changes**

The following rule changes will be published in the *Texas Register* for comment:

Proposed amendments to Chapter 172.15, Licensure, regarding a limited Public Health License.

#### **Disciplinary Actions**

The following are summaries of the Board actions and were taken based on the types of violations listed. The full text of the Board orders will be available on the Board's web site at <a href="www.tmb.state.tx.us">www.tmb.state.tx.us</a> about 10 days after the Board meeting. The orders provide all information that is public regarding the facts of the case and violations of the law.

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

# **QUALITY OF CARE VIOLATIONS**

- ANDELMAN, ROBERT PAUL, M.D., PORTLAND, TX, Lic. #K3669
  - On December 8, 2006, the Board and Dr. Andelman entered into an Agreed Order requiring that he complete additional continuing medical education in treatment of sepsis, surgical emergencies and radiological studies, and assessing an administrative penalty of \$500. The action was based on allegations that Dr. Andelman failed to meet the standard of care in the treatment of two patients in the emergency room in 1999 and 2003, respectively.
- GIOIA, ANTHONY ERIC, M.D., DALLAS, TX, Lic. #G9102
  On December 8, 2006, the Board and Dr. Gioia entered into an Agreed Order publicly reprimanding Dr. Gioia, requiring that he complete additional continuing medical education in the area of risk management, and assessing an administrative penalty of \$12,500. The action was based on allegations that Dr. Gioia violated the standard of care by performing wrong-site spine surgery on three patients, one in 1999 and two in 2004.
- HELDRIDGE, TOD CHARLES, M.D., BEDFORD, TX, Lic. #G8175
  On December 8, 2006, the Board and Dr. Heldridge entered into an Agreed Order requiring that his practice be monitored by another physician for one year, that he complete additional continuing medical education in the areas of cardiac care or critical care and risk management, and assessing an administrative penalty of \$2,500. The action was based on allegations that in 1999 Dr. Heldridge failed to appropriately diagnose a patient presenting with chest and back pain.
- KOLI, MALATHI VIJAY, M.D., SAN ANTONIO, TX, Lic. #G0624
  On December 8, 2006, the Board and Dr. Koli entered into an Agreed Order requiring that his practice be monitored by another physician for one year and that he complete additional continuing medical education in the areas of psychopharmacology and medical records. The action was based on allegations that Dr. Koli prescribed multiple medications for one patient in a manner that created the possibility for drug interactions or for a delirium and did not appropriately document his reasons for the many medication changes.
- LIAO, DAVID YING-CHIE, D.O., HEATH, TX, Lic. #K4485

  On December 8, 2006, the Board and Dr. Liao entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of medical records and risk management. The action was based on allegations that Dr. Liao operated on the wrong joint of a patient's finger, though both joints of the finger were affected with severe degenerative joint disease and Dr. Liao believed, as a mitigating factor, that he had obtained consent from the patient to operate on that joint.
- LIM, JAIME CHUNG, M.D., WICHITA FALLS, TX, Lic. #G9147
  On December 8, 2006, the Board and Dr. Lim entered into an Agreed Order extending the term of his existing order by one year and prohibiting him from admitting patients to a nursing home. The action was based on allegations that Dr. Lim failed to timely diagnose post-operative problems of one patient and failed to adequately document his care and treatment of three other patients.
- OLIVA, DAMASO ANDRES, M.D., SAN ANTONIO, TX, Lic. #K0968
  On December 8, 2006, the Board and Dr. Oliva entered into an Agreed Order requiring that his practice be monitored by another physician for one year, that he complete additional continuing medical education in the areas of medical records and recognizing and treating drug addiction in the psychiatric patient. The action was based on allegations that Dr. Oliva failed to quickly

recognize drug-seeking behavior in one patient and treat the patient accordingly, and failed to adequately document the treatment provided to the patient.

# • SUNDARESAN, SANJOY, M.D., WICHITA FALLS, TX, LIC. #K1083

On December 8, 2006, the Board and Dr. Sundaresan entered into a three-year Agreed Order requiring that his pain management practice be monitored by another physician, that he complete additional continuing medical education each year in the areas of ethics and medical records and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Sundaresan failed to produce adequate medical records regarding the treatment of his chronic pain patients.

# • TADLOCK, HUGHM., M.D., GEORGETOWN, TX, Lic. #G3835

On December 8, 2006, the Board and Dr. Tadlock entered into an Agreed Order requiring that his practice be monitored by another physician for one year, that he complete additional continuing medical education in the areas of medical records and risk management, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Tadlock failed to meet the standard of care in his evaluation and treatment of one patient's seizure activity and a resulting migraine headache.

### • THEIN, AUNG MYINT, M.D., BIG SPRING, TX, Lic. #K4814

On December 8, 2006, the Board and Dr. Thein entered into an Agreed Order requiring that he complete a course in risk management, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Thien failed to meet the standard of care in that he did not identify a non-depressed fracture of a small area of the skull of a patient and failed to appropriately communicate this finding, when he later discovered it, to the patient's treating physician.

# • THOMPSON, PEYTON LEE, M.D., ROCKDALE, TX, Lic. #D9687

On December 8, 2006, the Board and Dr. Thompson entered into an Agreed Order requiring that he complete additional continuing medical education each year for two years in the areas of acute conditions of the ears, eyes, nose and throat and in medical records. The action was based on allegations that Dr. Thompson failed to meet the standard of care in examining, diagnosing and treating a patient's eye condition.

# • TRAVIS, JO ANN FLATLEY, M.D., DALLAS, TX, Lic. #E7757

On December 8, 2006, the Board and Dr. Travis entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Travis failed to ensure that an anesthetic injection was made into the correct eye.

## • YUSUF, OAISER JAMAL, M.D., BAYTOWN, TX, Lic. #J1818

On December 8, 2006, the Board and Dr. Yusef entered into an Agreed Order requiring that his prescribing authority be modified to eliminate Schedule II drugs; that his practice be monitored by another physician for a period of three years; that he successfully complete the medical record keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, or an approved equivalent program; that he complete a course in pain management; and assessing an administrative penalty of \$5,000. The action was based on allegations that Dr. Yusef prescribed narcotic medications and benzodiazepines without having adequate medical information or previous medical records for patients and that he failed to meet the standard of care due to nontherapeutic prescribing of narcotics and controlled substances for four patients, some of whom demonstrated drug-seeking behavior.

### UNPROFESSIONAL CONDUCT VIOLATIONS

#### • BATTLE, ROBERT McREE, M.D., HOUSTON, TX, Lic. #D2355

On December 8, 2006, the Board and Dr. Battle entered into an Agreed Order assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Battle terminated a physician-patient relationship in an unprofessional manner.

## • BELLOMO, JOSEPH F., M.D., LANCASTER, TX, Lic. #H2987

On December 8, 2006, the Board and Dr. Bellomo entered into an Agreed Order requiring that he obtain an independent forensic evaluation from a Board-appointed psychiatrist and undergo any continuing psychiatric care recommended by the evaluating psychiatrist, that he successfully complete the program for distressed physicians offered by the Vanderbilt Medical Center for Professional Health, or an approved equivalent program, and complete 10 hours of ethics courses or programs. The action was based on allegations that there was an incident at a hospital during which Dr. Bellomo's actions were disruptive to staff and to a patient.

# • CAHAN, NINA GALE, M.D., COPPELL, TX, Lic #G6149

On December 8, 2006, the Board and Dr. Cahan entered into an Agreed Order assessing an administrative penalty of \$1,000 and requiring her to become familiar with Board rules regarding release and transfer of medical records. The action was based on allegations that Dr. Cahan, following the departure of, and a dispute with, another physician employed by her, instructed her staff to tell the departing physician's patients that they did not know her location or telephone number, though this was not true.

### • LAMPLEY, JOSEPH CARVER, D.O., SEMINOLE, TX, Lic. #J9149

On December 8, 2006, the Board and Dr. Lampley entered into an Agreed Order publicly reprimanding Dr. Lampley, requiring that he pass the Medical Jurisprudence examination within one year, and assessing an administrative penalty of \$10,000. The action was based on allegations that Dr. Lampley, during the process of re-credentialing with an insurance company after his membership in the American Board of Family Medicine had lapsed, did not pursue recertification by that board, but did submit to the insurance company an altered, fraudulent certificate purportedly from the American Board of Family Medicine to show he was certified by that board.

#### INAPPROPRIATE CONDUCT INVOLVING PHYSICIAN-PATIENT RELATIONSHIP

• DORMAN, JOHN WESLEY, M.D., AMARILLO, TX, Lic. #D5375

On December 8, 2006, the Board and Dr. Dorman entered into a three-year Mediated Agreed Order requiring that he obtain an independent forensic evaluation from a Board-appointed psychiatrist and undergo any continuing psychiatric care recommended by the evaluating psychiatrist, that any change of his employment that would include the treatment of females must be approved in advance by the executive director of the Board and requiring that he prepare a report regarding what he learned from attending the professional boundaries course at the Vanderbilt Medical Center for Professional Health and how he could apply this training. The action was based on allegations that Dr. Dorman behaved inappropriately during his examination of two female patients.

## INADEQUATE MEDICAL RECORDS VIOLATIONS

### • BALAT, ISAM YUSUOF, M.D., HOUSTON, TX, Lic. #E0795

On December 8, 2006, the Board and Dr. Balat entered into a Negotiated Agreed Order requiring that his practice be monitored by another physician for four quarters, subject to extension if there are continued documentation deficiencies, and that he complete additional continuing medical education in medical records. The action was based on allegations that Dr. Balat failed to maintain adequate medical records from 1997 to 1999.

# • BATES, EVAN SCOTT, M.D., DALLAS, TX, Lic. #J1619

On December 8, 2006, the Board and Dr. Bates entered into a mediated Agreed Order requiring that he complete additional continuing medical education in the area of record keeping/risk management. The action was based on allegations that Dr. Bates failed to adequately document his treatment of one patient.

# • FRANKLIN, RODNEY THOMAS, M.D., LUBBOCK, TX, Lic. #H0991

On December 8, 2006, the Board and Dr. Franklin entered into a Mediated Agreed Order requiring that he maintain adequate medical records on all patient office visits, consultations, surgeries performed, drugs provided and treatment rendered, that he complete additional continuing medical education in the areas of risk management and/or medical records, and assessing an administrative penalty of \$500. The action was based on allegations that Dr. Franklin violated Board Rule 165, which requires the maintenance of complete medical records.

• LEAL, ENRIQUE A. III, M.D., SAN AUGUSTINE, TX, Lic #G8896

On December 8, 2006, the Board and Dr. Leal entered into an Agreed Order requiring that his practice be monitored by another physician for one year, that he maintain adequate medical records on all patient office visits, consultations, surgeries performed, drugs provided and treatment rendered, that he complete additional continuing medical education in medical records, and assessing an administrative penalty of \$500. The action was based on allegations that Dr. Leal failed to maintain adequate medical records for one patient he treated from November of 2004 to September of 2005.

### IMPAIRMENT DUE TO ALCOHOL OR DRUGS

• HALEBIAN, PAUL HRATCH, M.D., DALLAS, TX, Lic. #F4036

On December 8, 2006, the Board and Dr. Halebian entered into an Agreed Order of Suspension suspending his license until such time as he appears before the Board and demonstrates that he is safe and competent to return to the practice of medicine. The action was based on allegations that Dr. Halebian was arrested for possession of marijuana, including four plants growing in his backyard, and concerns that he has been self-medicating and prescribing without a legitimate medical purpose and without adequate record-keeping.

• MAYS, JEFFRY PATRICK, BRADY, TX, Lic. #J7815

On December 8, 2006, the Board and Dr. Mays entered into an Agreed Order suspending his medical license for at least 90 days, placing him on probation for 15 years following his return to practice and requiring the following: that he surrender his Drug Enforcement Administration and Texas Department of Public Safety Controlled Substances Registration Certificates; pass the Medical Jurisprudence examination; abstain from consuming prohibited substances, including alcohol and drugs not prescribed for him; participate in the Board's program for testing for drugs and alcohol; continue to participate in the activities of Alcoholics Anonymous at least three times per week; continue to participate in the activities of a county or state medical society committee on physician health and rehabilitation; receive care from a treating psychiatrist; and requiring that his practice be monitored by another physician for one year after he returns to practice. The action was based on allegations of a history of alcohol and drug abuse.

## NONTHERAPEUTIC PRESCRIBING VIOLATIONS

• RITTENHOUSE, RALPH A., M.D., KINGWOOD, TX, Lic. #E5219

On December 8, 2006, the Board and Dr. Rittenhouse entered into an Agreed Order requiring that his practice be monitored by another physician for one year, that he complete courses in medical records and management of lipid disorders, and assessing an administrative penalty of \$500. The action was based on allegations that Dr. Rittenhouse refilled a patient's Lipitor prescription at the patient's first visit, but did not order adequate laboratory work or maintain adequate records for the patient.

#### OTHER STATES' BOARD ACTIONS

• HEMPHILL, JOHN MICHAEL, M.D., SAVANNAH, GA, Lic. #E2606
On December 8, 2006, the Board and Dr. Hemphill entered into an Agreed Order requiring that he comply with any terms and conditions imposed by the Georgia Composite State Board of

Medical Examiners. The action was based on the 2004 action of the Georgia Board placing Dr. Hemphill on probation for five years under various terms and conditions. The action of the Georgia Board was based on allegations relating to Dr. Hemphill becoming romantically involved with a patient in 1999 and prescribing medications to this patient without documenting the prescriptions or treatment from 1999 to 2001.

## • SAMUEL, DONALD RAY, M.D., JASPER, TX, Lic. #H5964

On December 8, 2006, the Board and Dr. Samuel entered into an Agreed Order with a minimum term of five years, requiring that his practice be monitored by another physician; that he undergo annual evaluations to determine if he is mentally and physically able to practice medicine with reasonable skill and safety; that he arrange for and successfully complete a custom continuing medical education (CME) program in obstetrics and gynecology through the University of California San Diego Physician Assessment and Clinical Education (PACE) program or an equivalent approved program; that he complete each year additional CME in obstetrics and gynecology; that he make detailed written chart notes prior to any non-emergent obstetrics and gynecological surgical procedure or hospital admissions; prohibiting him from supervising physician assistants or advanced nurse practitioners, and assessing an administrative penalty of \$250. The action was based on allegations stemming from the action of the Michigan Board of Medicine suspending Dr. Samuel's license in 2004 based on complaints alleging violations of the standard of care pertaining to a stillborn delivery in January of 1994 and a maternal death in October of 1998. The administrative penalty was based on allegations that Dr. Samuel failed to provide properly requested medical records within 15 business days.

### VIOLATIONS BASED ON FAILURE TO PROPERLY SUPERVISE OR DELEGATE

- COLEMAN, RALPH FRANKLIN, M.D., HOUSTON, TX, Lic. #E6756
  On December 8, 2006, the Board and Dr. Coleman entered into an Agreed Order requiring that he complete additional continuing medical education in the areas of risk management and medical records, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Coleman improperly delegated the taking of an x-ray to an unqualified person.
- GANDHI, BHARAT RANGILDAS, M.D., SUGAR LAND, TX, Lic. #J3477

  On December 8, 2006, the Board and Dr. Gandhi entered into a Mediated Agreed Order requiring that, prior to performing or supervising electromyography studies, he must become certified by the American Board of Electrodiagnostic Medicine or the American Board of Physical Medicine and Rehabilitation or the American Board of Psychiatry and Neurology, requiring that he complete additional continuing medical education (CME) in ethics, prepare a paper describing the benefits of ethics CME to his practice, and assessing an administrative penalty of \$2,500. The action was based on findings that Dr. Ghandi delegated to an electrodiagnostic technologist the performance of electromyography and nerve conduction studies on one of his patients, and on allegations that such delegation was improper because Dr. Ghandi was not qualified to supervise the studies and that, even if Dr. Ghandi had been qualified to perform the studies, the delegation to a non-physician was inherently a deviation from the standard of care.
- VENEGAS, CARLOS, M.D., DALLAS, TX, Lic. #K0566
  On December 8, 2006, the Board and Dr. Venegas entered into an Agreed Order requiring that he take and pass the Medical Jurisprudence examination, and assessing an administrative penalty of \$1,000. The action was based on allegations that Dr. Venegas failed to adequately supervise colonic procedures at the Dallas Colon Care Clinic for which he was medical director and was not present when the procedures were performed.

#### **VOLUNTARY SURRENDERS**

• ELSTON, STEPHEN FREDRICK A., M.D., BORGER, TX, Lic. #G9344
On December 8, 2006, the Board and Dr. Elston entered into an Agreed Order accepting the

voluntary surrender of Dr. Elston's medical license. The action was based on allegations that Dr. Elston pre-signed triplicate prescription forms for Schedule II narcotics and that he pled no contest to three felony counts for signing blank prescription forms for narcotics.

- MAEWAL, HRISHI KESH, M.D., FORT WORTH, TX, Lic. #E7175
  On December 8, 2006, the Board and Dr. Maewal entered into an Agreed Order accepting the voluntary and permanent surrender of Dr. Maewal's medical license. The action was based on a determination by the Board that Dr. Maewal is unable to practice medicine with reasonable skill and safety to patients because of a mental or physical condition.
- NEWMAN, JOSE, M.D., DALLAS, TX, Lic. #D5803
  On December 8, 2006, the Board and Dr. Newman entered into an Agreed Order accepting the voluntary and permanent surrender of Dr. Newman's medical license. The action was based on allegations that Dr. Newman committed boundary violations against two female patients during his examination of them.

#### MINIMAL STATUTORY VIOLATIONS:

The following licensees agreed to enter into orders with the Board for minimal statutory violations:

Afridi, Shah Nawaz, M.D., Victoria, TX, Lic. #K7961

Angel, Robert Tate, M.D., Waco, TX, Lic. #C8881

Garton, Susan Mary, D.O., San Antonio, TX, Lic. #H8061

Lloyd, Scott M., M.D., Tyler, TX, Lic. #H1799

Maggi, Sergio Pasquale, M.D., Austin, TX, Lic. #J2175

Youel, Leisa Sharon, M.D., Longwood, FL, Lic. #G2250

-30-

The Texas Medical Board, the state agency that regulates physicians, physician assistants, surgical assistants and acupuncturists, provides consumer protection through licensure, investigation and disciplinary action. The Board, under President Roberta M. Kalafut, D.O., and Executive Director Donald W. Patrick, M.D., J.D., and mandated by Senate Bill 104 of the 78th Legislature and S.B. 419 of the 79th Legislature, is strengthening and accelerating the disciplinary process for licensees who fail to meet the required standards of professional proficiency and behavior. Information on filing a complaint is on the agency web site at <a href="https://www.tmb.state.tx.us">www.tmb.state.tx.us</a> or by calling (800) 201-9353.