

## **Texas Medical Board Press Release**

**FOR IMMEDIATE RELEASE  
Wednesday, February 17, 2010**

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### **Medical Board Disciplines 70 Doctors and Issues 671 Licenses**

Since its November 5-6 meeting, the Texas Medical Board has taken disciplinary action against 70 licensed physicians.

The actions included one temporary suspension; 21 violations based on quality of care; five actions based on unprofessional conduct; four nontherapeutic prescribing violations; 17 actions based on inadequate medical records violations; one action based on failure to properly supervise or delegate; two actions based on violation of probation or prior order; two revocations and one action for impairment due to alcohol or drugs; one order modifying a prior order; four actions based on actions by another state or entity; seven voluntary surrenders; one action for failure to provide medical records; and three automatic suspension or revocation orders. In addition, the Medical Board issued one cease and desist order and took action against one surgical assistant.

At its February 4-5 meeting, the board issued 671 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:** proposed amendments to §175.5, relating to Payment of Fees or Penalties, regarding fee refunds for applicants who withdraw their applications within 45 days of initial application.

**Chapter 180, Operation of Program:** proposed new amendment §180.4, relating to Operation of Program, which establishes the requirements for eligibility, referrals, drug-testing, and fees for the Physician Health Program.

**Chapter 187, Procedural Rules:** proposed new amendments to §187.14, relating to Informal Resolution of Disciplinary Issues Against a Licensee, which amends the composition and functions of the Quality Assurance Committee that reviews investigated complaints filed with the Board.

### **PROPOSED RULE CHANGES**

The following proposed rule changes will be published in the March 5th *Texas Register*:

**Chapter 183, Acupuncture:** proposed change to §183.4, regarding licensure, increases number of attempts on Acupuncture JP exam upon showing of good cause; §183.9, regarding procedures for probable cause hearings for mental and physical examinations, implementation of Physician Health Program for Impaired Acupuncturists.

**Chapter 187, Procedural Rules:** proposed rule §187.43, Procedures for the Modification/Termination of Agreed and Disciplinary Orders, will prohibit probationers from requesting modification/termination of an order if the probationer is under investigation for alleged noncompliance with the order, and clarifies that modification/termination requests may be made yearly since the effective date of an order; §187.83, Proceedings for Cease and Desist Orders, establishes the procedures for cease and desist orders to be issued by the executive director after the opportunity for participation in an informal settlement conference; §187.84, Violation of Cease and Desist Orders, establishes the penalties for violation of cease and desist orders.

**Subchapter J, Procedures Related to Out of Network Health Benefit Claim Dispute Resolution, new subchapter based on passage of HB226 passed during the 81st Legislative session:** §187.85, Purpose and Construction; §187.86, Scope; §187.87, Definitions; §187.88, Complaint Process and Resolution; §187.89, Notice of Availability of Mandatory Mediation.

**Chapter 189, Compliance Program:** §189.2, Definitions amends the title "chief of compliance" to "compliance manager"; §189.3, Responsibilities of Probationers, sets out the requirements for third party reports submitted to the Board in relation to a probationer's order with the Board; §189.8, Procedures Relating to Non-compliance, amends the title "chief of compliance" to "compliance manager."

**Chapter 190, Disciplinary Guidelines:** §190.14, Disciplinary Sanction Guidelines, provides that if a physician is determined to have negotiated in bad faith in relation to an out-of-network health benefit claim, the licensee may be fined up to \$2,000 by the Board.

**Chapter 192, Office-Based Anesthesia Services and Pain Management Clinics:** proposed rule deletes references to Pain Management Clinics; §192.1, Definitions; §192.2, Provision of Anesthesia Services in Outpatient Settings, require that anesthesia services and equipment provided in an outpatient setting remain available until the patient is discharged; §192.4, Registration, excludes Level I services from registration requirements and deletes languages relating to pain management clinics; §192.5, Inspections; repeal §192.7, Operation of Pain Management Clinics.

**Chapter 195, Pain Management Clinics:** new chapter with language from Chapter 192 moved into this chapter; §195.1, Definitions; §195.2, Certification of Pain Management Clinics; §195.3, Inspections; §195.4, Operation of Pain Management Clinics, adds language about minimum requirements for quality assurance procedures.

**Chapter 198, Unlicensed Practice:** deletes language regarding cease and desist orders which is moved to Chapter 187; repeals §198.3, Investigation of Complaints; repeals §198.4, Cease and Desist Order; repeals §198.5, Contested Cease and Desist Proceeding; repeals §198.6, Violation of Cease and Desist Order.

## **DISCIPLINARY ACTIONS**

**Open records** requests for orders may be made to [openrecords@tmb.state.tx.us](mailto:openrecords@tmb.state.tx.us). **Media** contact Leigh Hopper at (512) 305-7018 or [leigh.hopper@tmb.state.tx.us](mailto:leigh.hopper@tmb.state.tx.us). Orders are posted on the TMB web site at [http://reg.tmb.state.tx.us/OnLineVerif/Phys\\_NoticeVerif.asp](http://reg.tmb.state.tx.us/OnLineVerif/Phys_NoticeVerif.asp) about 10 days after the board meeting.

## **TEMPORARY SUSPENSION**

### **Olmsted, William Robert, M.D., Lic. #J1550, Georgetown TX**

On February 3, 2010, the Board temporarily suspended without notice the license of Dr. Olmsted after determining that Dr. Olmsted's continuation in the practice of medicine presents a continuing threat to the public welfare. The action was based on Dr. Olmsted's failure to comply with a 2009 agreed order entered into with the Board requiring him to submit to an independent psychiatric evaluation by a Board-appointed psychiatrist within 30 days of the appointment of the psychiatrist and to continue with any treatment recommended by the psychiatrist. The Board found evidence that Dr. Olmsted continues to engage in a pattern of disregard for the 2009 agreed order. The 2009 agreed order followed Dr. Olmsted's 2006 arrest by Dallas police alleging indecency with a child, and a later plea of no contest to a charge of child indecency by contact, a second-degree felony, which required him to register as a sex offender and placed him on deferred adjudication. The Temporary Suspension (Without Notice of Hearing) will remain in effect until the Board takes further action.

## **QUALITY OF CARE VIOLATIONS**

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

On February 5, 2010, the Board and Dr. Angel entered into a mediated agreed order requiring Dr. Angel to pass, within one year of the order entry date, the SPEX exam given by the Federation of State Medical Boards. Dr. Angel has three attempts to pass the SPEX within this time period. Until Dr. Angel passes the SPEX within the designated time period, he must abstain from the practice of medicine involving direct patient contact and limit his medical practice to administrative, non-clinical medicine. Dr. Angel must also complete eight hours of CME in medical record-keeping within one year of the order entry date. The Board's action was based on Dr. Angel's failure to meet the standard of care, failure to maintain adequate medical records and his delivery of non-therapeutic medical care to three patients, one of whom died.

### **Bacon, Robert J., Jr., M.D., Lic. #F0861, Houston TX**

On February 5, 2010, the Board and Dr. Bacon entered into an agreed order requiring Dr. Bacon to pay an administrative penalty of \$2,500 within 90 days. The Board's action was based on Dr. Bacon's failure to meet the standard of care and maintain adequate medical records. The Board

found that Dr. Bacon did not prescribe methadone to a transferred patient with opioid dependence in a therapeutic manner.

**Burbano De Lara, Jose Luis, M.D., Lic. #F9254, Carrollton TX**

On February 5, 2010, the Board and Dr. Burbano De Lara entered into an agreed order requiring Dr. Burbano De Lara to complete 30 hours of CME in risk management, physician-patient communications, and in anticoagulation therapy or pulmonary medicine or management of pulmonary emboli. The Board's action was based on Dr. Burbano De Lara's failure to meet the standard of care with a patient on Coumadin treatment. The Board found that Dr. Burbano De Lara did not appropriately monitor the patient's care and communicate laboratory results and medication adjustments to her or warn her of potential risks associated with the drug.

**Carlin, Brian T., M.D., Lic. #E5354, Pollok TX**

On February 5, 2010, the Board and Dr. Carlin entered into an agreed order publicly reprimanding Dr. Carlin, and requiring him to successfully complete the assessment portion of the Knowledge, Skills, Training, Assessment and Research (KSTAR) program at Texas A&M within one year; and complete 18 hours of CME in endocrinology for adults and children, and in medical record-keeping, within one year. The action was based on the Board's finding that Dr. Carlin failed to practice medicine in an acceptable, professional manner and failed to safeguard against potential complications when he incorrectly treated a 10-year-old boy's diabetes.

**Gripon, Edward Brown, M.D., Lic. #D5020, Beaumont TX**

On February 1, 2010, the Board and Dr. Gripon entered into a three-year agreed order requiring Dr. Gripon to have a practice monitor and within one year complete 20 hours of CME in medical record-keeping and chronic pain management. The action was based on the Board's finding that Dr. Gripon failed to meet the standard of care, maintain adequate medical records and prescribe controlled substances in a manner consistent with public health and welfare for a patient with a psychiatric disorder as well as chronic pain.

**Hendricks, Joel R., M.D., Lic. #G9596, Kaufman TX**

On February 5, 2010, the Board and Dr. Hendricks entered into a mediated agreed order requiring Dr. Hendricks to pay an administrative penalty of \$2,000 within 90 days and complete 10 hours of CME in risk management and intra-abdominal emergency care within one year. The action was based on the Board's finding that Dr. Hendricks failed to meet the standard of care when he failed to take a patient with a gangrenous appendix to surgery in an expeditious manner.

**Huang, Wentian, M.D., Lic. #M1153, Garland TX**

On February 5, 2010, the Board and Dr. Huang entered into an agreed order requiring Dr. Huang to complete 10 hours of CME in risk management within one year and pay an administrative penalty of \$1,000 within 60 days. The Board's action was based on Dr. Huang's failure to meet the standard of care and exercise diligence in his treatment of a hospital patient. The Board found Dr. Huang didn't independently review the patient's CT scans, and thus failed to notify her of a kidney lesion, delaying her treatment for renal cell carcinoma.

**Johnson, Terry Lee, M.D., Lic. #J5795, Wichita Falls TX**

On February 5, 2010, the Board and Dr. Johnson entered into an agreed order requiring Dr.

Johnson to complete 20 hours of CME in medical record-keeping and physician-patient communication within one year, and pay an administrative penalty of \$1,000 within 90 days. The Board's action was based on Dr. Johnson's failure to meet the standard of care and maintain adequate medical records in the case of an infant. The Board found that Dr. Johnson remarked that the child had a "funny" facial appearance and did not adequately evaluate the infant's fever.

**Khan, Nameem Ullah, M.D., Lic. #L6235, Amarillo TX**

On February 5, 2010, the Board and Dr. Khan entered into a mediated agreed order of public reprimand barring Dr. Khan from performing conscious sedation and requiring Dr. Khan to complete a formal education program in conscious sedation within two years; and complete 20 hours of CME in orthopedic emergencies and pain management. The Board's action was based on Dr. Khan's failure to meet the standard of care by use of inappropriate anesthesia agents and procedures for sedation for a patient with a dislocated shoulder. As a result of Dr. Khan's action the patient died.

**Martinez, Ruben D., M.D., Lic. #F1783, Harlingen TX**

On December 14, 2009, the Board and Dr. Martinez entered into an agreed order requiring that Dr. Martinez have a practice monitor for three years; that within one year he obtain 10 hours of CME in high-risk obstetrics and 10 hours of CME in gynecological malignancies; and that within 120 days he pay an administrative penalty of \$5,000. The action was based on Dr. Martinez's failure to admit a patient with signs and symptoms of pregnancy-induced hypertension to the hospital for fetal surveillance and his treating a patient with hormones in whom such treatment was contraindicated.

**Moheb, Ramin, M.D., Lic. #L0430, Orange TX**

On February 5, 2010, the Board and Dr. Moheb entered into a four-year agreed order placing Dr. Moheb under the following terms and conditions: Dr. Moheb must limit his medical practice to a group, institutional setting or locum tenens position and continue to receive treatment from a Board-approved psychiatrist and psychotherapist once every four weeks. The Board based its action on Dr. Moheb's diagnosis of depression that resulted in standard of care issues.

**Nielson, David Hugh, M.D., Lic. #K0962, San Antonio TX**

On February 5, 2010, the Board and Dr. Nielson entered into an agreed order requiring Dr. Nielson to complete 15 hours of CME in medical record-keeping, risk management and ethics within one year; and pay an administrative penalty of \$4,000 within 60 days. The action was based on the Board's finding that Dr. Nielson failed to keep adequate medical records, failed to use proper diligence in his professional practice, and failed to adequately supervise the activities of those acting under his supervision. The Board found that digital photos that were part of patient records were inadvertently deleted and that Dr. Nielson authorized a person to represent his clinic and that person misrepresented risks and procedures for Dr. Nielson's treatment of rosacea.

**Nguyen, Howard H., D.O., Lic. #K0959, Dallas TX**

On February 5, 2010, the Board and Dr. Nguyen entered into an agreed order which placed Dr. Nguyen under certain terms and conditions for three years. The terms and conditions include: a practice monitor; 30 hours of CME including 10 hours in medical record-keeping within one

year, 10 hours in adult prescribing and 10 hours in pediatric prescribing within two years. The disciplinary action was based on the Board's finding that for 15 patients Dr. Nguyen failed to meet the standard of care, non-therapeutically prescribed narcotics and kept inadequate documentation. For most of the patients, Dr. Nguyen did not do appropriate work-ups for chronic cough conditions and prescribed excessive doses extended over long periods of time.

**Rajala, Teresa Dewlett, M.D., Lic. #G8079, McKinney TX**

On February 5, 2010, the Board and Dr. Rajala entered into an agreed order requiring Dr. Rajala to complete the physician prescribing course at University of California San Diego Physician Assessment and Clinical Education (PACE) or complete 24 hours of CME in ethics, medical record-keeping and prescribing controlled substances within one year. The action was based on the Board's finding that Dr. Rajala prescribed dangerous drugs without maintaining adequate medical records when she wrote 14 prescriptions for hydrocodone and Arthrotec over a 15-month period for a patient with a hip injury without establishing a proper physician-patient relationship.

**Sabbagh, Mouin Fayez, M.D., Lic. #J6229, Lake Jackson, TX**

On February 5, 2010, the Board and Dr. Sabbagh entered into a mediated agreed order requiring Dr. Sabbagh to: complete four hours of CME in risk management within one year; complete the courses in physician prescribing and medical record keeping offered by University of California San Diego Physician Assessment and Clinical Education (PACE); comply with the Board's prescribing rules; and maintain a logbook of all prescriptions written for scheduled drugs. The Board's action was based on Dr. Sabbagh's failure to meet the standard of care by prescribing dangerous drugs to family members without maintaining adequate medical records.

**Sanchez-Zambrano, Sergio, M.C., Lic. #E7263, Cleburne TX**

On February 5, 2010, the Board and Dr. Sanchez-Zambrano entered into an agreed order requiring Dr. Sanchez-Zambrano to complete 20 hours of CME in medical record-keeping, physician-patient communication and neurological emergencies/common problems. The Board's basis for action was Dr. Sanchez-Zambrano's failure to treat a patient according to the generally accepted standard of care and failure to maintain adequate medical records for one patient.

**Sudhivoraseth, Nippon, M.D., Lic. #F2468, Marshall TX**

On February 5, 2010, the Board and Dr. Sudhivoraseth entered into a three-year agreed order, requiring that Dr. Sudhivoraseth have a practice monitor; submit new accounting and billing protocols to the Board; complete 20 hours of CME in diagnosis and treatment of pediatric allergies within one year; pay a \$5,000 administration penalty within 60 days. In addition Dr. Sudhivoraseth shall prohibit his wife from signing office documents or treating patients under the auspices of the "R.N." designation she received in another state. The basis for action was the Board's finding that Dr. Sudhivoraseth violated the standard of care in his treatment of 10 pediatric patients by performing skin testing without proper controls; using expired extracts; and by performing intradermal airborne allergy testing without previous prick puncture testing.

**Tadlock, Hugh M., M.D., Lic. #G3835, Fort Hood TX**

On February 5, 2010, the Board and Dr. Tadlock entered into an agreed order requiring Dr. Tadlock to use a chaperone anytime he performs a physical exam on a female patient, making a

note of the chaperone's presence on the patient's chart; to complete 16 hours of CME in physician-patient communication within one year; and to pay an administrative penalty of \$5,000 within 60 days. The basis for disciplinary action was Dr. Tadlock's failure to meet the standard of care when he performed an exam on a female patient without explanation or informed consent.

**Villanueva, Rita L., M.D., Lic. #M0597, San Benito TX**

On February 5, 2010, the Board and Dr. Villanueva entered into an agreed order requiring Dr. Villanueva to pay an administrative penalty of \$2,000 within 60 days. The Board's action was based on Dr. Villanueva's failure to obtain proper informed consent for laser hair removal on a 16-year-old patient.

**Weldon, Lloyd Kent, D.O., Lic. #E6947, Fort Worth TX**

On February 5, 2010, the Board and Dr. Weldon entered into a three-year agreed order requiring Dr. Weldon to have a practice monitor; pay an administrative penalty of \$3,000 within 90 days; and complete 20 hours of CME in pain management and medical record-keeping within one year. The action was based on the Board's finding that Dr. Weldon failed to meet the standard of care in his treatment of six patients, treated for pain management issues. The Board further found that Dr. Weldon failed to maintain adequate medical records and follow guidelines for the treatment of intractable pain.

**Zamora, Jose L., M.D., Lic. #G6427, Houston TX**

On February 5, 2010, the Board and Dr. Zamora entered into an agreed order requiring Dr. Zamora to complete at least eight hours of CME in risk management within one year and pay an administrative penalty of \$1,000 within 90 days. The Board's action was based on Dr. Zamora's failure to meet the standard of care in performing medical services for two patients. The Board found that Dr. Zamora improperly attempted an initial catheterization and arteriogram through a patient's right groin, rather than his left groin, despite severe ischemia in the patient's right leg. Additionally, the Board found that Dr. Zamora failed to visualize under fluoroscopy the advancement of the balloon before inflation during another patient's angioplasty.

## **UNPROFESSIONAL CONDUCT VIOLATIONS**

**Anabtawi, Isam Nazmi, M.D., Lic. #D5588, Port Arthur TX**

On February 5, 2010, the Board and Dr. Anabtawi entered into an agreed order of public reprimand requiring Dr. Anabtawi to complete five hours of CME in ethics within one year and pay an administrative penalty of \$8,000. The Board's action was based on Dr. Anabtawi's indictment on 150 felonious counts of health care fraud and, in lieu of trial, entrance into a federal 18-month pretrial diversion program.

**Dipprey, Trisha L., M.D., Lic. #K2005, Plano TX**

On December 14, 2009, the Board and Dr. Dipprey entered into a five-year agreed order of public reprimand requiring that she undergo an independent psychiatric evaluation and continue care under a treating psychiatrist; that within one year she complete a professional boundaries course and obtain eight hours of continuing medical education in medical record-keeping and that within 90 days she pay an administrative penalty of \$5,000. The action was based on Dr.

Dipprey's assault and battery conviction on an individual with whom she lived and was romantically involved and on her prescription of controlled substances to the same individual, even though Dr. Dipprey knew or should have known this individual had a drug addiction, and on Dr. Dipprey's failure to maintain adequate medical records for these transactions.

**Miller, Jerry Winkler, M.D. Lic. #H1626, El Paso TX**

On February 5, 2010, the Board and Dr. Miller entered into an agreed order requiring Dr. Miller to complete eight hours of CME in medical ethics and eight hours of CME in risk management within one year; pay an administrative penalty of \$4,000 within 60 days; correct his physician profile on the Texas Medical Board website within 30 days; and submit to the Board a written plan for ensuring prompt response to on-call pages from hospital ER personnel. The Board's action was based on Dr. Miller's failure to practice medicine in an acceptable, professional manner; failure to use professional diligence; and failure to timely respond in person when on-call or when requested by emergency room or hospital staff.

**Smith-Blair, Gayle La Treece, M.D., Lic. #H4710, Dallas TX**

On February 5, 2010, the Board and Dr. Smith-Blair entered into a mediated agreed order requiring Dr. Smith-Blair to: complete 10 hours CME in ethics and risk management within one year; pass the Texas Jurisprudence Examination within three attempts within one year; pay an administrative penalty of \$1,000 within 60 days. The Board's action was based on Dr. Smith-Blair's using misleading and deceptive advertising and failure to supervise adequately the activities of those acting under her supervision, namely an ordained minister from Dr. Smith-Blair's church, identified by Dr. Smith-Blair as a "clinician" on her website, who was alleged to have given an unwanted kiss to an individual during a counseling session.

**Worrell, Paul Stephen, D.O., Lic. #F7329, Dallas TX**

On February 5, 2010, the Board and Dr. Worrell entered into an agreed order requiring that Dr. Worrell pass the Texas Medical Jurisprudence Examination within one year and within three attempts; and pay an administrative penalty of \$1,000 within 60 days. The basis for action was the Board's finding that Dr. Worrell provided false information to the Board, including his failure to report an April 2005 arrest when he renewed his license in 2008.

## **NONTHERAPEUTIC PRESCRIBING VIOLATIONS**

**Dyke, Marshall James, M.D., Lic. #D1619, Houston TX**

On February 5, 2010, the Board and Dr. Dyke entered into a mediated agreed order requiring Dr. Dyke to have his practice monitored monthly by another physician and to pay an administrative penalty of \$1,000 within 180 days. The Board's action was based on Dr. Dyke's nontherapeutic prescribing and unprofessional conduct. This order shall terminate in 120 days, provided that Dr. Dyke meets all of the requirements.

**Packard, Stanton Clark, M.D., Lic. #J6641, Pasadena TX**

On February 5, 2010, the Board and Dr. Packard entered into an agreed order placing Dr. Packard under the following terms and conditions: take and pass the Texas Medical Jurisprudence Examination within three attempts within one year; and complete 20 hours of CME in medical record-keeping and pain management within two years. The basis for action



was the Board's finding that Dr. Packard: inappropriately prescribed dangerous drugs or controlled substances to family members; violated Board rules regarding maintenance of adequate medical records and the treatment of pain; and failed to practice medicine in an acceptable, professional manner.

**Ritchey, Elizabeth E., M.D., Lic. #G6604, New Braunfels TX**

On February 5, 2010, the Board and Dr. Ritchey entered into a two-year agreed order requiring Dr. Ritchey to have a practice monitor; pass the Texas Medical Jurisprudence Exam within three attempts within one year; complete 20 hours of CME in medical record-keeping and chronic pain management within one year; and maintain a logbook of all prescriptions written for drugs with addictive potential or potential for abuse. The Board's action was based on Dr. Ritchey's failure to appropriately diagnose, treat or document care provided to several patients.

**Robinson, Eldon Stevens, M.D., Lic. #J9545, Lubbock TX**

On February 5, 2010, the Board and Dr. Robinson entered into a mediated agreed order requiring Dr. Robinson to pay an administrative penalty of \$1,000 within 30 days and complete within one year 10 hours of CME in the area of assessing, diagnosing and treating endocrine disorders. The Board's action was based on Dr. Robinson's nontherapeutic prescribing for one patient's possible hypothyroidism.

## **INADEQUATE MEDICAL RECORDS**

**Bennack, Laura J., M.D., Lic. #K0261, San Antonio TX**

On February 5, 2010, the Board and Laura J. Bennack, M.D., entered into an Agreed Order requiring Dr. Bennack to complete eight hours of CME in medical record-keeping and five hours of CME in risk management. The action was based on the Board's finding that Dr. Bennack's medical records were inadequate for one patient.

**Dar, Vaqar A., M.D., Lic. #K4878, Flower Mound TX**

On February 5, 2010, the Board and Dr. Dar entered into an agreed order requiring Dr. Dar to complete within one year eight hours of CME in medical record-keeping and pay an administrative penalty of \$1,000 within 60 days. The Board action was based on Dr. Dar's failure to meet the standard of care and keep adequate medical records when he wrote a prescription for a family friend on two occasions without documenting an examination or creating a medical record.

**Henderson, James Michael, M.D., Lic. #E4398, Childress TX**

On February 5, 2010, the Board and Dr. Henderson entered into a three-year mediated agreed order that requires Dr. Henderson to retain a practice management consultant approved by the Board who will recommend revised protocols for Dr. Henderson's supervision and delegation of prescriptive authority to physician extenders. Dr. Henderson must submit to the Board the names of up to three potential consultants within 30 days. Once approved by the Board, the consultant must provide a list of recommended revised protocols within 60 days. In addition, Dr. Henderson is required to have a physician monitor, designated by the compliance division of the Board, to review compliance with these revised protocols quarterly within 12 months. The action was based on the Board's finding that Dr. Henderson failed to maintain adequate medical records for

a single hospice patient with a recurrent complaint of shoulder pain. The patient was seen almost exclusively by a nurse practitioner between June 2004 and August 2007 when the patient was diagnosed with an inoperable tumor.

**Hughes, Larry Charles, D.O., Lic. #J1692, Groesbeck TX**

On February 5, 2010, the Board and Dr. Hughes entered into an agreed order requiring Dr. Hughes to have a physician monitor his practice for two years; pass the Texas Medical Jurisprudence Exam within one year; and complete 30 hours of CME in pain management and medical record-keeping within one year. The Board's action was based on Dr. Hughes' failure to maintain adequate medical records for 15 chronic pain patients, and specifically his failure to meet record-keeping standards for the treatment of intractable pain. The Board found Dr. Hughes did not adequately document: his rationale for prescribing large doses of controlled substances; treatment goals; a discussion of risks and benefits with the patients; assessment of the patients' potential for substance abuse; and results of additional diagnostic testing and lab results.

**Khan, Ahmed I., M.D., Lic. #H0073, Dallas TX**

On February 5, 2010, the Board and Dr. Khan entered into an agreed order requiring Dr. Khan to complete five hours of CME in medical record-keeping within one year. The basis for action was Khan's failure to maintain adequate medical records for one patient.

**Lichorad, Anna, M.D., Lic. #L4532, Bryan TX**

On February 5, 2010, the Board and Dr. Lichorad entered into an agreed order requiring Dr. Lichorad to complete 20 hours of CME in pain management within one year; teach a two-hour course to two groups of residents at Brazos Valley Family Medicine Program in medical record-keeping and appropriate documentation for chronic pain patients within one year. The Board's action was based on Dr. Lichorad's failure to maintain adequate medical records in the case of four patients with chronic pain conditions.

**Lipsen, Bryan Charles, M.D., Lic. #J8034, Houston TX**

On February 9, 2010, the Board and Dr. Lipsen entered into an agreed order requiring Dr. Lipsen to complete 10 hours of CME in medical record-keeping. The Board's action was based on Dr. Lipsen's failure to maintain adequate medical records for one patient.

**Michaels, Carla, D.O., Lic. #K0934, Murphy TX**

On February 5, 2010, the Board and Dr. Michaels entered into an agreed order requiring Dr. Michaels to complete 20 hours of CME in medical record-keeping and endocrinology with a focus on diabetes within one year; and pay an administrative penalty of \$500 within one year. The Board's action was based on Dr. Michaels' failure to use proper diligence in her professional practice and adequately document her diagnostic approach when she misdiagnosed a patient with pre-diabetes and metabolic syndrome.

**Prabhakar, Meenakshi Sundaram, M.D. Lic. #K3401, Dallas TX**

On February 5, 2010, the Board and Dr. Prabhakar entered into an agreed order requiring Dr. Prabhakar to complete 10 hours of CME in medical record-keeping within one year and pay an administrative penalty of \$1,000 within 60 days. The Board's action was based on Dr. Prabhakar's failure to maintain adequate medical records and comply with a Board subpoena.

**Rainey, William Cecil, M.D., Lic. #H9139, Abilene TX**

On February 5, 2010, the Board and Dr. Rainey entered into a mediated agreed order requiring Dr. Rainey to complete two CME courses, "Risk Management Essentials for Physicians" and "Risk Management Consult: Documentation" presented by MedRisk, within one year. The action was based on the Board's finding that Dr. Rainey did not maintain adequate medical records for three patients at the Abilene State School.

**Reyes, Jose, M.D., Lic. #H6540, San Antonio TX**

On February 5, 2010, the Board and Dr. Reyes entered into a two-year agreed order requiring Dr. Reyes to have a practice monitor; complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education program (PACE), or an equivalent course approved in advance; and complete 10 hours of CME in risk management within one year. The Board's action was based on Dr. Reyes' failure to maintain adequate records for one patient who suffered a harmful drug interaction.

**Routh, Lisa Carole, M.D., Lic. #H2742, Houston TX**

On February 5, 2010, the Board and Dr. Routh entered into a mediated agreed order requiring Dr. Routh to have a practice monitor for three years; complete 15 hours of CME in psychopharmacology and medical record-keeping and risk management within one year; and agree that a 30-day notice of a probationer show compliance proceeding to address any allegation of non-compliance is adequate notice for formal disciplinary action. After one year under these conditions, Dr. Routh may seek amendment or termination of these conditions. The Board action was based on Dr. Routh's failure to use diligence in her medical practice to maintain adequate medical records, findings that Dr. Routh disputes.

**Sabrsula, Irvin F. Jr., M.D., Lic. #F1959, Lake Jackson TX**

On November 6, 2009, the Board and Dr. Sabrsula entered into an agreed order requiring that within one year he obtain eight hours of CME in medical record-keeping and 10 hours of CME in primary care orthopedics. The action was based on Dr. Sabrsula's failure to document a visit, examination, or tests conducted on a patient with groin pain.

**Scharold, Mary Louise, M.D., Lic. #D5101, Houston TX**

On February 5, 2010, the Board and Dr. Scharold entered into an agreed order requiring Dr. Scharold to complete 16 hours of CME in medical record-keeping and risk management within one year; and pay an administrative penalty of \$2,000 within 60 days. The action was based on the Board's finding that Dr. Scharold's medical record documentation for one patient was "severely lacking".

**Sioco, Geraldo Manaloto, M.D., Lic. #J2337, San Antonio TX**

On February 5, 2010, the Board and Dr. Sioco entered into an agreed order requiring Dr. Sioco to complete 10 hours of CME in medical record-keeping. The basis for disciplinary action was the Board's finding that Dr. Sioco failed to maintain adequate medical records that adequately explained his decision to perform a heart catheterization on one patient.

**Wiseman, Richard John, M.D., Lic. #F0084, Austin TX**

On February 5, 2010, the Board and Dr. Wiseman entered into an agreed order requiring Dr.

Wiseman to complete the medical record-keeping course offered by the University of California Physician Assessment and Clinical Education (PACE) program within one year and pay an administrative penalty of \$1,000 within 60 days. The action was based on the Board's finding that for one patient Dr. Wiseman: kept inadequate medical records; provided, dispensed or distributed drugs without proper labeling or record-keeping; and dispensed drugs in violation of pharmacy laws.

**Zajac, Paul, M.D., Lic. #M8449, Odessa TX**

On February 5, 2010, the Board and Dr. Zajac entered into an agreed order requiring Dr. Zajac to complete at least 10 hours of CME in medical record-keeping within one year. The action was based on the Board's finding that Dr. Zajac's medical record documentation of one emergency room patient was sparse and inadequate.

## **SUPERVISION OR DELEGATION VIOLATIONS**

**Rivera, Rudolfo L., M.D., Lic. #E6894, Dallas TX**

On November 6, 2009, the Board entered a final order requiring that within one year Dr. Rivera take and pass the Special Purpose Examination (SPEX); that within 180 days he complete 10 hours of CME in ethics/risk management, including at least two hours on the physician-patient relationship, and 10 hours in medical recordkeeping, and that he properly supervise those under his supervision and personally examine and/or treat patients. The Board adopted the findings of an administrative law judge of the State Office of Administrative Hearings regarding Dr. Rivera's failure to properly delegate and supervise a pharmacist who provided drug therapy to a patient. Dr. Rivera filed a motion for rehearing within 20 days of the order. If the Board denies the motion, the order is final. If a motion for rehearing is filed and the Board grants the motion, the order is not final and a hearing will be scheduled.

## **AUTOMATIC REVOCATION AND SUSPENSION ORDERS**

**King, Clarence Gordon, Jr., M.D., Lic. #E1883, San Antonio TX**

On January 7, 2010, the Board entered an automatic revocation order for an indefinite period against Dr. King for a violation of a seven-year 2003 agreed order with terms and conditions related to substance abuse. The 2003 order required, among other things, that Dr. King abstain from the use of prohibited substances and undergo alcohol and drug screens. The 2003 order contained a provision allowing for an automatic revocation of Dr. King's license for a positive alcohol or drug screen. Due to low-level positive screens in 2004 and 2006, the Board twice-modified Dr. King's 2003 order by extending it each time by three years, resulting in a new termination date in 2015, but the Board did not exercise the auto-revocation provision due to mitigating circumstances. In May 2009, Dr. King again tested positive for a metabolite of ethanol consumption, and the Board exercised its authority under the 2003 order, as modified, to automatically revoke Dr. King's license.

**Marks, Timothy N., M.D., Lic. #J3719, Dallas, TX**

On January 8, 2010, the Board entered an automatic order of suspension for an indefinite period against Dr. Marks and it will remain in effect until superseded by a subsequent order of the Board. Authorized by a statutory mandate, the 2010 order was issued as the result of Dr. Marks'

incarceration in federal prison following his 2009 conviction in United States District Court for failing to file a tax return for three years.

**McNeill, Scott Shaw, M.D., Lic. #K7058, San Antonio TX**

On January 15, 2010, the Board entered an automatic revocation order for an indefinite period against Dr. McNeill for violations of a 2004 10-year agreed order. The 2004 order required, among other terms and provisions, that Dr. McNeill submit to random alcohol and drug screenings to ensure abstinence from alcohol and/or other prohibited substances. The 2004 order also provided that any violation of that provision by having a positive drug screen could result in the automatic revocation of Dr. McNeill's license. In addition to having other documented compliance violations, the immediate revocation of Dr. McNeill's license was based on his violation of the 2004 order by testing positive for alcohol on a drug and alcohol screen performed in March 2009.

**REVOCATIONS**

**Lengyel, Mircea Iaon, M.D., Lic. #D2805, Houston TX**

On February 5, 2010, the Board entered a final order against Dr. Lengyel, as issued by the State Office of Administrative Hearings in Docket No. 503-09-3769, revoking his medical license. The Order was based on Dr. Lengyel's failure to maintain adequate medical records; failure to treat a patient according to the standard of care; prescribing dangerous drugs without establishing a proper physician-patient relationship; unprofessional and dishonorable conduct; prescribing dangerous drugs to a known abuser of narcotics; and nontherapeutic prescribing.

**Massey, Charles R. Jr., M.D., Lic. #G5341, Fredericksburg TX**

On November 6, 2009, the Board entered a final order revoking Dr. Massey's Texas medical license. The Board adopted the findings of an administrative law judge of the State Office of Administrative Hearings in Docket No. 503-09-0554, regarding Dr. Massey's failure to comply with board subpoenas and requests for records and his refusal to recognize the board's authority to regulate his practice of medicine.

**CEASE AND DESIST ORDER**

**Osborn, Charles Ray, M.D., D.C., (no license #) Waxahachie TX**

On February 5, 2010, the Board and Dr. Osborn, who does not hold a current license to practice medicine in Texas, entered into an agreed cease and desist order. The order was based on Dr. Osborn's unlicensed practice of medicine in Ellis County, Texas, by: seeing and treating patients though the use of alternative medicine; offering alternative medicine consultations; and by using the "M.D." designation after his name in association with the offer of alternative medicine consultations and treatment, all of which is denied by Dr. Osborn. The order requires Dr. Osborn to immediately halt all such activity.

**VIOLATION OF PROBATION OR PRIOR ORDER**

**Sandbach, Emily Jane, M.D., Lic. #M0555, Austin TX**

On February 5, 2010, the Board and Dr. Sandbach entered into an agreed order modifying a

previous confidential rehabilitation order publicly reprimanding Dr. Sandbach, requiring her to pay an administrative penalty of \$1,000 within 90 days, and requiring that she file missing psychiatric reports. The Board's action was based on Dr. Sandbach's noncompliance with a 2004 confidential order.

**Smith, Michael Dean, M.D., Lic. #F4545, Houston TX**

On February 5, 2010, the Board and Dr. Smith entered into an agreed order modifying a prior order that states that any violation of Dr. Smith's 15-year 2008 order will result in immediate suspension of his license without a formal hearing, and that requires Dr. Smith to pay an administrative penalty of \$2,000 within 60 days. The Board's action was based on Dr. Smith's use of an alcohol-based hand sanitizer and failure to timely report to the Board taking Fioricet to treat a migraine, both violations of the 2008 order.

**ORDER MODIFYING PRIOR ORDER**

**Ward, Phillip Andrew, D.O., Lic. #L6710, Anahuac TX**

On February 5, 2010, the Board and Dr. Ward entered into an agreed order modifying a prior order placing him under certain restrictions, including having his practice monitored for two years. In addition, Dr. Ward must complete 40 hours of CME in office-based procedures and medical record-keeping within two years. The order modifies a February 2009 order based on the Board's finding that Dr. Ward failed to meet the standard of care in his improper treatment of an injury and failure to release medical records for a patient.

**VOLUNTARY SURRENDERS/SUSPENSIONS**

**Brown, Thomas Joseph, M.D., Lic. #J5712, San Antonio TX**

On February 5, 2010, the Board and Dr. Brown entered into an agreed voluntary surrender order whereby Dr. Brown voluntarily and permanently surrendered his Texas medical license due to illness and in lieu of further disciplinary proceedings.

**DiBona, Daniel J., M.D., Lic. #H0294, Austin TX**

On February 5, 2010, the Board and Dr. DiBona entered into an agreed order of voluntary suspension in lieu of further disciplinary proceedings. The Board's action was based on Dr. DiBona's inability to practice medicine with reasonable skill and safety because of numerous medical problems.

**Dickson, Teresa May, M.D., Lic. #H4285, Tyler TX**

On February 5, 2010, the Board and Dr. Dickson entered into an agreed voluntary surrender order, whereby Dr. Dickson voluntarily surrendered her license due to a medical condition.

**Espiritu, Edgardo T., M.D., Lic. #E4321, Sugar Land TX**

On February 5, 2010, the Board and Edgardo T. Espiritu, M.D., entered into an Agreed Voluntary Surrender Order wherein Dr. Espiritu voluntarily surrendered his license in lieu of further disciplinary proceedings related to issues of overprescribing controlled substances to multiple patients.

**Hinojosa, Jose Luis, M.D., Lic. #H0450, Edinburg TX**

On February 5, 2010, the Board and Dr. Hinojosa entered into an agreed order of voluntary surrender in which Dr. Hinojosa agreed to voluntarily and permanently surrender his Texas medical license in lieu of further disciplinary proceedings. The action was based on the Board's finding that Dr. Hinojosa: failed to comply with requirements and guidelines for practicing telemedicine; wrote refill prescriptions for three patients whom he never saw and whose prior prescriptions he never reviewed; did not document any therapeutic evaluation that would establish the basic need for such medication. The patients were located in Florida and the prescriptions were written to be filled in Florida, where Dr. Hinojosa has never been licensed to practice medicine.

**Kutz, Susan M.D., Lic. #K6634, Midland TX**

On February 5, 2010, the Board and Dr. Kutz entered into an agreed order of voluntary surrender in which the Board accepted Dr. Kutz's voluntary and permanent surrender of her medical license in lieu of further disciplinary proceedings. The action was based on the Board's finding that Dr. Kutz is unable to practice medicine due to a physical condition.

**Lewis, Jeffrey Earl, M.D., Lic. #F8555, Denton TX**

On February 5, 2010, the Board and Dr. Lewis entered into an agreed voluntary surrender order in which Dr. Lewis voluntarily and permanently surrendered his Texas medical license in lieu of further disciplinary proceedings. The action was based on Dr. Lewis having written several prescriptions for controlled substances with expired Drug Enforcement Agency (DEA) and Department of Public Safety (DPS) registrations.

**OTHER STATES' ACTIONS**

**Carstens, George John, III, M.D., Lic. #H0238, Tulsa OK**

On February 5, 2010, the Board and Dr. Carstens entered into an agreed order requiring Dr. Carstens to pay an administrative penalty of \$2,000 within 90 days and comply with all requirements of a 2007 Oklahoma State Board of Medical Licensure and Supervision Order. The Texas Medical Board's action was based on disciplinary action taken by Dr. Carstens' peers. Dr. Carstens is currently in full compliance with the Oklahoma Order which requires that: he not treat or prescribe any medication to himself or his family members; any hospital where he works at to send monitoring reports to the Oklahoma Board; and that he undergo polygraph testing every six months.

**Edwards, Michael Charles, M.D., Lic. #L2873, Thousand Oaks CA**

On February 5, 2010, the Board and Dr. Edwards entered into an agreed order subjecting Dr. Edwards to the following terms and conditions for 10 years: abstain from consumption of prohibited substances; submit to screenings for alcohol and drugs; submit to a psychological/psychiatric examination and comply with any treatment recommendations; limit his practice to a group or institutional setting; not supervise or delegate prescriptive authority to physician extenders for the first six months of this order; not treat or prescribe controlled substances for his immediate family; not dispense or prescribe any drugs with addictive potential except as is medically necessary for plastic surgery procedures; and attend Alcoholics Anonymous meetings five times a week. The Board's action was based on Dr. Edwards' abuse

of dangerous drugs, unprofessional conduct and disciplinary action taken by the Medical Board of California.

**Gapin, Tracy, M.D., Lic. #N1323, Sarasota FL**

On February 5, 2010, the Board and Dr. Gapin entered into an agreed order requiring Dr. Gapin, who is also licensed in Florida, to submit all relevant information regarding disciplinary action against him by the Florida Board of Medicine within 10 days, and comply fully with the Florida Board's Order. The Florida Order requires Dr. Gapin to pay a fine; perform 50 hours of community service; take five hours of CME in risk management; and provide a one-hour lecture on wrong-site surgeries.

**Greenwood, Denise R., M.D., Lic. #J7977, Little Rock AR**

On November 6, 2009, the Board entered a Final Order revoking Dr. Greenwood's Texas medical license, staying the revocation conditional on Dr. Greenwood's compliance with 2006 and 2007 orders of the Arkansas Medical Board and requiring that Dr. Greenwood appear before the board and provide evidence to indicate she is competent to safely practice before returning to Texas to practice. The Board adopted the findings of an administrative law judge of the State Office of Administrative Hearings regarding Dr. Greenwood's failure to comply with board subpoenas and requests for records and disciplinary action taken by the Arkansas and North Carolina medical boards.

## **IMPAIRMENT DUE TO ALCOHOL OR DRUGS**

**Havard, Thomas J., III, D.O., Lic. #E5103, North Richland Hills TX**

On February 5, 2010, the Board and Dr. Havard entered into an agreed order of suspension until Dr. Havard is able to provide clear and convincing evidence that he is physically and mentally competent to safely practice medicine via the Board's drug screening program and psychological and neuropsychiatric evaluations. During the suspension, Dr. Havard must abstain from the consumption of prohibited substances and be monitored by a psychiatrist. That Board's action was based on Dr. Havard's writing false prescriptions for dangerous drugs, and his inability to practice medicine with reasonable safety due to excessive use of drugs.

## **FAILURE TO PROVIDE MEDICAL RECORDS**

**Kadri, Abdu A., M.D., Lic. #J0545, San Antonio TX**

On February 5, 2010, the Board and Dr. Kadri entered into an agreed order requiring Dr. Kadri to complete within one year eight hours of CME in office management, and pay an administrative penalty of \$1,000 within 90 days. The Board's action was based on Dr. Kadri's interfering with a departing physician from posting notice and the sign required for patient notification, and withholding information from a departing physician that is necessary for notification of patients.

## **SURGICAL ASSISTANT**

**Coffey, Dorsey Shantel, S.A., Lic. #SA0060, Austin TX**

On February 5, 2010, the Board and Dorsey Shantel Coffey, S.A., entered into a five-year agreed



order of public reprimand requiring Ms. Coffey to abstain from the consumption of prohibited substances, except as prescribed by another physician for legitimate therapeutic purposes; participate in the Board's drug testing program; attend Alcoholics Anonymous meetings three times a week; and submit to a psychiatric examination and comply with recommended treatment. The Board's action was based on Ms. Coffey's habitual use of drugs to the extent that she could not safely perform as a surgical assistant.