

Texas Medical Board Press Release

FOR IMMEDIATE RELEASE

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Medical Board Issues 40 Disciplinary Orders at June Meeting

At its June 7-8, 2012 meeting, the Texas Medical Board disciplined 37 licensed physicians and issued three cease and desist orders. The disciplinary actions included 16 orders based on quality of care violations, seven voluntary surrenders and four based on non-therapeutic prescribing.

The Board issued 106 physician licenses at the June board meeting, bringing the total number of physician licenses issued in FY 12 to 2,806. Forty-five percent of physician licensure applications were completed in 10 days or less.

RULE CHANGES ADOPTED

The following Rule Changes were adopted at the June 7-8, 2012 Board meeting:

Chapter 163, LICENSURE: The amendment to **§163.2**, relating to Full Texas Medical License, sets out medical graduation requirements for 5th pathway applicants to be consistent with rules relating to other types of applicants for full licensure. The amendment to **§163.4**, relating to Procedural Rules for Licensure Applicants, provides that if an applicant for licensure has violated §170.002 or Chapter 171, Texas Health and Safety Code, the applicant will be considered ineligible for licensure. The amendment to **§163.5**, relating to Licensure Documentation, amends the clinical clerkship affidavit regarding US clinical clerkships so that language is consistent with the Board's processes; and provides a remedy for licensure to applicants who are otherwise ineligible for licensure due to a deficient medical clerkship obtained while in medical school.

Chapter 166, PHYSICIAN REGISTRATION: The amendment to **§166.1** provides that a physician will not be eligible for a registration permit if the physician has violated §170.002 or Chapter 171, Texas Health and Safety Code, consistent with HB 15 that was passed during the 82nd Legislative Session. The amendment to **§166.3** provides that in order for a physician to return to active status from retired status, the physician may have to prove competency or otherwise remediate any deficiencies in ways consistent with §163.11 of the Board's rules related to the active practice of medicine.

Chapter 172, TEMPORARY AND LIMITED LICENSES: The amendment to **§172.8**, relating to Faculty Temporary License, provides that applicants for Faculty Temporary Licenses (FTLs) shall be determined ineligible for FTLs based on the same reasons for ineligibility for full licensure. The amendment to **§172.15**, relating to Public Health License, provides that any clinical medicine performed under public health license may not count toward active practice requirements for full licensure. The amendment to **§172.16**, relating to Provisional Licenses for Medically Underserved Areas, provides that in addition to other reasons already provided by rule, a provisional license will be terminated upon determination of statutory ineligibility by the Executive Director.

Chapter 177, BUSINESS ORGANIZATIONS: Amendments to **§177.5**, concerning Special Requirements for 162.001(b) Health Organizations, provides changes consistent with SB 1661 passed during the 82nd Regular Session. Changes include requiring non-profit health organizations to adopt and enforce policies to ensure that physicians employed by the organization exercise independent medical judgment when providing care to patients.

Chapter 190, DISCIPLINARY GUIDELINES: Amendments to **§190.8**, concerning Violation Guidelines, adds that the Board will take disciplinary action if the physician is in violation of §170.002 or Chapter 171, Texas Health and Safety Code.

DISCIPLINARY ACTIONS

Quality of Care

Clark, Donald Will, M.D., Lic. No. C8225, Athens

On June 8, 2012, the Board and Donald Will Clark, M.D., entered into an Agreed Order requiring Dr. Clark to undergo an independent medical evaluation by a board-certified psychiatrist and follow all recommendations for care and treatment, limit his practice to a setting approved in advance by the Executive Director of the Board, refrain from reregistering or otherwise obtaining DEA/DPS controlled substance registration certificates, complete within one year eight hours of CME in ethics and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Clark failed to meet the standard of care when he prescribed medications to 14 people outside an office setting without maintaining adequate medical records for the patients and became financially or personally involved with a patient in an inappropriate manner.

Dumas, Natascha Tove, M.D., Lic. No. L4351, Houston

On June 8, 2012, the Board and Natascha Tove Dumas, M.D., entered into an Agreed Order publicly reprimanding Dr. Dumas and prohibiting Dr. Dumas from holding DPS/DEA controlled substances registrations, treating any chronic pain patients or supervising or delegating prescriptive authority to physician extenders. In addition, the order requires Dr. Dumas to pass within one year and within three attempts the Medical Jurisprudence Exam. The Board found Dr. Dumas violated

the standard of care in her treatment of 21 patients, used pre-signed prescriptions for disbursement by unlicensed staff members and entered into an unlawful business arrangement, obtaining a pain management certificate for a clinic she did not own.

Fennig, Roberta L., D.O., Lic. No. J2873, El Paso

On June 8, 2012, the Board and Roberta L. Fennig, D.O., entered into a five-year Agreed Order publicly reprimanding Dr. Fennig and prohibiting Dr. Fennig from treating any chronic pain patients or serving as a physician for her immediate family. In addition, Dr. Fennig must have another physician monitor her practice for eight monitoring cycles, complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, complete within one year 16 hours of CME in psychopharmacology and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Fennig failed to meet the standard of care, inappropriately prescribed to a family member and repeatedly prescribed opiates to one patient with a known history of substance abuse.

Hartman, Samuel Christian, M.D., Lic. No. K0487, Corpus Christi

On June 8, 2012, the Board and Samuel Christian Hartman, M.D., entered into an Agreed Order requiring Dr. Hartman to complete within one year eight hours of CME in medical record-keeping and four hours in chronic obstructive pulmonary disease. The Board found Dr. Hartman failed to meet the standard of care when he did not order a chest x-ray for a patient with a cough persisting over six months and four office visits, and failed to maintain adequate medical records.

Holliday, James Glen, D.O., Lic. No. D2791, Frisco

On June 8, 2012, the Board and James Glen Holliday, D.O., entered into a Mediated Agreed Order requiring Dr. Holliday to complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, complete within one year eight hours of CME in pharmacology and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Holliday failed to meet the standard of care when he prescribed Prozac and Phentermine to a patient for weight loss, when there was no indication for either drug. The order resolves a formal complaint against Dr. Holliday filed at the State Office of Administrative Hearings.

Johnson, Jeffrey Dale, D.O., Lic. No. J8607, Corpus Christi

On June 8, 2012, the Board and Jeffrey Dale Johnson, D.O., entered into an Agreed Order publicly reprimanding Dr. Johnson and requiring him to complete within one year four hours of CME in prescribing controlled substances, four hours in medical record-keeping and four hours in risk management. The Board found Dr. Johnson failed to meet the standard of care in his treatment of one patient, and non-therapeutically prescribed, after which prescription the patient died from a prescription drug overdose.

Johnson, Tone, Jr., M.D., Lic. No. G6946, Corpus Christi

On June 8, 2012, the Board and Tone Johnson Jr., M.D., entered into a Mediated Agreed Order requiring Dr. Johnson to have his practice monitored by another physician for 12 monitoring cycles, pass within one year and within three attempts the Medical Jurisprudence Exam, complete within one year 28 hours of CME including four hours in the topic of billing, eight hours in risk management, eight hours in office management and eight hours in supervising mid-level providers, and within four months complete the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Johnson violated the standard of care and failed to maintain adequate documentation for two patients, improperly billed for medical services and failed to adequately supervise delegates. The order resolves a formal complaint against Dr. Johnson filed at the State Office of Administrative Hearings.

Kern, James Hoyt, M.D., Lic. No. G7833, Houston

On June 8, 2012, the Board and James Hoyt Kern, M.D., entered into an Agreed Order requiring Dr. Kern to pass within one year and within three attempts the Medical Jurisprudence Exam; complete within one year 24 hours of CME including eight hours in medical record-keeping, eight hours in risk management, four hours in local anesthetic pharmacology and toxicity, four hours in ethics and four hours in physician/patient communication; register his practice as an office-based anesthesia practice within 30 days; to become and have his staff certified in Basic Life Support; provide verification to the Board that he has modified his advertising to remove misleading statements; and pay an administrative penalty of \$5,000 within 60 days. The Board found Dr. Kern failed to exercise diligence in his practice, failed to obtain adequate informed consent, used misleading advertising and did not register his office-based anesthesia practice.

Kesavan, Ramesh Babu, M.D., Lic. No. M6223, Kingwood

On June 8, 2012, the Board and Ramesh Babu Kesavan, M.D., entered into an Agreed Order requiring Dr. Kesavan to complete within one year 10 hours of CME in risk management. The action was based on Dr. Kesavan's failure to meet the standard of care and safeguard against potential complications when he did not personally review a patient's routine CT scan.

Lankes, Richard Allen, M.D., Lic. No. E6464, Carrizo Springs

On June 8, 2012, the Board and Richard Allen Lankes, M.D., entered into an Agreed Order requiring Dr. Lankes to complete 24 hours of CME including eight hours in the topic of preventative screenings, eight hours in medical record-keeping and eight hours in risk management. The Board found Dr. Lankes did not meet the standard of care when he failed to timely diagnose patient's cancer, and did not maintain adequate medical records.

Nash, Edward Alan, M.D., Lic. No. M3662, Houston

On June 8, 2012, the Board and Edward Alan Nash, M.D., entered into an Agreed

Order requiring Dr. Nash to complete within one year 16 hours of CME, in person, including eight hours in medical record-keeping and eight hours in risk management. The Board found Dr. Nash failed to meet the standard of care or maintain adequate medical records.

Parra, Rafael, M.D., Lic. No. E4040, San Antonio

On June 8, 2012, the Board and Rafael Parra, M.D., entered into an Agreed Order requiring Dr. Parra to complete within one year 12 hours of CME including four hours in medical record-keeping and eight hours in the topic of nerve conduction velocity and electromyography, and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Parra failed to meet the standard of care and maintain adequate medical records.

Ramirez, John P., M.D., Lic. No. H0743, Houston

On June 8, 2012, the Board and John P. Ramirez, M.D., entered into an Agreed Order prohibiting Dr. Ramirez from treating any chronic pain patients. Dr. Ramirez may treat acute pain, prescribing only on a one-time basis for immediate need. In addition, Dr. Ramirez must have another physician monitor his practice for 12 monitoring cycles, complete within one year eight hours of CME in medical record-keeping and pay an administrative penalty of \$5,000 within one year. This Order supersedes Dr. Ramirez's 2011 Order. The Board found Dr. Ramirez failed to meet the standard of care in his treatment of 15 patients, prescribed in a non-therapeutic manner and prescribed to a known abuser of narcotic drugs.

Roquet, Warren Paul, M.D., Lic. No. G0026, Bryan

On June 8, 2012, the Board and Warren Paul Roquet, M.D., entered into an Agreed Order requiring Dr. Roquet to refrain from serving as a physician for his immediate family, have another physician monitor his practice for eight monitoring cycles, pass within one year and within three attempts the Medical Jurisprudence Exam, complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, complete within one year eight hours of CME in chronic pain treatment and eight hours in ethics. The Board found Dr. Roquet failed to meet the standard of care in his treatment of one patient's abdominal pain, did not maintain adequate medical records and non-therapeutically prescribed.

Webb, John Q., Jr., M.D., Lic. No. E3137, Beaumont

On June 8, 2012, the Board and John Q. Webb Jr., M.D., entered into an Agreed Order requiring Dr. Webb to have his practice monitored by another physician for eight monitoring cycles, complete within one year the medical record-keeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, complete within one year eight hours of CME in risk management and four hours in identifying drug-seeking behavior and pay an administrative penalty of \$2,000 within 60 days. In addition, Dr. Webb

may not reregister or otherwise obtain DEA or DPS controlled substance registrations until he has written authorization from the Board. The Board found Dr. Webb breached the standard of care by non-therapeutically prescribing controlled substances to 25 patients, and that he did not maintain adequate medical records.

Weldon, Bill E., D.O., Lic. No. F4669, Fort Worth

On June 8, 2012, the Board and Bill E. Weldon, D.O., entered into a Mediated Agreed Order requiring Dr. Weldon to close his medical practice and cease all evaluation, diagnosis and treatment of patients, including all prescribing. For 45 days after the entry of this order, Dr. Weldon may see current patients for the purpose of referring them to other providers. In addition, Dr. Weldon may not engage in any practice of medicine that involves direct or indirect contact with patients after the closing of his medical practice. Dr. Weldon shall limit his medical practice to acting as a medical review officer, reviewing test results and medical records only. Dr. Weldon is not permitted to supervise or delegate prescriptive authority to physician extenders. The Board's basis for action was Dr. Weldon's failure to comply with his 2010 Order as well as failure to meet the standard of care in his treatment of a patient, non-therapeutic prescribing and prescribing to a person the physician should have known was an abuser of narcotic drugs. The order resolves a formal complaint filed August 2011 at the State Office of Administrative Hearings.

Non-Therapeutic Prescribing

Adugba, Ikenna, M.D., Lic. No. K6978, Denton

On June 8, 2012, the Board and Ikenna Adugba, M.D., entered into an Agreed Order requiring Dr. Adugba to complete within one year 12 hours of CME including eight hours in chronic pain management and four hours in ethics, submit within 60 days in writing a set of protocols as well as a pain contract that complies with Board Rule 170 related to the treatment of pain. The Board found Dr. Adugba failed to adequately supervise his delegates, maintain adequate medical records or use proper diligence in his practice.

Gullapalli, Uma Rani, M.D., Lic. No. J1256, Victoria

On June 8, 2012, the Board and Uma Rani Gullapalli, M.D., entered into an Agreed Order publicly reprimanding Dr. Gullapalli due to her non-therapeutic prescribing of controlled substances to 15 patients.

O'Hearn, Charles John, M.D., Lic. No. H5676, Southlake

On June 8, 2012, the Board and Charles John O'Hearn, M.D., entered into a Mediated Agreed Order requiring Dr. O'Hearn to refrain from serving as a physician for himself, maintain a logbook of all prescriptions for dangerous drugs and controlled substances with addictive potential written by Dr. O'Hearn, undergo an evaluation by a psychiatrist and begin recommended care and treatment. The basis for action was Dr. O'Hearn's inappropriate prescription of dangerous drugs or controlled substances to himself without creating and

maintaining a record, and in the absence of documented immediate need. The order resolves a formal complaint against Dr. O'Hearn filed at the State Office of Administrative Hearings.

Sacks, Steven Michael, M.D., Lic. No. J0658, Beaumont

On June 8, 2012, the Board and Steven Michael Sacks, M.D., entered into a Mediated Agreed Order requiring Dr. Sacks to have his practice monitored by a physician for eight monitoring cycles, complete within one year 32 hours of CME including eight hours in chronic pain management, eight hours in medical record-keeping, eight hours in recognizing signs of drug diversion/abuse and eight hours in risk management. In addition, Dr. Sacks must pass within one year and within three attempts the Medical Jurisprudence Exam and pay an administrative penalty of \$3,000 within 180 days. The Board found Dr. Sacks violated rules regarding maintenance of adequate medical records and regarding the treatment of chronic pain, non-therapeutically prescribed drugs and prescribed to a known abuser of narcotic drugs.

Inadequate Supervision

Dailey, Warren Bertrand, M.D., Lic. No. F8454, Liberty

On June 8, 2012, the Board and Warren Bertrand Dailey, M.D., entered into a Mediated Agreed Order, publicly reprimanding Dr. Dailey and requiring Dr. Dailey to provide within 30 days written protocols that outline standards of practice to be followed by all staff working under his supervision, maintain at all practice sites a logbook of all prescriptions written by midlevel practitioners, maintain at all practice sites a logbook of all charts reviewed by Dr. Dailey for patients treated by mid-level practitioners working under his supervision and complete within one year eight hours of CME in the topic of supervising midlevel practitioners. The basis for action was Dr. Dailey's failure to properly supervise staff working at a weight loss management clinic. The order resolves a formal complaint against Dr. Dailey filed at the State Office of Administrative Hearings.

Unprofessional Conduct

Hamer, Louis Marc, M.D., Lic. No. J3113, Pasadena

On June 8, 2012, the Board and Louis Marc Hamer, M.D., entered into an Agreed Order requiring Dr. Hamer to complete within one year an approved anger-management course, complete within one year four hours of CME in the topic of physician-patient boundaries and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Hamer engaged in behavior that was disruptive to hospital staff.

Voluntary Suspension

Pullen, Thomas F., Jr., M.D., Lic. No. E2801, Taylor

On June 8, 2012, the Board and Thomas F. Pullen, Jr., M.D., entered into an Agreed Order of Voluntary Suspension in which Dr. Pullen's medical license was suspended until such time as he appears before the Board and provides clear and convincing evidence that he is physically, mentally and otherwise competent to

safely practice medicine. The Board found Dr. Pullen violated the standard of care when he prescribed substantial amounts of controlled substances to three minor patients in amounts and dosages that are non-therapeutic for children, and that he engaged in an inappropriate personal relationship with an adult patient, the mother of the children.

Ritter, Jack Lendon, M.D., Lic. No. E4637, The Woodlands

On June 8, 2012, the Board and Jack Lendon Ritter, M.D., entered into an Agreed Order of Suspension in which Dr. Ritter's medical license was suspended until such time as he appears before the Board and provides clear and convincing evidence that he is physically, mentally and otherwise competent to safely practice medicine. The Board found Dr. Ritter, who self-reported alcohol abuse to the Texas Physician Health Program, violated his five-year monitoring agreement with PHP.

Smith, Donald W., M.D., Lic. No. D6870, Spring

On June 8, 2012, the Board and Donald W. Smith, M.D., entered into an Agreed Order of Suspension in which Dr. Smith's medical license was suspended until such time as he appears before the Board and provides clear and convincing evidence that he is physically, mentally and otherwise competent to safely practice medicine. In addition, prior to resuming active practice of medicine, Dr. Smith must complete the KSTAR clinical competency assessment program offered by Texas A&M University, and comply with the provisions of his 2003 Order, as modified. The Board found Dr. Smith violated his 2003 Order, as modified, when he failed to implement recommendations of the chart monitor, specifically, by reducing his number of pain patients and/or convert patients to non-addictive alternatives and obtaining and documenting more complete histories and explanations for treatments that correlate to diagnoses.

Williams, Brianne, M.D., Lic. No. M8428, Plainview

On June 8, 2012, the Board and Brianne Williams, M.D., entered into an Agreed Order of Suspension in which Dr. Williams medical license was suspended until such time as she appears before the Board and provides clear and convincing evidence that she is physically, mentally and otherwise competent to safely practice medicine. The Board found Dr. Williams, who self-reported substance abuse to the Texas Physician Health Program, violated her 2011 monitoring agreement with PHP.

Voluntary Surrender

Bullington, Karen Patricia, M.D., Lic. No. H9455, Marietta, GA

On June 8, 2012, the Board and Karen Patricia Bullington, M.D., entered into an Agreed Voluntary Surrender Order. The Georgia Medical Board entered an order due to Dr. Bullington's failure to meet the standard of care for one patient. Dr. Bullington indicated to the Board that she agreed to permanently surrender her Texas medical license in lieu of further disciplinary proceedings.

Chaudhry, Mohammad Akram, M.D., Lic. No. E2171, Fort Worth

On June 8, 2012, the Board and Mohammad Akram Chaudhry, M.D., entered into an Agreed Order of Voluntary Surrender. Due to a health condition, Dr. Chaudhry indicated to the board that he agrees to permanently surrender his Texas medical license and cease practicing medicine.

Pearce, Jay, D.O., Lic. No. H4608, Fulton

On June 8, 2012, the Board and Jay Pearce, D.O., entered into an Agreed Order of Voluntary Surrender. Dr. Pearce retired from medical practice in June 2011 due to illness.

Philbrick, Darey, M.D., Lic. No. J6662, Brownwood

On June 8, 2012, the Board and Darey Philbrick, M.D., entered into an Agreed Order of Voluntary Surrender. The Board had concerns about Dr. Philbrick's prescribing practices and medical record-keeping. Dr. Philbrick surrendered his Texas Medical license in lieu of disciplinary action.

Roy, Jacques A., M.D., Lic. No. G6995, DeSoto

On June 8, 2012, the Board and Jacques A. Roy, M.D., entered into an Agreed Order of Voluntary Surrender. In February 2012, Dr. Roy was arrested by the FBI for allegations of Medicare fraud, and indicated to the Board that he wished to surrender his Texas medical license in lieu of further disciplinary proceedings regarding allegations he failed to meet the standard of care for two patients and violation of state and federal law.

Turner, Stephen Lynn, M.D., Lic. No. G5711, Plainview

On June 8, 2012, the Board and Stephen Lynn Turner entered into a Voluntary Surrender Order in which the Board accepted Dr. Turner's permanent surrender of his Texas medical license. The Board opened an investigation on Dr. Turner based on unprofessional comments he made. Dr. Turner has self-reported an injury which affects his ability to practice medicine.

Wilder, Lowell E., M.D., Lic. No. C0655, Falfurrias

On June 8, 2012, the Board and Lowell E. Wilder, M.D., entered into an Agreed Voluntary Surrender Order. Dr. Wilder, who is 93, indicated to the Board he wished to permanently surrender his Texas medical license due to significant physical health problems.

Other States Actions

Geier, Mark, M.D., Lic. No. TM00268, Rockville MD

On June 8, 2012, the Board and Mark Geier, M.D., entered into an Agreed Order of Suspension. In April 2011, the Maryland State Board of Physicians suspended Dr. Geier's Maryland medical license based on his treatment of autistic children with the drug Lupron. Under the terms of the Agreed Order of Suspension, if Dr. Geier's Maryland medical license is revoked, his Texas license will be automatically revoked.

Whitfield, Dennis Wayne, M.D., Lic. No. D9722, Saint Helena CA

On June 8, 2012, the Board and Dennis Wayne Whitfield, M.D., entered into an Agreed Order publicly reprimanding Dr. Whitfield. The Board found Dr. Whitfield was subjected to disciplinary action by the state of California, where he is also licensed, due to a failure to treat a patient according to the generally accepted standard of care.

Violation of a Prior Order

Wong, Ronald Din, M.D., Lic. No. J5950, San Antonio

On June 8, 2012, the Board and Ronald Din Wong, M.D., entered into an Agreed Order requiring Dr. Wong to complete within 90 days the CME required in his 2009 Order for which he is deficient and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Wong did not timely obtain CME required in his 2009 Order and failed to timely pay a \$1,000 administrative penalty required in his 2011 Order.

Inadequate Medical Records

Pittard, Carlton Duwain, M.D., Lic. No. C6476, Grapevine

On June 8, 2012, the Board and Carlton Duwain Pittard, M.D., entered into an Agreed Order requiring Dr. Pittard to have a physician monitor his practice for 12 monitoring cycles, complete within one year 20 hours of CME including 10 hours in medical recordkeeping and 10 hours in risk management. The action was based on Dr. Pittard's failure to maintain adequate medical records for one patient.

Cease and Desist

Mitchell, Roby, Lic. No. H4560 (Cancelled), Amarillo

On May 25, 2012, the Board entered a Cease and Desist Order regarding Roby Mitchell, prohibiting him from acting as, or holding himself out to be, a physician and ordering him to cease and desist from engaging in any practice of medicine. Mr. Mitchell's Texas medical license was revoked in August 2005 for failing to obey a previous Board order. In April 2011, Mr. Mitchell evaluated and treated a patient for metastatic melanoma, after holding himself out as a cancer doctor. Mr. Mitchell prescribed a course of what he described as "Colostrum Bovine Treatment." This treatment involved drawing blood from the patient, and injecting that blood into the udder of a pregnant cow. The patient was then to drink milk from the cow. The patient paid \$2,500 to Mr. Mitchell and \$2,500 to the farmer with the cow. The patient died in hospice before he had the opportunity to drink any of the milk he paid for. The farmer wired back to the patient's family \$2,500; Mr. Mitchell refused to provide a refund.

Rowjee, Roshin A., No License, Lufkin

On May 25, 2012, the Board entered a Cease and Desist Order regarding Roshin A. Rowjee, prohibiting Mr. Rowjee from engaging in the unlicensed practice of medicine in Texas. The action was based on Mr. Rowjee's dispensing medical advice and diagnosis and soliciting payment for these services from patients through the Internet.

Thompson, Stephen Kelly, Lic. No. G2582 (Cancelled), Dallas

On May 25, 2012, the Board entered a Cease and Desist Order regarding Stephen Kelly Thompson, prohibiting Mr. Thompson from engaging in the practice of medicine or referring to himself as “Dr. Stephen Kelly Thompson” without clearly designating that he is not a medical doctor and that he is not licensed to practice medicine in the state of Texas. The Board found Mr. Thompson has been engaging in the unlicensed practice of medicine in Texas, referred to himself as “Dr. Stephen Thompson” in the context of a job interview and that he examined and diagnosed a patient with severe bursitis, administered pain medication and provided a prescription.