



# TEXAS

MEDICAL BOARD  
PHYSICIAN ASSISTANT BOARD  
STATE BOARD OF ACUPUNCTURE EXAMINERS

*Safeguarding the public through professional accountability*

July 2014

## FDA Announcement on Testosterone Therapy

At its May 2014 meeting, the Medical Board discussed the topic of testosterone therapy. The Board wishes to highlight this emerging health care issue, share information about an announcement by the FDA and mention relevant Board rules.

On January 31, 2014, the U.S. Food and Drug Association (FDA) issued a [safety announcement](#) that alerted the public that the FDA is “investigating the risk of stroke, heart attack, and death in men taking FDA-approved testosterone products.” The FDA, which stated that although it had previously been monitoring the risk related to Testosterone products, it decided to “reassess this safety issue based on the recent publication of two separate studies that each suggested an increased risk of cardiovascular events among groups of men prescribed testosterone therapy.”

The safety announcement stresses that the FDA has not concluded that FDA-approved testosterone increases the risk of stroke, heart attack, or death, and that patients should not stop taking prescribed testosterone products without first discussing any questions or concerns with their health care providers. What the FDA safety announcement does mean is that:

- The FDA is studying the issue of increased risk of stroke or heart attack death in men taking FDA-approved testosterone products;
- Health Care professionals should consider whether the benefits of FDA-approved Testosterone treatments is likely to exceed the potential risks of treatment;
- Prescribing information in the drug labels of FDA-approved testosterone products should be followed;
- Testosterone products are FDA-approved only for use in

*(Continued on page 2)*

## Office-Based Anesthesia Inspection Notice

The Medical Board decided during its June meeting that Office-based Anesthesia (OBA) inspections will be put on hold to make clarifications regarding inspection criteria and requirements.

It is important to note the temporary hold on location inspections does not exempt physicians from Board rules governing OBA.

Each physician who provides anesthesia services or performs a procedure for which anesthesia services are provided in an outpatient setting, including the use of analgesics and anxiolytics, must register and pay a fee to the Texas Medical Board. The current fee for office-based anesthesia is a total of \$210, per physician.

In addition, each physician who registers with the TMB for Office-based Anesthesia must identify what level of anesthesia services are provided at each practice site, with some exception for anesthesiologists.

Registration for OBA is combined with the physician biennial registration. If you need to register to provide OBA services between registrations, please contact Pre-Licensure, Registration and Consumer Services at (512) 305-7030, for the proper forms.

For additional information on OBA, please consult [Chapter 192](#) of Board rules and visit the [OBA page](#) on the TMB website.

### *Inside this Issue:*

<a href="#">Articles</a>	<a href="#">2</a>
<a href="#">Board Rule Changes</a>	<a href="#">3-5</a>
<a href="#">Formal Complaints</a>	<a href="#">6-7</a>
<a href="#">Disciplinary Actions</a>	<a href="#">8-24</a>
<a href="#">Licenses Issued</a>	<a href="#">25-35</a>

# FDA Testosterone Therapy Announcement, Cont.

men who lack or have low testosterone in connection with an associated medical condition. Examples of medical conditions include failure of testicles to produce testosterone because of reasons such as genetic problems or chemotherapy. Other examples include problems with the hypothalamus and pituitary, brain structures that control the production of testosterone by the testicles.

- The FDA is urging health care professional and patients to report side effects involving prescription testosterone products to the FDA [MedWatch](#) program.

The Medical Board wishes to stress that potential disciplinary issues with testosterone therapy could arise with the “off-label” use of testosterone if the physician does not provide and obtain proper informed consent for off-label use or if the physician does not discuss the benefits weighed against possible risks of the therapy.

Board rules providing standards for physicians practicing complementary and alternative medicine should be consulted. Chapter 200 of [Board rules](#) requires, in part: patient assessment, disclosure of expected outcomes, risks and benefits of treatment, a documented treatment plan with periodic review, adequate medical records, and therapeutic validity.

## Rules Reminder: Off-line EMS Medical Director

A physician who acts as an off-line medical director for an EMS service in the state of Texas is required to register as such with both the Texas Medical Board and the Texas Department of State Health Services (DSHS).

**As of July 2014, the TMB registration for off-line medical directors is part of the physician biennial registration process.**

An EMS Medical Director is defined in Board rule 197 as: “A physician licensed by the board who is responsible for all aspects of the operation of an EMS system concerning provision of medical care. This physician may also be referred to as the ‘**off-line medical director.**’”

In addition, TMB board rule states that an EMS off-line medical director shall be:

- a physician licensed to practice in Texas and who is registered as an EMS medical director with the Texas Department of State Health Services;
- familiar with the design and operation of EMS systems;
- experienced in prehospital emergency care and emergency management of ill and injured patients;
- actively involved in:
  - ◇ the training and/or continuing education of EMS personnel, under his or her direct supervision, at their respective levels of certification;

- ◇ the medical audit, review, and critique of the performance of EMS personnel under his or her direct supervision;
- ◇ the administrative and legislative environments affecting regional and/or state prehospital EMS organizations;

- knowledgeable about local multi-casualty plans;
- familiar with dispatch and communications operations of prehospital emergency units; and
- knowledgeable about laws and regulations affecting local, regional, and state EMS operations.

Please see [Board rule 197](#) for a complete list of EMS off-line medical director requirements, including registration exceptions by waiver and additional CME requirements.

Information on registration with DSHS as an EMS off-line medical director is available through the Office of EMS/Trauma Systems Coordination at the following link: <http://www.dshs.state.tx.us/emstraumasystems/provfro.shtm>

**Editor’s Note:** *The preceding articles are intended for general guidance only and do not replace the text of Board rules and laws or ensure compliance.*

# Board Rule Changes

*The following rule changes were adopted by the Board during the May and June meetings. After publication in the TX Register, the rules with effective date will be posted on the TMB website: <http://www.tmb.state.tx.us/page/board-rules>*

## MAY 2014

### CHAPTER 175. FEES AND PENALTIES

#### §175.1, Application and Administrative Fees

The amendments to 175.1, relating to Application and Administrative Fees, increases application fees in accordance with the 2014-2015 General Appropriations Act (Senate Bill 1), Texas Medical Board Contingent Revenue Rider 5 (83<sup>rd</sup> Reg. Session).

#### §175.2, Registration and Renewal Fees

The amendments to 175.2, relating to Registration and Renewal Fees, increases registration and renewal fees in accordance with the 2014-2015 General Appropriations Act (Senate Bill 1), Texas Medical Board Contingent Revenue Rider 5 (83<sup>rd</sup> Reg. Session).

### CHAPTER 185. PHYSICIAN ASSISTANTS

#### §185.2, Definitions

The amendments to §185.2, relating to Definitions, added definitions for “military service member,” “military spouse” “military veteran” based on SB0162 (83<sup>rd</sup> Reg. Session) that amended Chapters 55 of the Texas Occupations Code to credit certain verified service, training, or education for applicants with military experience and to create an expedited licensure process for military spouses. Further, clean up changes and a definition for “prescriptive authority agreement” was added based upon the passage of SB406 (83<sup>rd</sup> Reg. Session), which amended Chapter 157 of the Medical Practice Act so that a physician is authorized to delegate to a physician assistant the act of prescribing or ordering a drug or device through a prescriptive authority agreement.

#### §185.4, Procedural Rules for Licensure Applicants

The amendments to §185.4, related to Procedural Rules for Licensure Applicants, adds language to 185.4(f) requiring the Board to notify applicants who meet the definition of a military spouse in writing or by electronic means of license renewal requirements, in accordance with SB0162. Additionally, language is added creating a new subsection (g), which requires crediting certain verified service, training, or education for applicants with military experience, based on the passage of SB0162.

#### §185.10, Physician Assistant Scope of Practice

The amendments to §185.10, relating to Physician Assistant Scope of Practice, makes a correction in the first paragraph of the rule to a reference to the rule’s numbered subsections. Amendments to Subsections (8) and (9) deletes “sign a prescription drug order at a site” and “the signing or completion of a prescription”, and add “or order a drug or device” and “prescribing or ordering a drug or device” to comport with changes made by SB406 to Chapter 157 of the Medical Practice Act, which amends language so that a physician is authorized to delegate the prescribing or ordering of a drug or device rather than signing or completing a prescription.

#### §185.11, Tasks Not Permitted to be Delegated to a Physician Assistant

The amendment to §185.11, relating to Tasks Not Permitted to be Delegated to a Physician Assistant, deletes language referencing site-based prescriptive authority, in accordance with amendments made by SB406 to Chapters 157 and 204 of the Texas Occupation Code.

#### §185.13, Notification of Intent to Practice and Supervise

The amendments to §185.13, relating to Notification of Intent to Practice and Supervise, adds the language “prescriptive authority agreements” and “as applicable,” reflecting changes made by SB406’s amendment of Chapter 157 of the Medical Practice Act authorizing a physician to delegate to a physician assistant the act of prescribing or ordering a drug or device through a prescriptive authority agreement between the physician and the physician assistant.

#### §185.14, Physician Supervision

The amendments to §185.14, relating to Physician Supervision, deletes and adds language in subsection (b) as part of a general cleanup of the rule and adds language requiring a physician assistant to immediately notify his or her supervising physician of any change in licensure status, including, but not limited to a permit expiration, license cancellation, or entry of a disciplinary order. The terms “prescriptive authority agreements” is also added to subsection (d) to comport with changes made by SB406’s amendment of Chapter 157 of the Medical Practice Act authorizing a physician to delegate to a physician assistant the act of prescribing or ordering a drug or device through a prescriptive authority agreement between the physician and the physician assistant.

#### §185.30, Prescriptive Authority Agreements

*(Continued on page 4)*

## Board Rule Changes, Cont.

New section 185.30, titled Prescriptive Authority Agreements, generally, provides that physicians may delegate to a physician assistant acting under adequate physician supervision the act of prescribing or ordering a drug or device through a prescriptive authority agreement, in conformance with Chapter 157 of the Texas Occupations Code and Title 22, Chapter 193 of the Texas Administrative Code, as amended by SB 406.

### **§185.31, Prescriptive Authority Agreements**

New section 185.31, titled Prescriptive Authority Agreements: Minimum Requirements, sets forth minimum requirements for valid prescriptive authority agreements, including requirements for periodic face-to-meetings with the supervising physicians to discuss patient care, to comport with requirements under Chapter 157 of the Texas Occupations Code and Title 22, Chapter 193 of the Texas Administrative Code, as amended by SB406.

### **CHAPTER 187. PROCEDURAL RULES**

#### **§187.35, Presentations of Proposal for Decision**

The amendment to §187.35, relating to Presentation of Proposal for Decision, provides that the ALJ must be given notice of the opportunity to provide to the Board a summation of the proposal for decision, that the ALJ is not required to attend the presentation of the proposal for decision, and that notice may be provided to the ALJ by methods that include facsimile, e-mail, and telephone. Further, language is added referencing final orders.

#### **§187.37, Final Decisions and Final Orders**

The amendment to §187.37, relating to Final Decisions and Orders, adds procedural requirements and definitions for “Final Decision” and “Final Order.” The amendment further provides that the Board may only seek judicial review of an ALJ’s findings and conclusions of law in the form of a Final Decision, that the determination of that appeal is conclusive to both the board and licensee as to the findings of fact and conclusions of law, and that upon resolution of the Board’s appeal, the Board shall determine the charges on the merits and issue a Final Order, the sanctions of which may be appealed by the licensee. The amendment further provides that if the board does not seek judicial review of a Final Decision and issues instead a Final Order, the licensee retains the rights under the APA to appeal the Final Order’s findings of fact, conclusions of law, and the sanctions.

#### **§187.38, Motions for Rehearing**

The amendment to §187.38, relating to Motions for Rehear-

ing, makes references to “Final Order” and “Final Decision” and makes general edits of other language in order to maintain consistency with proposed amendments under §187.37.

### **CHAPTER 189. COMPLIANCE PROGRAM**

#### **§189.4 Limitation on Physician Probationer’s Practice**

The amendment to §189.4, relating to Limitation on Physician Probationer’s Practice, corrects a citation made to §185.2.

### **JUNE 2014**

### **CHAPTER 163. LICENSURE**

#### **§163.4, Procedural Rules for Licensure Applicants**

The Amendments to rule 163.4, relating to Procedural Rules for Licensure Applicants, relocates language located in Rule 187.13(a) to 163.4(d), in order to clarify the licensure process and options for applicants prior to appearing before the licensure committee as well as the procedures followed by the board during such process.

#### **§163.5, Licensure Documentation**

The Amendment to rule 163.5, related to Licensure Documentation, adds language to 163.5(b)(11) to clarify the mechanism by which an applicant can remedy a single deficient U.S. clerkship.

### **CHAPTER 166. PHYSICIAN REGISTRATION**

#### **§166.6, Exemption from Registration Fee for Retired Physician Providing Voluntary Charity Care**

The Amendments to rule 166.6, relating to Exemption from Registration Fee for Retired Physician Providing Voluntary Charity Care, adds language in Section 166.6(g)-(j) which sets forth the process for a retired physician, providing voluntary charity care, to return to active status.

### **CHAPTER 172. TEMPORARY AND LIMITED LICENSES**

#### **§172.5, Visiting Physician Temporary Permit**

The Amendments to rule 172.5, relating to Visiting Physician Temporary Permit, amends 172.5(b)(1)(B) to provide that a Visiting Physician Temporary Permit holder participating in KSTAR must be supervised by a physician that has not been the subject of a disciplinary order, unless administrative in

*(Continued on page 5)*

## Board Rule Changes, Cont.

nature.

### **§172.8, Faculty Temporary License**

The Amendment to rule 172.8, relating to Faculty Temporary License, is amended to provide that an applicant for a Faculty Temporary license is ineligible if they hold a license elsewhere that has been subject to disciplinary action.

## **CHAPTER 184. SURGICAL ASSISTANTS**

### **§184.4, Qualifications for Licensure for Surgical Assistants**

The Amendments to rule 184.4, relating to Qualifications for Licensure for Surgical Assistants, amends language in 184.4(a) (13)(B) in order to correctly identify substantially equivalent surgical assistant programs.

### **§184.16, Discipline of Surgical Assistants**

The Amendment to rule 184.16, related to Discipline of Surgical Assistants, deletes subsection (c) referencing confidential rehabilitative orders, and amends language under subsection (a) so that the Board may enter agreed orders or remedial plans with a surgical assistant.

## **CHAPTER 187. PROCEDURAL RULES**

### **§187.13, Informal Board Proceedings Relating to Licensure Eligibility**

The Amendment to rule 187.13, related to Informal Board Proceedings Relating to Licensure Eligibility, relocates language located in 187.13(a) to 163.4 (Relating to Procedural Rules for Licensure Applicants) in order to organize and group the procedural rules pertaining to the licensure process for an applicant who has been referred to appear before the licensure committee. The Amendment adds a definition for “disciplinary licensure investigation” to 187.13(b). The Amendment adds language to 187.13(c)(1) and (2) which sets forth effect of an applicant who withdraws an application or fails to appear before the licensure committee after being referred and the procedure followed by the Board. Additional Amendments to 187.13(c)(3) and (4) clarify the outcomes relating to an applicant who is offered licensure with terms and conditions and those who are determined ineligible by the licensure committee.

### **§187.24, Pleadings**

The Amendment to rule 187.24, related to Pleadings, adds language to 187.24(b) to set forth the procedure for an applicant to request an appeal of the board’s ineligibility determi-

nation at SOAH and delineates the board’s and applicant’s duties with respect to order of filings. The Amendment further sets forth the effect of an applicant who withdraws their intent to file an appeal at SOAH or fails to timely file the requisite affirmative pleading and the procedure followed by the Board after such events.

### **§187.26, Service in SOAH Proceedings**

The Amendment to rule 187.26, related to Service in SOAH Proceedings, deletes erroneous language relating to the required notice of default as it pertains to licensure cases at SOAH, due to its inapplicability in licensure cases.

### **§187.28, Discovery**

The Amendment to rule 187.28, related to Discovery, adds language to subsection (a) referencing §164.007(d) of the Medical Practice Act and deletes language under 187.28(b)(1) (C) requiring that an expert report be provided in the designation of a testifying expert witness.

### **§187.29, Mediated Settlement Conferences**

The Amendment to rule 187.29, related to Mediated Settlement Conferences, deletes language under 187.29(a)(1) referencing licensure matters.

## **CHAPTER 190. DISCIPLINARY GUIDELINES**

### **§190.8, Violation Guidelines**

The Amendment to rule 190.8, related to Violation Guidelines, amends subsection (L)(iii)(II) so that physicians are not required to establish a professional relationship prior to prescribing dangerous drugs for a patient’s close contacts if the physician diagnoses the patient with one or more of the listed infectious diseases. The amendments further add language defining a close contact and requiring that the physician document the treatment in medical record related to the patient connected to the close contact. The amendments delete language allowing a physician to provide such prophylactic treatment only in the case in which the patient has an illness determined by the Centers for Disease Control and Prevention, the World Health Organization, or the Governor’s Office to be pandemic, and limits the exception to the provision of dangerous drugs.

### **§190.14, Disciplinary Sanction Guidelines**

The Amendment to rule 190.14, related to Disciplinary Sanction Guidelines, amends the range and scope of sanctions for violations of the Medical Practice Act.



# Formal Complaints

Name	Lic. No.	Date Filed	Allegations
<b>Cazares-Zavala, Jose, M.D., El Paso</b>	D8679	3/28/14	Professional incompetence resulting in removal, suspension, limitation of hospital privileges, or other disciplinary action.
<b>Saetrum, Brent Bjorn, M.D., Santa Rosa, CA</b>	K4994	3/31/14	Disciplinary action taken in another state related to improper prescribing.
<b>Packard, Stanton Clark, M.D., Dallas</b>	J6641	4/1/14	Failure to meet the standard of care, non-therapeutic prescribing; improper operation of a pain management clinic; inadequate supervision of midlevels, and inadequate medical records.
<b>Smith, Raleigh Arnold, III, M.D., Aransas Pass</b>	F4547	4/1/14	Unprofessional conduct resulting in removal, suspension, limitation of hospital privileges, or other disciplinary action.
<b>Wimmer, Patrick Jeffrey, M.D., Bedford</b>	J2418	4/4/14	Failure to comply with prior Board Order.
<b>Pisharodi, Madhava A.P., M.D., Brownsville</b>	G0796	4/11/14	Failure to meet the standard of care; prescribing or administering a drug or treatment that is nontherapeutic in nature or non-therapeutic in the manner the drug or treatment is administered or prescribed.
<b>Alnajjar, Mohammed R., M.D., El Paso</b>	K9981	4/23/14	Failure to meet the standard of care, non-therapeutic prescribing, and inadequate medical records.
<b>Simmons, Jason Levon, M.D., Bronx, NY</b>	N4103	4/29/14	Failure to comply with prior Board Order.
<b>Hall, Rahn Garner, M.D., Houston</b>	G2981	5/7/14	Failure to meet the standard of care; nontherapeutic prescribing; improper operation of a pain management clinic; inadequate medical records; failure to follow Board rules.
<b>Hill, Alice Vela, P.A., Houston</b>	PA03877	5/7/14	Failure to meet the standard of care; non-therapeutic prescribing; failure to follow Board guidelines for treatment of pain and inadequate medical records.
<b>Cruz, Ramon Apostol, M.D., Denton</b>	K3703	5/8/14	Unprofessional conduct; criminal indictment related to illegal prescribing.

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## Formal Complaints, Cont.

Name	Lic. No.	Date Filed	Allegations
Abrams, David Paul, D.O., Houston	K7960	5/9/14	Failure to meet the standard of care; unprofessional conduct; nontherapeutic prescribing; failure to adequately supervise midlevels; improper delegation of professional medical responsibility or acts; and inadequate medical records.
Trevino, James Gregory, M.D., San Antonio	J7292	5/13/14	Unprofessional conduct; failure to comply with Board rules; and failure to cooperate with Board staff.
Husaini, Innad Hasan, M.D., Cleveland	K6006	5/22/14	Failure to meet the standard of care, non-therapeutic prescribing, improper operation of a pain management clinic, failure to adequately supervise midlevels, failure to follow Board guidelines for treatment of pain and inadequate medical records.
Saqer, Rezik A., M.D., Houston	K2282	5/23/14	Failure to meet the standard of care, unprofessional conduct, improper billing, and inadequate medical records.
Duru, Ella, P.A., Houston	PA07794	5/27/14	Failure to meet the standard of care; unprofessional conduct; nontherapeutic prescribing; improper operation of a pain management clinic; and inadequate medical records.
Ravichandran, Guruswami K., M.D., Houston	F3588	5/27/14	Failure to meet to the standard of care; nontherapeutic prescribing; unprofessional conduct; and inadequate medical records.
Gross, Robert Hadley, M.D., San Angelo	G5152	5/29/14	Failure to meet the standard of care; unprofessional conduct; and inadequate medical records.
Yi, Zanhua, M.D., Houston	N9666	6/17/14	Failure to meet the standard of care; unprofessional conduct; inadequate medical records.
James, Kevin Bernard, M.D., Southlake	M4201	6/24/14	Failure to meet the standard of care; unprofessional conduct; improper billing; and inadequate medical records.
Washington, Ronald J., M.D., Dallas	E1172	7/9/14	Failure to meet the standard of care; non-therapeutic prescribing; improper operation of a pain management clinic; failure to follow Board guidelines for the treatment of pain; unprofessional conduct; and inadequate medical records.

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## Disciplinary Actions

*The following disciplinary actions have been taken since the previous bulletin was issued. To read previous bulletins and news releases, visit: <http://www.tmb.state.tx.us/page/news>*

### TEMPORARY SUSPENSION/RESTRICTION

#### **Bittle, Charles Carroll, M.D., Lic. No. H0184, Tahoka**

On April 22, 2014, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the Texas medical license of Charles Carroll Bittle, M.D., after determining his continuation in the practice of medicine would constitute a continuing threat to the public welfare. The suspension was effective immediately. The Board found Dr. Bittle, was a continuing threat due to inappropriate prescribing of controlled substances to multiple patients. A temporary suspension hearing with notice will be held as soon as practicable with 10 days' notice to Dr. Bittle, unless the hearing is specifically waived by Dr. Bittle. The temporary suspension remains in place until the Board takes further action.

#### **Chong, Soo Young, M.D., Lic. No. N5626, Houston**

On June 16, 2014, a disciplinary panel of the Texas Medical Board temporarily suspended, with notice, the Texas medical license of Soo Young Chong, M.D., after determining his continuation in the practice of medicine would constitute a continuing threat to the public welfare. The suspension was effective immediately. The Board panel found Dr. Chong's continued practice of medicine, including assisting a mid-level provider in the improper operation of a pain management clinic, and including the method and manner in which controlled substances were prescribed, pose a continuing threat to public welfare. The temporary suspension remains in place until the Board takes further action.

#### **De Leon, Oscar, M.D., Lic. No. P1287, Grand Prairie**

On June 12, 2014, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the Texas medical license of Oscar De Leon, M.D., after determining his continuation in the practice of medicine would constitute a continuing threat to the public welfare. The suspension was effective immediately. The Board panel found Dr. De Leon on May 29, 2014 was arrested by the City of Dallas Police Department pursuant to allegations of violations of Texas Penal Code Section 21.11, Indecency with a Child, a second degree felony offense. The panel found based on his arrest, Dr. De Leon is a continuing threat and a real danger to the health of his patients or to the public. A temporary suspension hearing with notice will be held as soon as practicable with 10 days' notice to Dr. De Leon, unless the hearing is specifically waived by Dr. De Leon. The temporary suspension remains in place until the Board takes further action.

#### **Joselevitz, Joel, M.D., Lic. No. J1703, Houston**

On June 19, 2014, a disciplinary panel of the Texas Medical Board temporarily restricted, with notice, the Texas medical

license of Joel Joselevitz, M.D., after determining his continuation in the unrestricted practice of medicine poses a threat to public welfare. The restriction was effective immediately. The restriction prohibits Dr. Joselevitz from prescribing Schedules II - V. The temporary restriction was based on the panel's findings that Dr. Joselevitz's care and treatment of 17 pain patients demonstrate a pattern of practice of substandard care and non-therapeutic prescribing. The temporary restriction remains in place until the Board takes further action.

#### **Sauceda, Francisco Basil, M.D., Lic. No. H8375, Falfurrias**

On June 12, 2014, a disciplinary panel of the Texas Medical Board temporarily suspended, with notice, the Texas medical license of Francisco Basil Saucedo, M.D., after determining his continuation in the practice of medicine would constitute a continuing threat to the public welfare. The suspension was effective immediately. The Board panel found Dr. Saucedo is unable to safely practice medicine with reasonable skill and safety due to abuse of drugs or other substances that could endanger a patient's life. The temporary suspension remains in place until the Board takes further action.

#### **Smith, Barlow, M.D., Lic. No. F9026, Marble Falls**

On April 3, 2014, a disciplinary panel of the Texas Medical Board temporarily suspended, with notice, the Texas medical license of Barlow Smith, M.D., after determining his continuation in the practice of medicine poses a continuing threat to public welfare. The suspension was effective immediately. On November 6, 2013, the Drug Enforcement Administration (DEA) and Texas Medical Board staff raided Dr. Smith's office. During the raid, the DEA and Board staff found 13 pre-signed official prescription blanks in his office. Dr. Smith's staff acknowledged that he kept pre-signed official prescription blanks in his office. As a result of the information obtained during the raid, Dr. Smith was indicted on January 7, 2014, on three felony counts: two related to fraudulent delivery of controlled substances for DEA Schedules III/IV/V drugs and one related to fraudulent delivery of controlled substances for DEA Schedule II drugs. During the course of the investigation, Board staff obtained charts for 12 patients which were reviewed by an expert who found numerous, serious standard of care violations, including: the prescription of controlled substances and dangerous drugs without adequate medical workups and without justification; prescription of various medications without first obtaining medical history or performing a physical examination; prescription of several drugs that would cause a negative interaction with medications the patient was already taking; and failure to order labs and review lab work even when it was clearly indicated. The temporary suspension remains in place until the Board takes further action.

#### **Suarez, Laura A., M.D., Lic. No. H2819, San Antonio**

On April 22, 2014, a disciplinary panel of the Texas Medical Board temporarily suspended, without notice, the Texas medical



license of Laura A. Suarez, M.D., after determining her continuation in the practice of medicine would constitute a continuing threat to the public welfare. The suspension was effective immediately. The Board found Dr. Suarez is unable to safely practice medicine due to abuse of substances, including alcohol. A temporary suspension hearing with notice will be held as soon as practicable with 10 days' notice to Dr. Suarez, unless the hearing is specifically waived by Dr. Suarez. The temporary suspension remains in place until the Board takes further action.

## QUALITY OF CARE

### **Aggarwal, Ajay, M.D., Lic. No. J7879, Bay City**

On June 27, 2014, the Board and Ajay Aggarwal, M.D., entered into an Agreed Order requiring Dr. Aggarwal to limit his interventional pain management procedures to those procedures he is currently performing, specifically: lumbar epidural steroid injections, cervical epidural steroid injections, joint injections, SI joint injections, tailbone coccyx injections, median branch blocks, and radio frequency lumbar and cervical nerve ablation, using the visual aids he is currently employing; maintain one midlevel provider at each of his practice sites at any time he is performing procedures; have his practice monitored by another physician for consecutive monitoring cycles until this term is modified or terminated; and within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Aggarwal did not use proper diligence in his practice and did not adequately document his treatment of multiple patients, including documenting history for suboxone patients and the medical necessity for the treatment of patients with interventional treatments.

### **Aguilera, R. Juan, M.D., Lic. No. E2966, Edinburg**

On June 27, 2014, the Board and R. Juan Aguilera, M.D., entered into an Agreed Order requiring Dr. Aguilera to within one year complete at least eight hours of CME in risk management. The Board found Dr. Aguilera's employee discharged a patient prior to the completion of the 20 minute waiting period following an allergy shot. The patient had an adverse reaction that required an emergency room visit and hospitalization. Dr. Aguilera's employee administered an incorrect dosage of the shot possibly leading to the adverse reaction.

### **Alvarez, Flavio Humberto, M.D., Lic. No. K4849, San Antonio**

On June 27, 2014, the Board and Flavio Humberto Alvarez, M.D., entered into an Agreed Order requiring Dr. Alvarez to have his practice monitored by another physician for four consecutive monitoring cycles; and within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours of risk management. The Board found Dr. Alvarez failed to sufficiently indicate that an order of 10mmol potassium phosphate to be administered intravenously to a patient had been updated to 20 mmol. This resulted in the nurse and the pharmacist reading the order as "120 mmol" rather than "20 mmol." The resulting death of the patient was caused by a

system failure at the hospital, in that neither the pharmacist nor the nurse questioned the extremely unusual order for 120 mmol of potassium phosphate.

### **Ariyo, Adeniran A., M.D., Lic. No. L4224, Dallas**

On May 2, 2014, the Board and Adeniran A. Ariyo, M.D., entered into a Mediated Agreed Order requiring Dr. Ariyo to within one year complete at least 16 hours of CME, divided as follows: eight hours in defibrillator indications/surgical technique/troubleshooting complications and eight hours in medical recordkeeping ; and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Ariyo failed to appropriately interpret the signs indicating the misplacement of the lead following a pacemaker placement procedure. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

### **Bader, Elliot, M.D., Lic. No. F0129, DeSoto**

On June 27, 2014, the Board and Elliot Bader, M.D., entered into an Agreed Order on Formal Filing, subjecting Dr. Bader to the following terms and conditions: shall not perform any type of surgical procedures, limiting Dr. Bader's practice to non-surgical procedures and shall appear before a Board panel should he desire to return to performing surgery; and shall obtain an assessment of his practice of medicine by the Texas A&M Health Science Center Rural and Community Health Institute (K-STAR) prior to requesting an appearance before a panel of this Board. The Board found Dr. Bader failed to meet the standard of care in treatment of one patient. Specifically, Dr. Bader performed a laparoscopic cholecystectomy that led to an unplanned nephrectomy. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

### **Blair, Donald Levester, Jr., M.D., Lic. No. H4171, Dallas**

On June 27, 2014, the Board and Donald Levester Blair, Jr., M.D., entered into an Agreed Order requiring Dr. Blair to within one year complete at least 16 hours of CME, divided as follows: eight hours in handling high-risk obstetrics cases and eight hours in risk management. The Board found Dr. Blair failed to appropriately evaluate and treat a patient's high blood sugar, and signed another patient's electronic medical record without notifying the physician in his practice who was the patient's primary care physician of the abnormal glucose test results in the record. The patient's primary care physician discovered the abnormal results and followed up with the patient.

### **Beene, Ronda Lawaine, D.O., Lic. No. J1871, Dallas**

On May 2, 2014, the Board and Ronda Lawaine Beene, D.O., entered into an Agreed Order requiring Dr. Beene to within a year complete at least 18 hours of CME, divided as follows: eight hours in medical records, four hours in risk management, and six hours in adult sepsis (evaluation/diagnosis/treatment); and issue a written apology to the family of the patient within 90 days. The Board found Dr. Beene's medical records were not adequate and that Dr. Beene admitted to failing to follow up on the clinical presentation of the patient.

**Fraser, Ronald Leo, M.D., Lic. No. E7929, Houston**

On May 2, 2014, the Board and Ronald Leo Fraser, M.D., entered into an Agreed Order on Formal Filing restricting Dr. Fraser under the following terms and conditions: shall not perform any surgery; practice shall be limited to office consultations, non-invasive office diagnostic procedures, and trigger point injections; shall not treat chronic pain patients; shall not prescribe any Schedule II drugs for any purpose; within 14 days surrender DEA/DPS controlled substances registration certificates; not prescribe any controlled substances, except for patients who have had orthopedic or spinal surgical procedures within three weeks of the patient's office visit with Dr. Fraser and shall not be permitted to prescribe any controlled substances to these patients for a period of more than 14 days; not prescribe refills or authorize approval of refills of controlled substances; must have a chaperone who is able to directly observe Dr. Fraser when performing a physician examination of a female patient; not be permitted to supervise and/or delegate prescriptive authority to physician assistants and/or advanced practice nurses; abstain from prohibited substances, except as prescribed by another physician for legitimate and document therapeutic purposes; submit to an independent medical evaluation and follow all recommendations for care and treatment. The Board found Dr. Fraser prescribed controlled substances for Patient A, Patient B and himself in a non-therapeutic manner and failed to maintain adequate medical records regarding his care and treatment of Patient A, Patient B and himself. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Hale, Samuel A., Jr. M.D., Lic. No. F6700, Lubbock**

On May 2, 2014, the Board and Samuel A. Hale, Jr., M.D., entered into an Agreed Order requiring Dr. Hale to within one year complete at least four hours of CME in risk management. The Board found Dr. Hale during the course of an eye exam, negligently administered hemocult fixator drops instead of Tetracaine drops into the patient's left eye when he selected the wrong bottle of drops.

**Holland, Scott Woodrow, M.D., Lic. No. M2351, Gilmer**

On May 2, 2014, the Board and Scott Woodrow Holland, M.D., entered into a Mediated Agreed Order requiring Dr. Holland to within one year complete at least 28 hours of CME, divided as follows: four in risk management, eight hours in medical recordkeeping and 16 hours in management of pediatric emergencies (including infectious diseases). The Board found Dr. Holland discharged a patient without adequately assessing or treating the patient's symptoms of sepsis. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Isom, Matthew James, M.D., Lic. No. M4196, Katy**

On May 2, 2014, the Board and Matthew James Isom, M.D., entered into an Agreed Order requiring Dr. Isom to within one year complete at least 16 hours of CME, divided as follows: eight hours in risk management and eight hours in high-risk pregnancy management. The Board found Dr. Isom failed to admit and monitor two patients who both had adverse post-partum events that led to their maternal deaths. The order makes no finding

regarding the causes of those maternal deaths.

**Khouw, Raymond S., M.D., Lic. No. G3516, Dallas**

On May 2, 2014, the Board and Raymond S. Khouw, M.D., entered into an Agreed Order requiring Dr. Khouw to within a year complete at least 16 hours in CME, divided as follows: eight hours in appropriate supervision and delegation skills and eight hours in post-operative management. The Board found Dr. Khouw failed to provide a personal post-operative visit prior to discharging patients in each case and that his failure to do so amounted to a lack of professional diligence.

**Kohli, Nandini Dhir, M.D., Lic. No. L2969, Austin**

On June 27, 2014, the Board and Nandini Dhir Kohli, M.D., entered into an Agreed Order publicly reprimanding Dr. Kohli and requiring Dr. Kohli to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; and within one year complete at least 16 hours of CME, divided as follows: eight hours in diagnosis and management of pulmonary emboli and eight hours in reactive airway disease. The Board found Dr. Kohli failed to treat a patient's complaints of persistent chest tightness and shortness of breath, failed to monitor the patient's medications properly, and failed to keep adequate medical records for the patient.

**Miranda, Hernan Emilio, M.D., Lic. No. N0984, Amarillo**

On June 27, 2014, the Board and Hernan Emilio Miranda, M.D., entered into an Agreed Order requiring Dr. Miranda to have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 20 hours of CME, divided as follows: eight hours in risk management, eight hours in medical recordkeeping, and four hours in evaluation, treatment and diagnosis of adult liver disease; pay an administrative penalty of \$3,000 within 60 days; and Dr. Miranda shall not engage in locum tenens work. The Board found Dr. Miranda's diagnosis of "hepatic tumor with porcelain gallbladder" in a patient was not medically supported and he failed to adequately document the basis of this diagnosis and his recommendation for future diagnostic testing based on the suspicion of porcelain gallbladder and hepatic tumor. Dr. Miranda lacked diligence in his approach to the treatment of the patient; failed to maintain adequate medical records for the patient; and was terminated by the medical center where he worked as a locum tenens physician.

**Mitchell, Thomas Alexander, M.D., Lic. No. G1721, Plano**

On May 2, 2014, the Board and Thomas Alexander Mitchell, M.D., entered into an Agreed Order requiring Dr. Mitchell to within one year complete at least 12 hours of CME, divided as follows: eight hours in risk management and four hours in physician patient communication; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Mitchell failed to respond immediately and evaluate an acute patient that had suffered an apparent stroke, and that Dr. Mitchell admitted that he should have responded sooner.

**Nelson, Jane Carolyn, M.D., Lic. No. J9238, Austin**

On May 2, 2014, the Board and Jane Carolyn Nelson, M.D., entered into an Agreed Order requiring Dr. Nelson to complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in evaluating diseases of the breast. The Board found Dr. Nelson failed to document that she discussed risks and benefits of surgery or the patient's concerns about options. Dr. Nelson stated that she did discuss the option of a tissue diagnosis with the patient, but admitted that documentation of her discussions with the patient about options for evaluating the discharge and the patient's concerns was lacking.

**Saucedo, Juan, D.O., Lic. No. J2303, Eagle Pass**

On May 2, 2014, the Board and Juan Saucedo, D.O., entered into an Agreed Order publicly reprimanding Dr. Saucedo and requiring Dr. Saucedo to have his practice monitored by another physician for eight consecutive monitoring cycles; and within one year complete at least 8 hours of CME in recognizing and treating surgical complications. The Board found Dr. Saucedo violated the standard of care by failing to appropriately address the patient's complications resulting from a C-Section, specifically the patient's acute hemorrhaging; failed to adequately document the patient's condition upon arrival to the hospital, including the patient's vitals and amount of blood loss; failed to exercise diligence by failing to timely call in a consultant obstetrician to treat the patient's acute hemorrhaging; and in late 2012, Dr. Saucedo was subject to peer review action where the patient was seen and delivered.

**Weaver, Robert Anthony, M.D., Lic. No. H6694, Houston**

On May 2, 2014, the Board and Robert Anthony Weaver, M.D., entered into an Agreed Order publicly reprimanding Dr. Weaver and imposing the following terms and conditions: restriction from treating patients in the area of oncology, except in the context of a clinical research organization; permission to supervise and delegate prescriptive authority to a physician assistant, advanced practice nurse and/or supervise a surgical assistant except those who treat oncology patients; within one year complete at least eight hours of in-person CME, divided as follows: four hours in informed consent and four hours in ethics; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Weaver failed to meet the standard of care in his treatment of one patient by implementing multiple therapies, which had insufficient evidence of clinical efficacy and high probability of additive toxicities; failed to obtain adequate informed consent from the patient in both the clinical trial and, subsequently, as a private patient; and Dr. Weaver did not adequately inform the patient of all risks, benefits, and alternative treatments.

**Yentis, Richard David, M.D., Lic. No. D5333, Fort Worth**

On June 27, 2014, the Board and Richard David Yentis, M.D., entered into an Agreed Order requiring Dr. Yentis to have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete the medical recordkeeping course offered by the University of California San Diego

Physician Assessment and Clinical Education (PACE) program; within one year complete at least 16 hours of CME, divided as follows: eight hours in identifying drug seeking behavior, and eight hours in risk management; and pay an administrative penalty of \$5,000 within 60 days. The Board found Dr. Yentis prescribed drugs, including Xanax and Adderall, both of which have high risk of abuse, to a patient with a known addiction, and confirmed diagnoses of ADHD (attention deficit hyperactivity disorder) and anxiety, increased the above dosages throughout the patient's treatment but did not adequately document the rationale for the increased dosages, failed to document the results of drug screens that he performed on the patient in his medical records, and failed to obtain previous medical records from treatment programs. The Board also found that for a second patient, Dr. Yentis prescribed Xanax and Ritalin without adequately documenting the second patient's mental status and/or evaluation for such treatment.

**UNPROFESSIONAL CONDUCT**

**Anderson, Charles C., M.D., Lic. No. J6854, Tulsa, OK**

On May 2, 2014, the Board and Charles C. Anderson, M.D., entered into an Agreed Order on Formal Filing prohibiting Dr. Anderson from practicing in Texas until he has petitioned the Board and appears before the Board to provide sufficient evidence that he is physically, mentally, and otherwise competent to safely practice; and within seven days surrender his DEA/DPS controlled substances registration certificates. The Board found Dr. Anderson did not respond to Board staff's correspondence regarding an investigation that was opened as a result of Dr. Anderson reporting on his annual registration he had surrendered his Drug Enforcement Administration registration. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Anderson, Timothy W., M.D., Lic. No. F5819, Houston**

On June 27, 2014, the Board and Timothy W. Anderson, M.D., entered into an Agreed Order requiring Dr. Anderson to within six months complete at least eight hours of in-person CME, divided as follows: four hours in risk management and four hours in medical ethics; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Anderson failed to obtain the hours required within the time set out in his 2012 Order. Dr. Anderson has since completed the eight pre-approved hours.

**Buford, Reginald, M.D., Lic. No. H8593, Houston**

On May 1, 2014, the Board approved a Final Order requiring Reginald Buford, M.D., to within one year complete at least 25 hours of CME, divided as follows: 10 hours in medical recordkeeping, 10 hours in CPT code billing, and five hours in ethics; have his billing practices monitored by a billing monitor for four consecutive monitoring cycles; and pay an administrative penalty of \$5,000 within 60 days. The Board found Dr. Buford in connection with his performance of surgeries and billing under CPT Code 11471, submitted billing statements that he knew or should have known were improper and failed to maintain medi-

cal records to support the billing for CPT code 15734. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Buford has 20 days from the service of the order to file a motion for rehearing.

**Brener, Daniel Michael, M.D., Lic. No. E2479, Houston**

On May 2, 2014, the Board and Daniel Michael Brener, M.D., entered into an Agreed Order requiring Dr. Brener to within one year and three attempts pass the Medical Jurisprudence Exam; and within one year complete the professional boundaries course offered by Vanderbilt University or the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Brener engaged in non-sexual professional boundaries violations with the patient by engaging in numerous phone calls with the patient outside of office hours; by repeatedly hugging the patient; and by disclosing significant amounts of personal information to the patient.

**Christian, Lewis S., M.D., Lic. No. E4254, Uvalde**

On May 2, 2014, the Board and Lewis S. Christian, M.D., entered into an Agreed Order publicly reprimanding Dr. Christian and requiring Dr. Christian to within one year complete at least 12 hours of in-person CME, divided as follows: four hours in medical recordkeeping, four hours in risk management, and four hours in ethics; within one year and three attempts pass the Medical Jurisprudence Exam; and pay an administrative penalty of \$2,500 within 60 days. The Board found Dr. Christian admitted to improperly prescribing to himself and to family members, failed to complete required CME classes in 2012, and provided false information to the Board about his completed CME credits.

**Collins, Timothy M., D.O., Lic. No. J7454, Arlington**

On July 18, 2014, the Board and Timothy M. Collins, D.O., entered into an Agreed Order publicly reprimanding Dr. Collins and suspending Dr. Collins' Texas medical license; staying the suspension and placing Dr. Collins on probation for 6 months under the following terms: reapply to the Drug Enforcement Agency (DEA) and the Texas Department of Public Safety (DPS) to obtain controlled substance registration for Schedules IV and V only; have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete at least 24 hours of CME, divided as follows: eight hours in ethics, eight hours in medical recordkeeping, and eight hours in pain management; and within one year and three attempts pass the Medical Jurisprudence Exam. The Board found Dr. Collins engaged in unprofessional conduct by soliciting financial assistance from a patient, failed to cooperate with Board staff, and maintained medical records that did not have adequate medical evidence to support controlled substance prescriptions to multiple patients.

**Ellis, Jaishree Riva, M.D., Lic. No. M9998, Spring**

On May 2, 2014, the Board and Jaishree Riva Ellis, M.D., entered into an Agreed Order publicly reprimanding Dr. Ellis and sus-

pending Dr. Ellis' medical license; staying the suspension and placing Dr. Ellis on probation for 10 years under the following terms: within 30 days submit to an evaluation by the Physician Health Program; not possess, administer, dispense, or prescribe any controlled substances or dangerous drugs with addictive potential or potential for abuse, with the exception of prescribing such drugs post-operatively for seven days, without refills, for treatment of OB/GYN patients in a hospital setting or ambulatory surgery center for OB/GYN surgical procedures; not treat or otherwise serve as a physician for herself, immediate family, and shall not prescribe, dispense, administer or authorize medication, including but not limited to controlled substances or dangerous drugs with addictive potential or potential for abuse to Dr. Ellis or Dr. Ellis' friends, immediate family or others in which there is a close personal relationship; within one year and three attempts pass the Medical Jurisprudence Exam; and pay an administrative penalty of \$3,000 within 180 days. The Board found Dr. Ellis admitted to writing false and fictitious prescriptions for controlled substances over a number of years and diverting those medications for her own use and admitted that she was an addict.

**Fischer, Charles Henry, M.D., Lic. No. G6438, Austin**

On May 2, 2014, the Board and Charles Henry Fischer, M.D., entered into an Agreed Order on Formal Filing continuing a prior suspension of Dr. Fischer's license until such time as he personally 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. Fischer, on January 22, 2013, was arrested in a public park for public lewdness after officers witnessed him engaging in sex acts with another person in a wooded area. In addition, Dr. Fischer remains involved in another criminal proceeding related to sexual misconduct with a minor. If Dr. Fischer is found guilty, by a plea; plea agreement or by a judge or jury, or if he enters into an agreement involving deferred adjudication, for the pending criminal matters he will immediately voluntarily and permanently surrender his license to practice medicine in Texas. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Gao, Xing, M.D., Lic. No. 43973, El Paso**

On May 2, 2014, the Board and Xing Gao, M.D., entered into an Agreed Order requiring Dr. Gao to within one year complete at least 24 hours of CME, divided as follows: eight hours in risk management, eight hours in physician patient communication, and eight hours in communication with colleagues; and pay an administrative penalty of \$2,000 within 60 days. The Board found there were issues concerning Dr. Gao's actions based on allegations of misusing equipment, behavioral conduct and various incidents involving poor communication at University Medical Center in El Paso.

**Gardner, Lisa Liberty, D.O., Lic. No. L9698, Fort Worth**

On June 27, 2014, the Board and Lisa Liberty Gardner, D.O., entered into an Agreed Order requiring Dr. Gardner to pay an administrative penalty of \$1,000 within 90 days. The Board

found Dr. Gardner failed to timely respond to Board staff's inquiries regarding the completion of CME hours required by her November 30, 2012 Remedial Plan.

**Killyon, Garry W., M.D., Lic. No. M2673, Sugar Land**

On May 1, 2014, the Board approved a Final Order requiring Garry W. Killyon, M.D., to within one year complete at least 25 hours of CME, divided as follows: 10 hours in medical record-keeping, 10 hours in CPT code billing, and five hours in ethics; have his billing practices monitored by a billing monitor for four consecutive monitoring cycles; and pay an administrative penalty of \$5,000 within 60 days. The Board found Dr. Killyon in connection with his performance of surgeries and billing under CPT Code 11471, submitted billing statements that he knew or should have known were improper and failed to maintain medical records to support the billing for CPT code 15734. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Killyon has 20 days from the service of the order to file a motion for rehearing.

**Krantz, Jeffrey S., M.D., Lic. No. J7343, El Paso**

On May 2, 2014, the Board and Jeffrey S. Krantz, M.D., entered into an Agreed Order requiring Dr. Krantz to within 30 days submit to a psychiatric evaluation and follow any and all recommendations for care and treatment; and within one year complete at least four hours of CME in ethics. The Board found Dr. Krantz engaged in a pattern of domestic violence and inappropriate displays of anger over a period of time and failed to timely report his 2002 arrest and plea to the Board.

**Mongare, Job B., M.D., Lic. No. K8954, Athens**

On May 2, 2014, the Board and Job B. Mongare, M.D., entered into a Mediated Agreed Order requiring Dr. Mongare to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 12 hours of CME, divided as follows: eight hours in physician-patient boundaries and four hours in ethics; and pay an administrative penalty of \$1,500 within 60 days. The Board found Dr. Mongare entered into a personal friendship with a female patient that raised concerns as to the boundaries of an appropriate physician-patient relationship. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Murcia, Jamie Daniel, M.D., Lic. No. J4661, Plainview**

On June 27, 2014, the Board and Jamie Daniel Murcia, M.D., entered into a Mediated Agreed Order requiring Dr. Murcia to have a chaperone present anytime he performs a physical examination on a female patient or performs a physical examination on any patient where a female family member of the patient is present; for two years, make his medical records available for inspection by the Compliance Division of the Board; within one year complete the Maintaining Proper Boundaries course offered by the Santé Institute of Professional Education and Research through the University of Texas Southwestern Medical Center; and within one year and three attempts pass the Medi-

cal Jurisprudence Exam. The Board found Dr. Murcia engaged in sexually inappropriate behavior towards a patient, a patient's family member, and two employees. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Patzakis, Nick John, D.O., Lic. No. C7410, Houston**

On May 2, 2014, the Board and Nick John Patzakis, D.O., entered into an Agreed Order revoking Dr. Patzakis' medical license; staying the revocation and placing Dr. Patzakis on probation for 10 years under the following terms: shall not be permitted to delegate prescriptive authority to a physician assistant or advanced practice nurse and shall not be permitted to supervise a physician assistant or an advanced practice nurse; shall not serve as a medical director of a home health care agency or emergency management services agency; within one year and three attempts pass the Medical Jurisprudence Exam; and within one year complete at least 16 hours of CME, divided as follows: eight hours in ethics and eight hours in risk management. The Board found Dr. Patzakis was initially convicted of a felony for providing false statements relating to health care matters, in violation of Title 18, United States Code, §§1035 and 2.

**Pucillo, Ronald Michael, M.D., Lic. No. G2207, Sugar Land**

On June 27, 2014, the Board and Ronald Michael Pucillo, M.D., entered into an Agreed Order publicly reprimanding Dr. Pucillo and requiring him to have a chaperone present when performing a physician examination on a female patient; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete at least eight hours of CME in ethics; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Pucillo admitted to having sexual encounters with a patient in May and June of 2013.

**Rizo-Patron, Carlos, M.D., Lic. No. J9303, Lubbock**

On June 27, 2014, the Board and Carlos Rizo-Patron, M.D., entered into a Mediated Agreed Order requiring Dr. Rizo-Patron to within one year and three attempts pass the Medical Jurisprudence Exam; and within one year complete at least 14 hours of CME, divided as follows: six hours in anger management and eight hours in ethics. The Board found Dr. Rizo-Patron engaged in unprofessional conduct by verbally abusing other licensees and staff members at his workplace. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Roberts, Dennis Donald, M.D., Lic. No. M6362, Woodville**

On June 27, 2014, the Board and Dennis Donald Roberts, M.D., entered into an Agreed Order publicly reprimanding Dr. Roberts and requiring Dr. Roberts to within ten days present proof to the Board that he has cured his student loan default with Texas Guaranteed Student Loan Corporation. The Board found Dr. Roberts defaulted on his Texas Guaranteed Student Loan Corporation Loan and was still in default at the time of the ISC hearing.



**Villacres, David F., M.D., Lic. No. H7099, Kingwood**

On June 27, 2014, the Board and David F. Villacres, M.D., entered into an Agreed Order publicly reprimanding Dr. Villacres and requiring him to have a chaperone present anytime he performs a physical examination on a female patient; within one year complete the professional boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 16 hours of CME, divided as follows: eight hours of ethics and eight hours of medical recordkeeping; and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Villacres engaged in inappropriate behavior with a patient on or about May 9, 2009 by exposing his genitalia to a female patient in an exam room during the course of treatment. Dr. Villacres subsequently employed the patient as an assistant in his clinic and entered into an inappropriate relationship with the patient.

**REVOCATION****Allen, David Daniel, M.D., Lic. No. H6007, McKinney**

On May 1, 2014, the Board approved a Final Order revoking David Daniel Allen, M.D.'s Texas medical license. The Board found Dr. Allen failed to meet the standard of care with regards to two patients by improperly prescribing controlled substances, and failing to maintain adequate medical records. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Allen has 20 days from the service of the order to file a motion for rehearing.

**Alvear, Joel, M.D., Lic. No. L1514, Katy**

On May 1, 2014, the Board approved a Final Order revoking Joel Alvear, M.D.'s Texas medical license. The Board found Dr. Alvear engaged in nontherapeutic prescribing of controlled substances to six patients; and violated the Board's standards for medical recordkeeping. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Alvear has 20 days from the service of the order to file a motion for rehearing.

**Leong, Daniel K., D.O., Lic. No. G1462, Plano**

On June 27, 2014, the Board approved a Final Order revoking Daniel K. Leong, D.O.'s Texas medical license. The Board found Dr. Leong pleaded guilty to one felony count of Conspiracy to Commit Health Care Fraud and was sentenced to 48 months of imprisonment, followed by one year of supervised release. Dr. Leong is currently incarcerated following his conviction. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Leong has 20 days from the service of the order to file a motion for rehearing.

**Mosig, David A., D.O., Lic. No. H2623, Nacogdoches**

On May 2, 2014, the Board approved a Final Order revoking David A. Mosig, M.D.'s Texas medical license. The Board found Dr. Mosig pleaded guilty to the federal felony offense of making a false statement on a federal income tax return. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Mosig has 20 days from the service of the order to file a motion for rehearing.

**Nwora, Emmanuel Mbanefo, M.D., Lic. No. M2428, Houston**

On May 1, 2014, the Board approved a Final Order revoking Emmanuel Mbanefo Nwora, M.D.'s Texas medical license. The Board found Dr. Nwora pleaded guilty to one felony count of conspiracy to commit health care fraud and entered into a formal plea arrangement. On November 22, 2013, Dr. Nwora's conviction for a felony count of health care fraud became final, and the U.S. District Court sentenced him to 25 months' incarceration to begin immediately. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Nwora has 20 days from the service of the order to file a motion for rehearing.

**Shin, David Joseph, M.D., Lic. No. F4523, Houston**

On May 1, 2014, the Board approved a Final Order revoking David Joseph Shin, M.D.'s Texas medical license. The Board found Dr. Shin was involved in the operation of an illegally registered pain management clinic that as owned, in whole or part, by a person who did not have a license to practice medicine in Texas. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Shin has 20 days from the service of the order to file a motion for rehearing.

**Swate, Tommy Ernest, M.D., Lic. No. E3781, Houston**

On May 1, 2014, the Board approved a Final Order revoking Tommy Ernest Swate, M.D.'s Texas medical license. The Board found Dr. Swate failed to meet the standard of care in his treatment of 10 patients for chronic pain; that his prescribing or treatment was nontherapeutic with respect to five of these patients; failed to take action in response to warning signs that patients were misusing or diverting medications and that he continued prescribing medications to these patients despite abnormal drug screens and other aberrant behavior; and failed to maintain adequate medical records. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Swate has 20 days from the service of the order to file a motion for rehearing.

**Whitefield, Barrett Doyle, D.O., Lic. No. L1495, Odessa**

On May 1, 2014, the Board approved a Final Order revoking Barrett Doyle Whitefield, D.O.'s Texas medical license. The Board

found on May 6, 2013, Dr. Whitefield pleaded guilty to the federal Class A felony offense of Conspiracy to Possess with Intent to Distribute and Distribute 500 Grams or More of a Mixture and Substance Containing a Detectable Amount of Methamphetamine and 50 Grams or More of Methamphetamine Actual; and a Quality of a Mixture and Substance Containing a Detectable Amount of Hydrocodone. Dr. Whitefield was sentenced to federal prison for 87 months, to be followed by five years of supervised release. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Whitefield has 20 days from the service of the order to file a motion for rehearing.

## **VOLUNTARY REVOCATION**

### **Bianchi, Anthony Steven, M.D., Lic. No. K1161, Fallbrook, CA**

On June 27, 2014, the Board and Anthony Steven Bianchi, M.D., entered into an Agreed Order of Revocation, revoking Dr. Bianchi's Texas Medical license and requiring him to immediately cease practice in Texas. Dr. Bianchi agreed to the revocation of his license in lieu of further disciplinary proceedings. The Board found on December 20, 2013, Dr. Bianchi entered into a Stipulated Settlement and Disciplinary Order with the Medical Board of California, suspending Dr. Bianchi for 30 days and then placing him on probation for five years during which he may not treat female patients. This action was based on unprofessional conduct with two female patients.

### **Covington, Karl K., M.D., Lic. No. G9083, Houston**

On June 27, 2014, the Board and Karl G. Covington, M.D., entered into an Agreed Order of Voluntary Revocation, revoking Dr. Covington's Texas medical license and requiring him to immediately cease practice in Texas. Dr. Covington agreed to the revocation of his license in lieu of further disciplinary proceedings. The Board found Dr. Covington pled guilty to the second degree felony offense of engaging in organized criminal activity, which resulted in an Order of Deferred Adjudication, which placed him on community supervision for five years. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

### **Gorman, Mary, M.D., Lic. No. H3249, Austin**

On June 27, 2014, the Board and Mary Gorman, M.D., entered into an Agreed Voluntary Revocation Order, revoking Dr. Gorman's Texas medical license and requiring her to immediately cease practice in Texas. Dr. Gorman agreed to the revocation of her license in lieu of further disciplinary proceedings. The Board found Dr. Gorman, on multiple occasions, prescribed controlled substances to a close personal friend while she was not on duty at the hospital. Dr. Gorman admitted that she committed the violations and stated that she continued to violate her 2011 Order. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

### **Lockett, Edgar A., M.D., Lic. No. H4020, Amarillo**

On May 2, 2014, the Board and Edgar A. Lockett, M.D., entered into an Agreed Order of Revocation, revoking Dr. Lockett's Texas medical license and requiring him to immediately cease practice in Texas. Dr. Lockett agreed to the revocation of his license in lieu of further disciplinary proceedings. The Board found Dr. Lockett was convicted on six counts of federal income tax evasion in the U.S. District Court for the Northern District of Texas, Amarillo Division.

### **Padron, Nicolas Alfonso, M.D., Lic. No. H2662, Dallas**

On May 2, 2014, the Board and Nicolas Alfonso Padron, M.D., entered into an Agreed Voluntary Revocation Order, revoking Dr. Padron's Texas medical license and requiring him to immediately cease practice in Texas. Dr. Padron agreed to the revocation of his license in lieu of further disciplinary proceedings. The Board found Dr. Padron was indicted on October 1, 2012, for his role in a scheme to defraud Medicare and later pled guilty to one charge of conspiracy to commit health care fraud.

### **Ramsey, Edward Earl, Jr., M.D., Lic. No. J6679, Houston**

On June 27, 2014, the Board and Edward Earl Ramsey, Jr., M.D., entered into an Agreed Order of Revocation, revoking Dr. Ramsey's Texas medical license and requiring him to immediately cease practice in Texas. Dr. Ramsey agreed to the revocation of his license in lieu of further disciplinary proceedings. Dr. Ramsey was under investigation by the Board for allegations that include failure to meet the standard of care, nontherapeutic prescribing, failure to adequately supervise delegates, and operation of an illegal pain management clinic.

### **Randecker, Harold Herman, Jr., M.D., Lic. No. J3195, Lake Stevens, WA**

On May 2, 2014, the Board and Harold Herman Randecker, Jr., M.D., entered into an Agreed Order of Revocation, revoking Dr. Randecker's Texas medical license and requiring him to immediately cease practice in Texas. Dr. Randecker agreed to the revocation of his license in lieu of further disciplinary proceedings. The Board found Dr. Randecker was convicted of making false statements under oath during a bankruptcy hearing, a Class C felony offense.

### **Saetrum, Brent Bjorn, M.D., Lic. No. K4994, Santa Rosa, CA**

On June 27, 2014, the Board and Brent Bjorn Saetrum, M.D., entered into an Agreed Order of Revocation, revoking Dr. Saetrum's Texas Medical license and requiring him to immediately cease practice in Texas. Dr. Saetrum agreed to the revocation of his license in lieu of further disciplinary proceedings. The Board found on April 8, 2013, the Medical Board of California revoked Dr. Saetrum's California medical license, stayed the revocation, and placed Dr. Saetrum on probation with suspension. This action was based on Dr. Saetrum's diversion of controlled substances for his own personal use by writing fictitious prescriptions.

## **VOLUNTARY SURRENDER**

### **Bittle, Charles Carroll, M.D., Lic. No. H0184, Tahoka**

On June 27, 2014, the Board and Charles Carroll Bittle, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Bittle agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings and requiring Dr. Bittle to immediately cease practice in Texas. Dr. Bittle was currently suspended from practicing medicine in the state of Texas, after the Board entered an Order of Temporary Suspension on April 22, 2014, related to Dr. Bittle's nontherapeutic prescribing to seven patients.

### **Harris, Michael Justin, M.D., Lic. No. M3574, Los Angeles, CA**

On June 27, 2014, the Board and Michael Justin Harris, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Harris agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings and requiring Dr. Harris to immediately cease practice in Texas. The Board found Dr. Harris is currently under investigation for allegations related to his self-report of a DUI in the state of California, non-compliance with the Texas Physician Health Program (PHP), and a Consent Order entered by the Arizona Medical Board.

### **Holliday, James Glen, D.O., Lic. No. D2791, Dallas**

On May 2, 2014, the Board and James Glen Holliday, D.O., entered into an Agreed Order of Voluntary Surrender in which Dr. Holliday agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Holliday was under investigation regarding allegations that he failed to follow the standard of care in treating an additional patient by providing a courtesy thyroid prescription.

### **Huq, Nisar Mikail, M.D., Lic. No. M0761, Amarillo**

On June 27, 2014, the Board and Nisar Mikail Huq, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Huq agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings and requiring Dr. Huq to immediately cease practicing in Texas. The Board found Dr. Huq on January 23, 2014, signed an Undertaking with the College of Physicians and Surgeons of Ontario (CPSO) voluntarily restricting his practice to non-invasive/non-interventional cardiology in an ambulatory clinical setting. Dr. Huq reported to the Board that he has a medical condition which precludes him from practicing medicine with reasonable skill and safety to patients.

### **Marmell, Howard, M.D., Lic. No. E4892, Houston**

On May 2, 2014, the Board and Howard Marmell, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Marmell agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Marmell failed to comply with the terms and conditions of his 2012 Order.

### **Pierce, Samuel Joel, M.D., Lic. No. H9473, San Antonio**

On May 2, 2014, the Board and Samuel Joel Pierce, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr.

Pierce agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Pierce pled guilty to health care fraud, a felony, in United States District Court, Western District in San Antonio, Texas. As part of the probation requirement, Dr. Pierce was ordered to surrender his Texas medical license.

### **Robinson, Herbert Joel, M.D., Lic. No. D5568, Windcrest**

On June 27, 2014, the Board and Herbert Joel Robinson, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Robinson agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings and requiring Dr. Robinson to immediately cease practice in Texas. Dr. Robinson was under investigation for allegations of non-therapeutic prescribing and failure to meet the standard of care in relation to several patients.

### **Smith, Michael, M.D., Lic. No. F4545, South Padre Island**

On May 2, 2014, the Board and Michael Smith, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Smith agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. Dr. Smith was under investigation for allegations related to his failure to comply with an Agreed Order entered by the Board on October 10, 2008, and subsequently modified in 2010 and 2011.

### **Szumlas, Rick Allen, M.D., Lic. No. L3154, Seneca, SC**

On May 2, 2014, the Board and Szumlas, Rick Allen, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Szumlas agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Szumlas has reported that he has a medical condition which precludes him from practicing medicine with reasonable skill and safety.

### **Wimmer, Patrick, M.D., Lic. No. J2418, Bedford**

On June 27, 2014, the Board and Patrick Wimmer, M.D., entered into an Agreed Voluntary Surrender Order in which Dr. Wimmer agreed to voluntarily surrender his Texas medical license in lieu of further disciplinary proceedings and requiring Dr. Wimmer to immediately cease practice in Texas. Dr. Wimmer was under investigation for allegations related to his failure to comply with his June 14, 2013 Order. Dr. Wimmer reported to the Board that he has a medical condition which precludes him from practicing medicine with reasonable skill and safety to patients. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

## **SUSPENSION**

### **Ahmed, Yassar I., M.D., Lic. No. M5611, Houston**

On June 27, 2014, the Board and Yassar I. Ahmed, M.D., entered into an Agreed Order of Voluntary Suspension, suspending Dr. Ahmed's Texas medical license until such a time as he requests in writing to have the suspension stayed or lifted, appears be-

fore the Board and provides clear and convincing evidence that he is physically, mentally, and otherwise competent to safely practice medicine. Such evidence and information shall include at a minimum, but shall not be limited to the following: complete and final resolution of any and all criminal charges and investigations that are currently pending, or any charges that may be brought as a result of the allegations in the findings. The Board found Dr. Ahmed, on or about May 22, 2014, was arrested in Montgomery County, Texas and charged with two counts of online solicitation of a minor. Dr. Ahmed has not been indicted or convicted of the charges and remains involved in criminal proceedings that are ongoing with no estimated time of completion.

**Stigler, Del Barker, M.D., Lic. No. E4703, Caldwell**

On May 2, 2014, the Board and Del Barker Stigler, M.D., entered into an Agreed Order of Suspension, suspending Dr. Stigler's Texas medical license until such a time as he requests in writing to have the suspension stayed or lifted, 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. Stigler was arrested for driving while intoxicated in relation to a single vehicle accident, received 12 months deferred adjudication but failed to abide by the terms of his probation, was arrested for public intoxication and arrested two more times on warrants based on Motions to Revoke Probation. Dr. Stigler has indicated he has a physical and/or mental condition that may impact his ability to safely practice medicine.

**Vance, Carol Klett, M.D., Lic. No. F7253, Idaho Falls, ID**

On June 27, 2014, the Board and Carol Klett Vance, M.D., entered into an Agreed Order of Suspension, suspending Dr. Vance's Texas medical license until such a time as she requests in writing to have the suspension stayed or lifted, 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. Vance is currently being investigated by the Idaho State Board of Medicine for impairment that may impede her ability to safely and effectively practice medicine. In view of the actions by the Idaho State Board of Medicine, Dr. Vance agreed to the voluntary suspension of her license to practice medicine in the state of Texas.

**TERMINATION OF SUSPENSION**

**Herring, Theodore M., Jr., M.D., Lic. No. E2228, Houston**

On May 2, 2014, the Board and Theodore Herring, Jr., M.D., entered into an Agreed Order Terminating the Order Suspending Dr. Herring's Texas medical license and prohibiting Dr. Herring from performing abortion procedures until he has provided sufficient evidence to the Compliance Division of the Board, and received notice from the Board that the evidence is sufficient, that he has obtained admitting privileges at a hospital that provides obstetric or gynecological healthcare services located within 30 miles of the location where he will perform abortion procedures.

The Board found Dr. Herring performed abortion procedures at a facility but did not hold active admitting privileges at a hospital providing obstetrical or gynecological health care services no further than 30 miles from the facility. This Order supersedes the previous Temporary Suspension Order.

**CRIMINAL ACTIVITY**

**O'Neal, Don Martin, M.D., Lic. No. E2769, Sulphur Springs**

On May 1, 2014, the Board approved a Final Order publicly reprimanding Don Martin O'Neal, M.D., and requiring Dr. O'Neal to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 16 hours of CME in ethics; and pay an administrative penalty of \$10,000 within 60 days. The Board found Dr. O'Neal pled guilty to a first degree felony of misapplication of fiduciary property and was placed on deferred adjudication under community supervision for that offense. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. O'Neal has 20 days from the service of the order to file a motion for rehearing.

**PEER REVIEW ACTIONS**

**Rath, Albert Ernest, M.D., Lic. No. D7264, New Braunfels**

On May 2, 2014, the Board and Albert Ernest Rath, M.D., entered into a Mediated Agreed Order requiring Dr. Rath to within one year complete at least 12 hours of CME, divided as follows: eight hours in risk management and four hours in ethics; and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Rath performed sterilization by tubal ligation on one patient without obtaining proper informed consent from the patient and Dr. Rath was the subject of peer review action at the hospital where he performed the tubal ligation in question. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Santos, Alejandro, M.D., Lic. No. H1725, Austin**

On June 27, 2014, the Board and Alejandro Santos, M.D., entered into an Agreed Order requiring Dr. Santos to pay an administrative penalty of \$1,000 within 120 days. The Board found Dr. Santos' privileges were terminated by University General Hospital in Dallas for practicing medicine with an expired and/or delinquent Texas medical license.

**Virlar, Jesus Alfredo, M.D., Lic. No. L7592, San Antonio**

On June 27, 2014, the Board and Jesus Alfredo Virlar, M.D., entered into an Agreed Order publicly reprimanding Dr. Virlar and requiring him to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 24 hours of CME, divided as follows: eight hours in risk management, eight hours in ethics and eight hours in professional communications; and pay an administrative penalty of \$5,000 within 180 days. The Board found Dr. Virlar was the subject of discipli-

nary action by peers at Methodist Healthcare System which resulted in Dr. Virilar's membership and clinical privileges being revoked.

## OTHER STATES' ACTIONS

### **Basco, Michael Angelo, M.D., Lic. No. H5151, Frederick, MD**

On June 27, 2014, the Board and Michael Angelo Basco, M.D., entered into an Agreed Order publicly reprimanding Dr. Basco. In addition, Dr. Basco shall not practice medicine in Texas until such a time as he requests in writing to have the suspension stayed or lifted, appears before the Board and provides clear and convincing evidence that he is physically, mentally, and otherwise competent to safely practice medicine. Dr. Basco shall comply with all terms of the Order entered by the Maryland Board of Physicians. The Board found on May 29, 2013, the Maryland Board of Physicians entered an Order of Summary Suspension of License to Practice Medicine against Dr. Basco.

### **Bohman, Van Reid, M.D., Lic. No. H3228, Las Vegas, NV**

On June 27, 2014, the Board and Van Reid Bohman, M.D., entered into an Agreed Order requiring Dr. Bohman to within one year complete at least six hours of CME in medical recordkeeping and ethics; and pay an administrative penalty of \$1,500 within 90 days. The Board found Dr. Bohman was disciplined by the Nevada State Board of Medical Examiners after being the subject of a medical malpractice suit that was dismissed with prejudice and inadequate medical recordkeeping in regard to one patient.

### **Burkett, David Scott, M.D., Lic. No. K7675, Monroe, LA**

On May 2, 2014, the Board and David Scott Burkett, M.D., entered into an Agreed Order prohibiting Dr. Burkett from practicing in Texas until he has petitioned the Board and appears before the Board to provide sufficient evidence that he is physically, mentally, and otherwise competent to safely practice. The Board found Dr. Burkett was suspended and subsequently disciplined by the Louisiana State Board of Medical Examiners as a result of Dr. Burkett violating the terms of his agreement during his evaluation for chemical dependency with the Louisiana Physicians Health Program.

### **DeSantis, James Michael, M.D., Lic. No. P1452, Marietta, GA**

On May 2, 2014, the Board and James Michael DeSantis, M.D., entered into an Agreed Order requiring Dr. DeSantis to comply with this Order and any terms and conditions imposed by the Georgia Composite Medical Board and the State of Alabama Medical Licensure Commission. The Board found Dr. DeSantis had his license to practice medicine suspended by the Georgia Composite Medical Board and the State of Alabama Medical Licensure Commission due to allegations of impairment caused by the intemperate use of alcohol or drugs.

### **Gaddis, Todd Donavon, M.D., Lic. No. P3152, Aubrey**

On June 27, 2014, the Board and Todd Donavon Gaddis, M.D., entered into an Agreed Order requiring Dr. Gaddis to provide

the Board evidence of full compliance with the terms and conditions of the Louisiana State Board of Medical Examiners' Consent Order entered against Dr. Gaddis on September 23, 2013. The Board found Dr. Gaddis was disciplined by the Louisiana State Board of Medical Examiners following allegations that Dr. Gaddis violated Louisiana telemedicine rules.

### **Khan, Humaira V., M.D., Lic. No. J5677, Ft. Lauderdale, FL**

On May 2, 2014, the Board and Humaira V. Khan, M.D., entered into an Agreed Order requiring Dr. Khan to within one year complete at least eight hours of CME in risk management; and pay an administrative penalty of \$3,000 within 120 days. The Board found Dr. Khan was disciplined by the State of Florida Board of Medicine for standard of care violations related to one patient, and inadequate medical records.

### **Schilling, Paul Joseph, M.D., Lic. No. H6584, Gainesville, FL**

On June 27, 2014, the Board and Paul Joseph Schilling, M.D., entered into an Agreed Order requiring Dr. Schilling to within one year complete at least eight hours of CME in risk management; and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Schilling entered into a Settlement Agreement with the Florida Board of Medicine (FBM). The terms of the agreement included a Letter of Concern, \$7,500 administrative fine, completion of 15 hours of CME, and the requirement to present a one hour seminar addressing brachytherapy quality assurance. On December 20, 2013 the FBM issued a Final Order accepting the Settlement Agreement.

## FAILURE TO PROPERLY SUPERVISE OR DELEGATE

### **Abbate, Robert, D.O., Lic. No. N4873, Dallas**

On May 2, 2014, the Board and Robert Abbate, D.O., entered into a Mediated Agreed Order requiring Dr. Abbate to within one year complete at least 16 hours of CME, divided as follows: eight hours in supervision of mid-level providers and eight hours in medical recordkeeping; and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Abbate failed to adequately document his supervision of his nurse practitioner, including his efforts to instruct her as to appropriate chronic pain treatment protocols and the nurse practitioner refused to modify her treatment of the patients to conform to Dr. Abbate's protocols and failed to improve her medical record keeping pursuant to Dr. Abbate's instructions. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

### **Erickson, Carl Frederick, M.D., Lic. No. H2361, San Antonio**

On June 27, 2014, the Board and Carl Frederick Erickson, M.D., entered into an Agreed Order requiring Dr. Erickson within one year complete at least 10 hours of CME in risk management, including two hours in supervision of mid-level providers and delegation; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Erickson did not take adequate measures to verify the license status of a physician assistant that was under his supervision.



**Rocha, Ricardo A., M.D., Lic. No. D3385, Dallas**

On June 27, 2014, the Board and Ricardo A. Rocha, M.D., entered into an Agreed Order publicly reprimanding Dr. Rocha and requiring him to within 90 days submit copies of his office protocols for delegation and/or supervision processes and procedures to the Board; within one year complete at least 20 hours of CME, divided as follows: eight hours in risk management, eight hours in ethics and four hours in recordkeeping; and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Rocha improperly supervised and allowed an unlicensed individual to practice medicine and failed to keep adequate medical records.

**Simmons, Clyde W., Jr. M.D., Lic. No. D7303, Humble**

On May 2, 2014, the Board and Clyde W. Simmons, Jr., M.D., entered into an Agreed Order requiring Dr. Simmons to not engage in the practice of treating chronic pain; not prescribe controlled substances, except to post-operative patients for a period of no more than seven days from the date of surgery; within one year and three attempts pass the Medical Jurisprudence Exam; and within one year complete at least eight hours of CME in medical ethics. The Board found Dr. Simmons failed to adequately supervise his mid-level practitioner, Linda Lin, APN, who failed to maintain adequate medical records and failed to meet the standard of care in treatment and prescribing to 15 patients.

**Walker, Richard W., Jr., M.D., Lic. No. G0641, Houston**

On June 27, 2014, the Board and Richard W. Walker, Jr., M.D., entered into an Agreed Order on Formal Filing, requiring Dr. Walker to complete the following terms and conditions: have his practice monitored by another physician for eight consecutive monitoring cycles; within one year complete at least 12 hours of CME, divided as follows: four hours in medical recordkeeping, four hours in medical ethics and four hours in pain management; and pay an administrative penalty of \$2,500 within 60 days. The Board found Dr. Walker failed to adequately supervise non-licensed clinic staff while serving as the medical director of a clinic. Specifically, the staff placed facsimiles of Dr. Walker's signature on unauthorized prescriptions for controlled substances issued to five patients without Dr. Walker's knowledge. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**NON-THERAPEUTIC PRESCRIBING****Clark-Reed, Monica Andrea, M.D., Lic. No. M7120, Houston**

On May 2, 2014, the Board and Monica Andrea Clark-Reed entered into an Agreed Order on Formal Filing requiring Dr. Clark-Reed to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 10 hours of CME in risk management; within seven days request modification of DEA/DPS controlled substances registrations to eliminate Schedules II, III, and IV; and pay an administrative penalty of \$2,000 within 90 days. The Board found that although Dr. Clark-Reed was not the initial physician for the patients when she joined the practice in 2009, she was an integral part of perpetu-

ating prescriptions of controlled substances non-therapeutically. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Echols-Elliott, Sabrina Marie, M.D., Lic. No. K9261, Houston**

On May 2, 2014, the Board and Sabrina Marie Echols-Elliott, M.D., entered into a Mediated Agreed Order requiring Dr. Echols-Elliott to within seven days request modification of her DEA/DPS controlled substances registration certificates to eliminate Schedule II and III; be prohibited from prescribing all opioids and benzodiazepines regardless of DEA classification and prescribing carisoprodol; not treat chronic pain patients; not delegate prescriptive authority to a physician assistant or advanced practice nurse, but may supervise a physician assistant or advanced practice nurse for other medical acts delegated to them by Dr. Echols-Elliott; have her practice monitored by another physician for eight consecutive monitoring cycles; within one year complete the physician prescribing course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in risk management; and pay an administrative penalty of \$1,500 within 120 days. The Board found Dr. Echols-Elliott failed to adequately supervise her midlevel providers that provided care and treatment for patients at CJ Medical Clinic which was owned and operated by Dr. Echols-Elliott, medical records for the patients treated at CJ Medical Clinic revealed that treatment was below the standard of care, patients were non-therapeutically prescribed medications that included controlled substances, and were inconsistent with Board rules establishing the requirements for adequate medical records. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Ng, Federico Roman, M.D., Lic. No. J6623, San Antonio**

On May 2, 2014, the Board and Federico Roman Ng, M.D., entered into an Agreed Order requiring Dr. Ng to have his practice monitored by another physician for eight consecutive monitoring cycles; complete the physician-patient boundaries course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year complete at least 28 hours of CME, divided as follows: eight hours in medical recordkeeping, eight hours in identifying drug-seeking behaviors, eight hours in risk management, and four hours in ethics; and pay an administrative penalty of \$1,000 within 90 days. The Board found Dr. Ng prescribed controlled substances to himself and individuals in a close personal relationship to himself without appropriately establishing a physician-patient relationship; prescribed substances to two patients, his girlfriend at the time, and his girlfriend's son, beyond the 72-hour period of immediate need; prescribed controlled substances to himself on two occasions, and violated the standard of care by treating patients in close personal relationship to himself without maintaining adequate medical records or referring those patients to their own physicians.

## INAPPROPRIATE PRESCRIBING

### **Lee, Robert Louis, M.D., Lic. No. K0511, Granbury**

On June 27, 2014, the Board and Robert Louis Lee, M.D., entered into an Agreed Order requiring Dr. Lee to within one year complete at least 12 hours of CME, divided as follows: eight hours in risk management and four hours in ethics; and pay an administrative penalty of \$1,000 within 90 days. The Board found Dr. Lee prescribed Darvocet to his girlfriend without conducting a proper physical examination and without making a proper medical record.

### **Tarango, Gabriel, D.O., Lic. No. N5429, San Antonio**

On June 27, 2014, the Board and Gabriel Tarango, D.O., entered into an Agreed Order requiring Dr. Tarango to within one year and three attempts pass the Medical Jurisprudence Exam; comply with any and all recommendations made by the Texas Physician Health Program (TxPHP); and not reregister or otherwise obtain DEA or DPS Controlled Substances Registration Certificates without authorization from the Board. The Board found Dr. Tarango was self-prescribing Alprazolam with a different doctor's DEA number and that he voluntarily surrendered his DPS and DEA Controlled Substance Registration Certificates. The Board found Dr. Tarango entered into an in-patient treatment program and signed a contract with the TXPHP on August 5, 2013. Dr. Tarango is in compliance with TXPHP currently and does not have a controlled substance registration.

## VIOLATION OF PRIOR ORDER

### **Howie, David Ian, M.D., Lic. No. H2472, Cleveland**

On June 27, 2014, the Board and David Ian Howie, M.D., entered into an Agreed Order Modifying Prior Order requiring Dr. Howie to submit to the Compliance Division of the Board letters from up to three physicians who are board certified in psychiatry and who agreed to serve as Dr. Howie's approved treating psychiatrist and follow the treating psychiatrist's recommendations for care and treatment. Failure to comply shall constitute a violation of the Agreed Order and Board representatives may direct the Executive Director to immediately suspend Dr. Howie's Texas medical license. The Board found Dr. Howie is not in compliance with his December 2013 Order. Specifically, Dr. Howie has failed to timely provide letters from three board certified psychiatrists who agree to serve as his treating psychiatrist.

### **Judd, Kathryn, D.O., Lic. No. M8065, San Antonio**

On May 2, 2014, the Board and Kathryn Judd, D.O., entered into an Agreed Order requiring Dr. Judd to pay an administrative penalty of \$1,000 within 60 days and making public the Confidential Agreed Licensure Rehabilitation Order entered on September 5, 2007, and the Agreed Order Modifying Confidential Agreed Licensure Rehabilitation Order entered on November 30, 2012. All terms as modified and attached to this Order remain in effect.

### **Koch, Justin Lee, M.D., Lic. No. M7339, Lake Charles, LA**

On May 2, 2014, the Board and Justin Lee Koch, M.D., entered

into a Mediated Agreed Order prohibiting Dr. Koch from practicing medicine in Texas until he meets the following requirements: request permission in writing to resume practice in Texas; personally appear before the Board to orally petition for permission to resume practice in Texas; and provide clear and convincing evidence that he is physically, mentally, and otherwise competent to safely practice medicine. The Order also requires Dr. Koch to maintain full compliance with all terms of the Louisiana Physicians Health Program contract; maintain full compliance with all terms of the Texas Physician Health Program contract; and comply with all terms and conditions of his Louisiana State Board of Medical Examiners' Consent Order. The Board found Dr. Koch violated the Agreed Order he entered into with the Texas Medical Board on November 9, 2009, when he failed to abstain from the consumption of alcohol. Dr. Koch was under investigation for his role as a supervising physician at a pain management clinic in Texas and for failing to supervise midlevel providers at that clinic. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

### **Le, Richard Allen, M.D., Lic. No. L0372, Houston**

On May 2, 2014, the Board and Richard Allen Le, M.D., entered into an Agreed Order requiring Dr. Le to pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Le violated his prior order because he did not obtain the CME hours required within the time set out in the order.

### **Mann, Christopher Rolan, D.O., Lic. No. H2559, Fort Worth**

On June 27, 2014, the Board and Christopher Rolan Mann, D.O., entered into an Agreed Order requiring Dr. Mann to within one year and three attempts pass the Medical Jurisprudence Exam and within seven days provide a sworn affidavit to the Board that he has completed referrals of all chronic pain patients. The Board found Dr. Mann violated his 2013 Order by continuing to treat chronic pain patients that he was unable to refer within 30 days as required by the Order.

### **Quintana, Oscar Francisco, M.D., Lic. No. K5672, Houston**

On May 2, 2014, the Board and Oscar Francisco Quintana, M.D., entered into an Agreed Order requiring Dr. Quintana to undergo an independent medical evaluation and follow any and all recommendations for care and treatment. The Board found Dr. Quintana violated his 2004 Order, as modified, by testing positive for EtG/EtS, indicating he may have consumed alcohol in violation of the abstention provision of his order.

## VIOLATION OF BOARD RULES

### **Chang, Peter Ping-Chung, M.D., Lic. No. G8044, San Angelo**

On July 28, 2014, the Board and Peter Ping-Chung Chang, M.D., entered into an Agreed Order prohibiting Dr. Chang from treating patients for chronic pain, or engaging in the practice of pain management; requiring Dr. Chang to have his practice monitored by another physician for 12 consecutive monitoring cycles; within one year complete at least 24 hours of CME, divided as follows: eight hours in medical recordkeeping, eight hours in risk management and eight hours in treatment of chronic pain;

and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Chang failed to adequately document his clinical rationale for his treatment of and prescribing to multiple chronic pain patients, and failed to keep adequate medical records with respect to his treatment of these patients.

**Keepers, Jerry M., M.D., Lic. No. G1453, Friendswood**

On May 2, 2014, the Board and Jerry M. Keepers, M.D., entered into an Agreed Order requiring Dr. Keepers to within one year complete at least four hours of CME in risk management; and within one year and three attempts pass the Medical Jurisprudence Exam. The Board found Dr. Keepers failed to maintain adequate tracking logs related to controlled substances and failed to adequately secure controlled substances.

**Mack, William Harold, M.D., Lic. No. D3923, Houston**

On May 2, 2014, the Board and William Harold Mack, M.D., entered into an Agreed Order requiring Dr. Mack to within 30 days furnish the Board's Executive Director copies of delegation orders and protocols related to the EMS companies for which Dr. Mack is serving as Medical Director; within one year complete at least 16 hours of CME, divided as follows: 12 hours in EMS medical direction and four hours in risk management; and within one year complete the required 24 hours of CME regarding Dr. Mack's license renewal period of 2011 and 2013, with at least two of the CME hours in medical ethics and/or professional responsibility, as required by Board rules. The Board found Dr. Mack failed to adequately supervise the EMS companies under his supervision, failed to notify the Board at the time of his registration of his position of medical director for numerous EMS companies, failed to meet additional educational requirements for physicians serving as off-line directors of EMS companies, failed to obtain a waiver for holding a position as off-line medical director for more than 20 EMS companies, made attempts to inform DSHS of his intent to terminate his relationship with several EMS companies, but did not comply with the rules of such reporting, and failed to meet his annual CME requirements by failing to take 24 hours of Category I CME within the last year.

**Warfield, Brett Henry, M.D., Lic. No. L9003, Houston**

On June 27, 2014, the Board and Brett Henry Warfield, M.D., entered into a Mediated Agreed Order requiring Dr. Warfield to within 30 days, provide the Board a copy of the consent forms he provides to all patients he treats with anesthesia procedures/care; within one year complete at least eight hours of CME in risk management; and pay an administrative penalty of \$500 within 60 days. The Board found Dr. Warfield failed to obtain the consent necessary to formalize the treatment provided and to document that a doctor-patient relationship had been established. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**TEXAS PHYSICIAN HEALTH PROGRAM (PHP)**

**VIOLATION**

**Davis, Randy J., D.O., Lic. No. N2053, Arlington**

On June 27, 2014, the Board and Randy J. Davis, D.O., entered into an Agreed Order requiring Dr. Davis to within 30 days submit to and obtain an independent medical evaluation and follow all recommendations for care and treatment; continue participating in Alcoholics Anonymous or similar approved program; continue participating in the activities of a county or state medical society committee on physician health and rehabilitation, including participation in weekly meetings, if any; abstain from the consumption of prohibited substances; and participate in the Board's drug testing program. The Board found Dr. Davis was referred back to the Board from the Texas Physician Health Program (TXPHP) following concerns with his overall program compliance and apparent lapse in his sobriety. Dr. Davis' history and poor compliance with TXPHP warrants an order requiring that he participate in the Board's monitoring program. Due to Dr. Davis' violation of his confidential agreement with TXPHP, his past participation in the program is no longer confidential.

**Klima, Eva, M.D., Lic. No. H9227, Carrollton**

On May 2, 2014, the Board and Eva Klima, M.D., entered into an Agreed Order requiring Dr. Klima to within 30 days submit to an evaluation by the Texas Physician Health Program and comply with any and all recommendations; not treat or otherwise serve as a physician for herself, immediate family, and shall not prescribe dispense, administer or authorize controlled substances or dangerous drugs with addictive potential or potential for abuse to Dr. Klima or Dr. Klima's immediate family, with the exception of drugs prescribed by another physician for legitimate medical purposes and in compliance with the orders and directions of such physician; within one year and three attempts pass the Medical Jurisprudence Exam; and within one year complete at least eight hours of CME in ethics. The Board found Dr. Klima was referred back to the Board from the Texas Physician Health Program for non-compliance after testing positive for prohibited substances.

**INADEQUATE MEDICAL RECORDS**

**Bruce, Lena Rochelle, M.D., Lic. No. H6081, Santa Fe**

On May 2, 2014, the Board and Lena Rochelle Bruce, M.D., entered into an Agreed Order requiring Dr. Bruce to have her practice monitored by another physician for four consecutive monitoring cycles; and within one year complete at least 16 hours of CME, divided as follows: four hours in medical recordkeeping, eight hours in pain management and four hours in identifying drug seeking behavior. The Board found Dr. Bruce's documentation of her treatment of patients was inadequate and did not accurately reflect her thought process and treatment decisions, and Dr. Bruce failed to meet the Board's guidelines for the treatment of chronic pain related to documentation of treatment.

**McClain, Gregory Dewayne, M.D., Lic. No. N3408, Columbia, MD**

On May 2, 2014, the Board and Gregory Dewayne McClain, M.D., entered into an Agreed Order requiring Dr. McClain to complete at least eight hours of CME, divided as follows: four hours in medical recordkeeping and four hours in risk management. The Board found Dr. McClain failed to adequately document his treatment of three patients.

**Pham, Chi Manh, M.D., Lic. No. G1993, Houston**

On June 27, 2014, the Board and Chi Manh Pham, M.D., entered into a Mediated Agreed Order requiring Dr. Pham to have his practice monitored by another physician for six consecutive monitoring cycles; and within one year complete at least 18 hours of in-person CME, divided as follows: 18 hours in medical recordkeeping, with at least six hours in medical recordkeeping in the context of the treatment of chronic pain. The Board found Dr. Pham failed to maintain adequate medical records with respect to five patients. Specifically, Dr. Pham's medical records lacked documentation of the medical decision-making process, including adequate documentation of the patients' outcomes. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Smith, Renee Christine, M.D., Lic. No. L6649, Decatur**

On May 2, 2014, the Board and Renee Christine Smith, M.D., entered into a Mediated Agreed Order requiring Dr. Smith to within one year successfully complete the medical recordkeeping course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board found Dr. Smith did not document alternative treatments during the labor process and failed to timely recognize and address the signs and symptoms of the patient's bowel injury. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Stephens, Chad Bryan, D.O., Lic. No. L3143, Decatur**

On May 2, 2014, the Board and Chad Bryan Stephens, D.O., entered into a Mediated Agreed Order requiring Dr. Stephens to within one year complete at least 16 hours of CME, divided as follows: eight hours in medical recordkeeping and eight hours in risk management; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Stephens failed to timely assess Patient 1's post-surgery blood pressure and that Dr. Stephens' medical records were inadequate for both patients and could use improvement by giving more detail. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Weber, Ammon D., M.D., Lic. No. M4646, Borger**

On May 2, 2014, the Board and Ammon D. Weber, M.D., entered into an Agreed Order requiring Dr. Weber to within one year and three attempts pass the Medical Jurisprudence Exam; within one year complete at least 24 hours of CME, divided as follows: eight hours in ethics, eight hours in handling high risk pregnancy cases, and eight hours in medical recordkeeping. The Board found Dr. Weber failed to document that he discussed with a patient

the risks and benefits associated with performing a cesarean section for a stillbirth rather than a vaginal delivery, and failed to document that he obtained informed consent from the patient for a tubal ligation, or timely document that he performed the ligation (it was later added to the record as an addendum).

**FAILURE TO USE TEXAS ELECTRONIC DEATH REGISTRY SYSTEM**

**Aleman, Ruben, M.D., Lic. No. G3106, McAllen**

On June 27, 2014, the Board approved a Final Order requiring Dr. Aleman to within one year and three attempts pass the Medical Jurisprudence Exam; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Aleman did not make a good faith effort to file a death certificate electronically within the time frame required by the Texas Health and Safety Code. The action was based on the findings of an administrative law judge at the State Office of Administrative Hearings. This order resolves a formal complaint filed at the State Office of Administrative Hearings. Dr. Aleman has 20 days from the service of the order to file a motion for rehearing.

**NON-CERTIFIED RADIOLOGICAL TECHNICIAN**

**Arreola, Laura, N.C.T. Permit No. NC05220, Raymondville**

On March 31, 2014, the Board entered an order of automatic suspension regarding the non-certified radiologic technician permit of Laura Arreola. The Board suspended Ms. Arreola's permit and ordered her to cease practicing as an NCT in Texas due to unprofessional conduct by defaulting on her student loan.

**CEASE AND DESIST**

**Ahee, Steven, No License, Dallas**

On May 2, 2014, the Board entered an Agreed Cease and Desist Order regarding Steven Ahee, prohibiting him from practicing medicine in the State of Texas. Mr. Ahee shall cease and desist any practice of medicine. The Board found Mr. Ahee has engaged in the unlicensed practice of medicine by administering injections of Spascupreel and Cortisone to a patient in his chiropractic practice on May 25, 2012, from a supply that was prescribed to him by his treating physician.

**Black, Dennis, No License, Carrollton**

On June 6, 2014, the Board entered a Cease and Desist Order regarding Dennis Black prohibiting him from acting as, or holding himself out to be, a licensed physician in the state of Texas. Mr. Black shall not refer to himself as Dr. Dennis Black, Dr. Dennisblack.com, Dr. Black, and Dr. Dennis Black, N.D., without clearly designating that he is not a medical doctor and that he is not licensed to practice medicine in the state of Texas. This applies to Mr. Black's information listed in websites, products he attempts to sell, letterhead, stationary, postings in and around his office and in any advertising materials, or as designated in Medical Practice Act, Section 165.156. The designation that he is

not a medical doctor and that he is not licensed to practice medicine in Texas, shall appear immediately following any reference to “Doctor” or “N.D.” and the designation must immediately reference the authority under which the title is used. The Board found Mr. Black, through his website, used the designation of doctor without adequately disclosing the basis upon which he used the designation and that Mr. Black engaged in the practice of medicine by offering to treat people. Mr. Black also maintains a Facebook page of “Dr. Dennis Black, Carrollton, Texas.” On this Facebook page Mr. Black gives health tips and medical advice. Mr. Black also has a radio show called “Dr. Dennis Black Live on Word 100.7, Christian Talk Radio.”

**Broach, Whitney, M.S., L.S.O., No License, Houston**

On July 17, 2014, the Board entered a Cease and Desist Order regarding Whitney Broach, M.S., L.S.O., prohibiting her from engaging in the unlicensed practice of medicine in the state of Texas. Ms. Broach shall cease and desist any unlicensed practice of medicine; shall cease and desist using the term “Dermalogist” in her business and on her website tatremove.com; and shall cease and desist from advertising that she is certified by the D.N.A. Institute of Facials to perform Botox cosmetic injections and multiple laser surgery procedures to treat and remove freckles, acne scars, and veins, among other skin condition. The Board found Ms. Broach has been engaging in the unlicensed practice of medicine in the state of Texas, and represented herself as a medical doctor and/or board certified dermatologist.

**Diaz, J. Luis, No License, Houston**

On June 27, 2014, the Board entered a Cease and Desist Order regarding J. Luis Diaz, prohibiting from engaging in the unlicensed practice of medicine in the state of Texas. Mr. Diaz shall cease and desist any unlicensed practice of medicine. The Board found Mr. Diaz has practiced medicine in the state of Texas by evaluating, diagnosing and treating patients in Texas at the medical office of J. Jesus Diaz, M.D., while no physician was present at that clinic. Mr. Diaz was identified as a physician by himself, patients and staff.

**Izekor, Imafidon “Thomas,” No License, Arlington**

On May 30, 2014, the Board entered a Cease and Desist Order regarding Imafidon “Thomas” Izekor requiring him to immediately cease posting on websites that he is a medical doctor or doctor without disclosing that he is not licensed in Texas. Furthermore, Mr. Izekor shall not refer to himself with the title “Dr.” or “doctor” without clearly indicating that he is not licensed to practice medicine in the state of Texas. The Board found Mr. Izekor publicly professed/posted on a prominent social media website, LinkedIn, that he was a Medical Doctor in Arlington, Texas. Mr. Izekor’s designation of “Medical Doctor” failed to state as a required disclosure that he is not licensed to practice medicine in Texas.

**Jimenez, Julio, No License, San Antonio**

On May 2, 2014, the Board entered an Agreed Cease and Desist Order regarding Julio Jimenez, prohibiting him from practicing medicine in the State of Texas. Mr. Jimenez shall cease and de-

sist any practice of medicine, and shall cease and remove all publications noted. The Board found Mr. Jimenez has published information including Internet websites and other postings, that represents that he is a medical doctor, including the use of the term “doctor” or “Dr.” associated with Mr. Jimenez’s name, and that he evaluates or treats any medical or physical conditions, including any chronic conditions, of persons.

**Payne, Robert Brett, D.C., No License, Euless**

On June 27, 2014, the Board entered an Agreed Cease and Desist Order regarding Robert Brett Payne, D.C., prohibiting him from practicing medicine in the state of Texas without a license issued by the Texas Medical Board. Mr. Payne shall refrain from practicing outside the scope of chiropractic and shall cease and desist in diagnosing, treating, or offering to diagnose or treat any condition which is in the absence or licensure or an exception under the law would constitute the unlicensed practice of medicine. The Board found it received a complaint that Mr. Payne engaged in the unlicensed practice of medicine by diagnosing medical conditions and under the direction of a medical director and pursuant to joint agreed treatment protocols, administering IV vitamins and nutritional supplements.

**Sinha, Sangeeta, No License, Houston**

On June 27, 2014, the Board entered an Agreed Cease and Desist Order regarding Sangeeta Sinha, prohibiting her from acting as, or holding herself out to be, a licensed physician in the state of Texas. Ms. Sinha shall not refer to herself as a doctor or physician and Dr. Sangeeta Sinha without clearly designating that she is not licensed to practice medicine in the state of Texas. This applies to information listed on any websites, electronic mail addresses, letterhead, stationary, postings in or around Ms. Sinha’s office, and in any advertising materials, or as designated in the Medical Practice Act, Section 165.156. The Board found Ms. Sinha held herself out to the public as “Dr.” and “Doctor” in the context of advertising her services in Texas on various websites, including Facebook and LinkedIn.

## Texas Physician Assistant Board Disciplinary Actions

### TEMPORARY SUSPENSION/RESTRICTION

**Cooper, William Levi, P.A., Lic. No. PA04093, Bryan**

On April 16, 2014, a disciplinary panel of the Texas Physician Assistant Board temporarily suspended, without notice, the Texas physician assistant license of William Levi Cooper, P.A., after determining his continuation in practice as a physician assistant would constitute a continuing threat to public welfare. The suspension was effective immediately. The Board found Mr. Cooper, who is a physician assistant working in the Public Health Service (PHS) at a Federal Prison Camp (FPC) in Bryan, Texas, had sexual relations with three inmates that were under his care and treatment as patients. Three patients confirmed sexual acts with Mr. Cooper while under his care and treatment while they were



incarcerated and/or subject to federal house arrest. A temporary suspension hearing with notice will be held as soon as practicable with 10 days' notice to Mr. Cooper, unless the hearing is specifically waived by Mr. Cooper. The temporary suspension remains in place until the Board takes further action.

**Reid, Rodger Daniel, P.A., Lic. No. PA07124, Fort Worth**

On May 28, 2014, a disciplinary panel of the Texas Physician Assistant Board temporarily suspended, without notice, the Texas physician assistant license of Rodger Daniel Reid, P.A., after determining his continuation in practice as a physician assistant would constitute a continuing threat to public welfare. The suspension was effective immediately. The Board found Mr. Reid, on or about May 12, 2014, was arrested on charges of aggravated sexual assault of a minor under 14 years of age, penal code 22.021(a)(1)(b). The nature of Mr. Reid's arrest and the potential for him to interact with children as a licensed physician assistant make his continued practice of medicine a continuing threat to the public health and safety. A temporary suspension hearing with notice will be held as soon as practicable with 10 days' notice to Mr. Reid, unless the hearing is specifically waived by Mr. Reid. The temporary suspension remains in place until the Board takes further action.

\* \* \*

## Physician Licenses

**The Texas Medical Board issued 1,579 physician licenses between March 18, 2014 and July 18, 2014. Congratulations to the following:**

Montserrat Abadie Sole, M.D.  
 Siu Han Paola Abate, M.D.  
 Ali Abbasi, M.D.  
 Abraham George Abbott, M.D.  
 Basem Abdelfattah, M.D.  
 Kazeen Nuri Abdullah, M.D.  
 Saif Abdullah, M.D.  
 Henia Azhar Abid, D.O.  
 Frieda Aboul Fotouh, M.D.  
 Amir Aboutalebi, M.D.  
 Shiny Mary Abraham, M.D.  
 Hanan Abu Alnaaj, M.D.  
 Hazem Abugrara, M.D.  
 Jason Luis Acevedo, M.D.  
 Brandey Lynne Ackerman, M.D.  
 Mohammed T. Adamu, D.O.  
 Adebukola Aden Alexander Adedeji, M.D.  
 Adewale Adeniran, M.D.  
 Adebayo Shakir Adewale, M.D.  
 Sanjay Gautam Adhia, M.D.  
 Nazila Adib, M.D.  
 Bernice Darko Adu Gyamfi, M.D.  
 Murali Adusumalli, M.D.  
 Sanjeetha Aella, M.D.  
 Syed Mujtiba Afzal, M.D.  
 Usman Afzal, M.D.  
 Amit Kumar Agarwal, M.D.  
 Abib Ayomide Agbetoba, M.D.  
 Sumesh Aggarwal, M.D.  
 Ritwick Agrawal, M.D.  
 Javier Aguirre, M.D.  
 Bethany Anne Agusala, M.D.  
 Kartik Agusala, M.D.  
 Javid Ahadi, D.O.  
 Muhammad Ismail Ahmad, M.D.  
 Hassan Ahmed Abdelhadi Ahmed, M.D.  
 Reem Ahmed, M.D.  
 Subhan Ahmed, M.D.  
 Titilopemi Ao Aina, M.D.  
 Fadi Ajine, M.D.  
 Christopher Anikwe Ajufo, M.D.  
 Stephen D. Ake, D.O.  
 Mani Akhtari, M.D.

Edith F. Akintokunbo, M.D.  
 Hilary Chukwudolue Akpudo, M.D.  
 Zaina Al-Mohtaseb, M.D.  
 Saima Alam, M.D.  
 Muhammad Ali, M.D.  
 Nadia Ali, M.D.  
 Rafiq Qasam Ali, M.D.  
 Sajid Asim Ali, M.D.  
 Shahla Ali, M.D.  
 Cheen Alkhatib, M.D.  
 Mhd Adnan Alsaka, M.D.  
 Nnewueze Stella Amaechi, M.D.  
 Judith Kwarteng Amaning, M.D.  
 Sreekanth Ambati, M.D.  
 Jennifer Amico, M.D.  
 Ameer Amin, M.D.  
 Ashraf Anani, M.D.  
 Kenton Lee Anderson, M.D.  
 Marquita Anderson, M.D.  
 Isaac Andrade, M.D.  
 Reena Andrews, M.D.  
 Nana Ama Esi Ankumah, M.D.  
 Nadeem Ebad Ansari, D.O.  
 Ramin Ansari, M.D.  
 Sofia Tauqeer Ansari, M.D.  
 Brian Daniel Antoniano, M.D.  
 Mara B. Antonoff, M.D.  
 Agith Antony, D.O.  
 Sara Anvari, M.D.  
 Ifechi Anyadioha, M.D.  
 Mala Appachi, M.D.  
 Harsha Aramada, M.D.  
 Elizabeth Arcila, M.D.  
 Adriana Sofia Ardeljan, D.O.  
 Daniel Michael Arsenault, Jr., M.D.  
 Athis Rajh Arunachalam, M.D.  
 Saba Asad, M.D.  
 Rida Ashraf, M.D.  
 Omer Muhammad Asif Siddiqui, M.D.  
 Waqas Aslam, M.D.  
 Kolawole Omodayo Atandeyi, M.D.  
 Cameron Theodore Atkinson, M.D.  
 Phyu Phyu Aung, M.D.  
 Jordan Daniel Averbach, M.D.  
 Martina Toma Ayad, M.D.  
 Santiago M. Ayala, M.D.  
 Katherine Omuetti Ayoade, M.D.  
 Bilal Aziz, M.D.

Brent Leland Bachim, M.D.  
 Razan Bader, M.D.  
 Eric Wayne Baggerman, M.D.  
 Arya Navid Bagherpour, D.O.  
 Muhammad Rais Baig, M.D.  
 Puneet Bajaj, M.D.  
 Christi Anne Baker, M.D.  
 Vanitha Bala, M.D.  
 Rajeev Balchandani, M.D.  
 Amit Banga, M.D.  
 Rajashekhar Bangalore Harish, M.D.  
 David Banh, M.D.  
 Gursaran Banipal, D.O.  
 Suvin Banker, D.O.  
 Atif Baqai, M.D.  
 Shalini Rao Barlapudi, M.D.  
 Stephen Barman, M.D.  
 Susan Kim Barnes, M.D.  
 John Dean Barr, M.D.  
 Jubilee Barton, M.D.  
 Holly Elizabeth Baselle, D.O.  
 Zachary John Baselle, D.O.  
 Abdul Basit, M.D.  
 Shazia Basit, M.D.  
 Arti Baskaran, M.D.  
 Gautam Baskaran, M.D.  
 Apram Apar Basra, D.O.  
 Michael Bass, M.D.  
 Alexander Bastidas Palacios, M.D.  
 John Charles Bates, III, M.D.  
 Juan Carlos Batlle, M.D.  
 Zachary Baum, D.O.  
 Kelly Davis Baylan, M.D.  
 William Clarence Beck, M.D.  
 Stephen Matthew Becker, M.D.  
 Kathleen Martin Beckum, M.D.  
 Tilahun Worku Belay, M.D.  
 Andrey Belayev, M.D.  
 Jonathan Alexander Benfield, D.O.  
 Anastasia Marie Benson, D.O.  
 Ana Paula Atihe Benveniste, M.D.  
 Ericka Lynn Berger, M.D.  
 Jennifer Lynn Bergeron, M.D.  
 Bennie Johannes Berkvens, M.D.  
 Gemma Almira Berlanga, M.D.  
 Eileen Bernal, M.D.  
 Jennifer Ann Nicole Bernard, M.D.  
 Lis Carol Bernuy, M.D.

Scott John Bevan, M.D.	Amelia Buben, D.O.	Katrina Chaung, M.D.
Aseem Kumar Bhandari, M.D.	Catherine O'Neill Buck, M.D.	Jay Mark Cheek, M.D.
Naumit Bhandari, M.D.	Larisa Buck, D.O.	Nadia Lauren Cheek, M.D.
Reshma Arun Bhanushali, M.D.	Antonio Bueso, M.D.	Fareeha Hussain Cheema, M.D.
Priya Bhaskar, M.D.	John Duc Bui, D.O.	Daniel Cheeran, M.D.
Neil Rajendra Bhatt, M.D.	Daniel Esteban Bujanda, M.D.	Justin Ray Chen, M.D.
John Nelken Bienvenu, M.D.	Jon Buras, M.D.	Leechuan Andy Chen, M.D.
Corey Matthew Bilbo, M.D.	Scott Alan Burdette, M.D.	Robert Chen, M.D.
Shagun Bindlish, M.D.	Ashley K. Burdex, D.O.	Saradha Chexal, M.D.
Raju Bishwakarma, M.D.	Elio Elio Burgos, M.D.	Nora Chiu, D.O.
Sheena Rachel Black, M.D.	David Bruce Burkholder, M.D.	Jinhee Choi, M.D.
Lorne Howard Blackbourne, M.D.	Rebecca Lynn Burson, M.D.	Sooyeon Choi, M.D.
James Alan Blair, Jr., M.D.	Renesha Christine Butler, M.D.	Adrienne Nicole Choksi, M.D.
Pierre Blais, M.D.	Alberto Velasco Cabo Chan, Jr., M.D.	Ahsanul Choudhury, D.O.
Katherine Elizabeth Blalock, M.D.	Carlos Humberto Cabrera, Jr., D.O.	Charoo Chouhan, M.D.
Cristina Blejan, M.D.	Heather Ottmers Caddell, M.D.	Cecil Frenklin Christian, M.D.
Gina Marie Blocker, D.O.	Xuan Cai, M.D.	Donald Sinclair Christman, M.D.
Dexter William Blome, M.D.	Scott Caldwell, M.D.	Justin Edward Chronister, M.D.
Gary Michael Bloomgarden, M.D.	Elizabeth Calvin, M.D.	Anthony Ted Chuang, D.O.
Yair Blumenfeld, M.D.	Pamela Elizabeth Camacho, M.D.	Chandril Chugh, M.D.
Diana Kate Blythe, M.D.	Claire Marie Campbell, M.D.	Olayemi Chukwuogo, M.D.
Alisha Dione Bogus, M.D.	Thomas B. Campbell, M.D.	Sirisha Chunduri, M.D.
Timothy Lee Bollinger, D.O.	Weiwei Cao, M.D.	Daun Chung, D.O.
Rachelle Bond, D.O.	Magdaleno Rafael Cardenas, Jr., M.D.	Scott Anthony Cimino, M.D.
Leslie Bradford Boothby, M.D.	Matthew Carlson, M.D.	Francesca Rose Civitarese, D.O.
Nirica Maria Borges, M.D.	Jerome Cardinal Carolino, Jr., M.D.	David Alan Claassen, M.D.
Kerem Hakki Bortecen, M.D.	Christopher Carr, M.D.	Melissa E. Cloonan, M.D.
Vasile Mihai Bota, M.D.	Jenny Lynn Dequilla Carreon, M.D.	Matthew Zachary Coburn, M.D.
Isaac Alexander Bowman, M.D.	Christin Alejnikov Carroll, M.D.	Rivkah R. Colen, M.D.
Ritvij Bowry, M.D.	Matthew Carroll, M.D.	Alfred John Colfry, III, M.D.
Jonathan Dale Boyd, M.D.	Courtney Carter, D.O.	Clyde Collins, M.D.
Allison Marie Boyle, M.D.	Jason Andrew Carter, M.D.	Meredith Suzanne Collins, M.D.
Kevin Michael Brady, M.D.	Sonia Carolina Carvajal Guzman, M.D.	Christian Patrick Conderman, M.D.
Rachel Elizabeth Brady, M.D.	Luis Antonio Castagnini, M.D.	Rhonda Kaylynn Cooke, M.D.
Byron Charles Branch, M.D.	Ricardo Esteban Castellon Inestroza, M.D.	Amber Marie Coon, M.D.
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 David Lynne Zimmerman, M.D.  
 Renee Marie Zimmermann, M.D.  
 Wojciech Zolcick, M.D.  
 Auzhand Zonozy, M.D.  
 Thomas John Zyniewicz, II, D.O.

**Note: there were no physician assistant or acupuncturist licenses issued between March 18, 2014 and July 18, 2014.**

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## **TMB MISSION STATEMENT**

*Our mission is to protect and enhance the public's health, safety and welfare  
 by establishing and maintaining standards of excellence used in regulating  
 the practice of medicine and ensuring quality health care for the citizens of Texas  
 through licensure, discipline and education.*