NO. 503-95-0676
E-3781

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| IN THE MATTER OF THE | § | BEFORE THE |
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| COMPLAINT AGAINST | § | TEXAS STATE BOARD |
| | § | |
| TOMMY ERNEST SWATE, M.D. | § | OF MEDICAL EXAMINERS |

COMPLAINT

TO THE HONORABLE TEXAS STATE BOARD OF MEDICAL EXAMINERS:

COMES NOW, the staff of the Texas State Board of Medical Examiners ("the Board"), making this Complaint against Tommy Ernest Swate, M.D. ("Respondent"), based on alleged violations of the Medical Practice Act ("the Act"), V.A.C.S., article 4495b.

This Complaint and requested relief are necessary to protect the health of the citizens of the State of Texas as mandated by Section 1.02 of the Act.

In support of this Complaint and based on information and belief, the Board charges and alleges the following:

I

1. Respondent holds Texas medical license E-3781.

2. Respondent's Texas medical license was in full force and effect at all times and dates material and relevant to this Complaint.

3. All jurisdictional requirements have been satisfied.

II

The Texas State Board of Medical Examiners is informed and believes, and upon such information and belief, the Board staff charges and alleges that:

Count 1

1. On January 24, 1992, Respondent entered into an Agreed Order with the Texas State Board of Medical Examiners based upon repeated or recurring health care liability claims. Said Order placed Respondent on five (5) years probation and provided, inter alia, that Respondent comply with the Medical Practice Act.

2. On January 28, 1993, Respondent entered into a Consent Order with the Louisiana Board of Medical Examiners. The Louisiana Board determined that the public interest of Louisiana citizens was properly served by Respondent's execution of a Consent Order with Louisiana by virtue of which Respondent's Louisiana medical license would be placed on probation consistent with the specified terms and conditions imposed by the Texas Board, together with the requirement that Respondent notify the Louisiana Board of any intention to relocate Respondent's practice of medicine to Louisiana. The Louisiana Order was drafted in response to the action taken by the Texas Board with the Texas Board Order effective January 24, 1992. The Louisiana Order specifically states that the license of Respondent is revoked, with revocation stayed, and his license placed on probation for four years to run concurrent with the probationary period ordered by the Texas Board through January 24, 1997. In addition, the Louisiana Consent Order contains conditions indicating that Respondent must maintain strict adherence to the terms and conditions of the Texas Board Order and that if he wished to practice medicine in Louisiana he shall provide written notification to the Louisiana Board at least 60 days prior to his relocation to Louisiana. It also mandates that Respondent would appear personally before the Louisiana Board prior

to the time that he would wish to commence practice of medicine in the State of Louisiana to allow the Louisiana Board to assess his compliance and to discuss his intended plans for the practice of medicine in Louisiana.

3. On January 20, 1994, a Superseding Consent Order was entered by the Louisiana Board. The Consent Order was in response to a March 25, 1993 meeting between Respondent and the Louisiana Board in which he advised them that he had been offered a position to practice obstetrics and gynecology in Louisiana. At that time Respondent expressed his desire to develop a practice in the State of Louisiana. The Superseding Consent Order specifically states that Respondent acknowledged that he was not engaged in the practice of medicine in any form for the past three years and that he had failed to report the pendency of the investigation which led to the Texas Board Order on several of his renewal applications for Louisiana licensure.

4. The Superseding Consent Order continued to mandate Respondent's compliance with the Louisiana Board Superseding Consent Order. The Superseding Consent Order placed Respondent's license on probation for four years subject to Respondent's acceptance of strict compliance with the terms and conditions in the Texas Board Order. Respondent was ordered not to practice medicine in any form in the State of Louisiana until the Board issued and served Respondent a written order reinstating his license to practice medicine. It also ordered Respondent to complete a mini-residency program concentrating in obstetrics and gynecology of at least three months continuous duration. The Order required that he must supply the Board with written certification from the physician or supervising physician in the mini-residency evidencing Respondent's completion of and satisfactory performance

in the mini-residency before he would be considered for the practice of obstetrics and gynecology in Louisiana as was his request with a position offered in Franklin, Louisiana.

5. Respondent has continued to fraudulently testify and falsify application documents to the Louisiana Board. Respondent was indeed practicing medicine for the three years since his Texas Board Order in 1992. Respondent continued to function as a physician in the position of Medical Director at two Methadone clinics he owned and operated in Houston, Texas. Furthermore, Respondent fraudulently withheld additional information during his meeting with the Louisiana Board regarding the revocation of the narcotic registrations for both Methadone clinics. Prior to his meetings with the Louisiana Board, the registrations were revoked by DEA and the Texas Department of Health for multiple violations. Respondent clearly continued to defraud the Louisiana Board, has indicated to them as contained in their Superseding Consent Order that he had not practiced medicine for three years in any form or fashion and he also has fraudulently withheld information regarding the revocation of his Methadone narcotic registrations along with information pertaining to the investigation and hearing procedure regarding the revocation of those permits.

6. Respondent has been licensed in Louisiana since June 17, 1971. A review of the annual Louisiana renewals by Respondent from 1987 to 1994 show that he falsified his applications by indicating annually that he has not been the subject of any type of disciplinary action or inquiry by any licensing authority, institution, or society. A review of the Texas State Board of Medical Examiner's summary of complaints indicates that, with the exception of 1984, Respondent has had an investigation filed with the Texas State Board of Medical Examiners every year from 1982 through 1994. Some years have contained multiple investigations. Respondent was notified by mail of each investigation.

Count 2

1. On or about April 27, 1992, the Texas Department of Health ("TDH") and the Drug Enforcement Administration ("DEA") closed the Chemical Dependence Associates of Houston, 16 Pinedale, Houston, Texas, for violations of state and federal law. The site was occupied by Respondent as a sponsor and owner of the facility.

2. In April, 1992, Respondent abandoned the location of his drug abuse program. Drug abuse patient records identifying patients were left at the site.

3. In October, 1992, the site was repossessed by the mortgagor, Mrs. Nancy Crawford Schiffbauer.

4. On or about October 16, 1992, David Lee Bayliss purchased the referenced building at 16 Pinedale, which housed Respondent's drug abuse treatment program. When the site at 16 Pinedale was abandoned, the patient treatment files were left unsecured in different areas of the facility. The records were not secured in accordance with the regulation 42 C.F.R. 2.19, Confidentiality of Alcohol and Drug Abuse Patient Records.

5. On or about October 26, 1992, Mr. Bayliss found in the abandoned building, a large volume of individual patient records, sufficient to fill 21 cardboard cartons, located in several areas of the building. Many of the records identify drug abuse treatment patients. Mr. Bayliss boxed the records and placed them on the outside rear porch of 16 Pinedale. The patient records were not secured in accordance with regulation 42 C.F.R. Section 2.19, Confidentiality of Alcohol and Drug Abuse Patient Records.

6. On or about October 26, 1992, at the 16 Pinedale address, Mr. Bayliss began to clean the inside of the home where there was a large volume of records present which belonged to Respondent.

The records were boxed and placed on the backyard porch because Mr. Bayliss believed the former owner had had plenty of time to remove the property. Mr. Bayliss made an attempt to contact Respondent regarding these records. On October 27, 1992, a Rita Marquez called Mr. Bayliss and identified herself as Respondent's fiancee. She advised him that Respondent would like to make arrangements to have the records picked up. She was told that the records were on the back porch waiting to be hauled off. Mr. Bayliss states that he observed several days later that the boxes were not arranged as he had placed them, therefore, he assumed Respondent or one of his representatives had come by and taken what they wanted. Mr. Bayliss called Ms. Marquez one more time, on November 10, 1992, and she informed him that if Respondent wanted anything else she would contact him. As of November 23, 1992, no contact was made from Respondent to Mr. Bayliss.

7. On or about November 12 and 13, 1992, investigators from the Food and Drug Administration ("FDA") collected approximately 21 boxes of the patient medical records from 16 Pinedale (formerly Chemical Dependence Associates of Houston) which were abandoned. The records were transported to the FDA Houston office at 1445 North Loop West, Suite 420, Houston, Texas 77008.

8. On or about November 16, 1992, Respondent was notified in a telephone conversation by FDA Supervisory Investigator, Carlos Dixie, that the FDA had retrieved the abandoned records and that the records were available for Respondent to pick up at its Houston office.

9. As a result of Respondent's failure to control and dispose of patient records, the Dallas District of FDA recommended advising Respondent by letter that the FDA intended to destroy the abandoned records unless picked up by Respondent. A warning letter dated March 16, 1993, was sent to Respondent. The letter cited the

circumstances regarding the abandonment of the records as well as citing 42 C.R.F. Section 2.19, Confidentiality of Patient Records. The letter also cited previous FDA telephone conversations which had been held with Respondent regarding his picking up the abandoned records. Respondent's response to the warning letter was dated March 29, 1993, stating that if the agency would provide a time he would make an individual available and a site where the records could be delivered.

10. On April 30, 1993, a letter issued to Respondent from the Dallas District advising of the numerous telephone calls attempting to reach him in order to set up a time for pick up of the records. The letter advised Respondent that he was welcome to pick up the records at any time between the hours of 8:00 a.m. and 4:00 p.m. Several unsuccessful telephone calls were placed to Respondent with no calls being returned by him.

11. Respondent addressed a letter to the District Director on May 13, 1993, advising that he had not received dates and time for delivery of his records, he again responded in his letter that he would provide a time and place and detailed instructions for delivery of the records if the agency would provide him with dates and times.

12. On June 24, 1994, a letter was addressed to Respondent advising him that on June 30, 1993, at 1:00 p.m., the Houston office would deliver the medical records to Respondent's business address in Kountze, Texas. The letter advised that the FDA was prepared to dispose of the subject records in accordance with 42 CFR Section 2.19.

13. A facsimile transmission dated June 28, 1994, from Respondent advised the District Director not to deliver the medical records to the Kountze, Texas address, as there was no one there

authorized to accept the records. Respondent advised he would send an address for delivery as soon as storage arrangements could be made. Nothing was heard from Respondent since that facsimile.

14. FDA representatives from the Dallas District subsequently discussed the subject records with Fred Jackson, attorney for Respondent, who advised that Respondent did not need the subject records.

15. The Dallas District of the FDA eventually located a Houston firm for incineration of Respondent's records. It was the decision of the Dallas District of the FDA that it was obvious that Respondent had no intention of obtaining the subject records. The records were eventually destroyed on September 24, 1993.

Count 3

1. In addition to the above record-keeping deficiencies alleged in Count 2 above, Respondent's drug treatment facility was also the subject of a DEA show cause order for immediate suspension of registrations on March 18, 1992 based upon the following:

a. Methadone was dispensed to an undercover agent without verification that the agent was in a detoxification program. No physician ever saw the client. The agency received no physical examination or blood test;

b. DEA seized records and reviewed two six month audits for the date July 9, 1991 through January 9, 1992. One audit used daily methadone rosters and the other used daily methadone dispensing logs. The audit using the daily methadone rosters showed a shortage of 2,980 mg. of methadone diskettes and 75,874 mg. of methadone liquid. The audit using the daily methadone dispensing logs

showed a shortage of 3,165 mg. of methadone diskettes and 78,634 mg. of methadone liquid;

c. Patients were admitted to the program without proper documentation of a history of addiction or drug dependence;

d. Respondent failed to submit documentation to the Texas Department of Health of employees trained to document addiction, admit patients, receive methadone shipments, or dispense methadone to patients;

e. Transfer patients were admitted to the program without documentation or confirmation of treatment in another program;

f. Patients did not qualify for the take home methadone levels received;

g. Patients were not made to take observed doses at the facility and received double doses;

h. Treatment plans, progress reports, and counseling sessions were nonexistent or inadequate;

i. Patients were not being put on probation for dirty drug screens or screens negative for methadone (if a patient is on the methadone program his drug screens should show positive for methadone, otherwise it must be assumed that the methadone is being sold or in some was diverted);

j. Patients were not meeting the eight point criteria for taking home methadone doses;

k. Patients were allowed to obtain additional doses from other methadone clinics;

l. Dosage increases were granted without documentation, justification, or physician's orders;

m. Syphilis and TB tests were not documented;

n. Patients were enrolled without a valid identification;

o. The facility failed to participate in the central registry as required;

p. Records of the methadone wholesaler indicate that an unknown person had signed for a methadone shipment;

q. A former employee indicated that in their eleven months of employment, Respondent never performed physicals on the patients as required but would complete the paperwork as if the physicals had been done. The employee further indicated that Respondent instructed them to take the patient's word regarding dosages they may have been on from other clinics. Further, the employee indicated that Respondent instructed the employee to make entries into the chart for dosage changes indicating it was a verbal order when no verbal orders were given;

r. In addition, DEA conducted an additional audit on March 13, 1992, two months after the previous audit and found an additional shortage in that period from January 9, 1992 to March 13, 1992 showing that an additional shortage of 2,463 mg. of methadone liquid.

2. The Department of Health and Human Services/FDA by the inspection of the facility on April 2, 1991 through April 4, 1991, found multiple violations of FDA regulations including:

a. Patients receiving initial dosages without prior examination or proper documentation;

b. Patients were admitted to the program without documented history and physical examination;

c. "Consent to methadone treatment" forms lacked proper dates and signatures;

d. Failure to test for benzodiazepines when they were determined to be abused in this locality;

e. Treatment plans were inappropriate and incomplete.

3. The Department of Health and Human Services/FDA inspection of the facility on April 4, 1992 through April 16, 1992, found the following violations of FDA regulations:

a. Failed to document adequately a history of addiction on multiple clients;

b. Failed to include documentation on multiple clients from previous treatment programs, no indication those programs were contacted by Respondent to verify the clients' attendance or doses schedules at those programs;

c. A newly admitted client of July 1991, had his dosages changed to a "Special level" in August 1991, and was provided with four take home doses at a time on a regular basis;

d. Third parties were allowed to pick up multiple take home doses for clients without approval;

e. Doses dispensed were not specified in writing by a physician;

f. Failure to test patients for benzodiazepines when they were known to be abused in this locality;

g. Failure to meet the eight point criteria before clients were given a reduction in clinic visits;

h. Employee clients/client were allowed to received methadone from two facilities with take home doses of 80 mg. from both facilities on the same days;

i. Improper treatment plans;

j. Failure to assure first day methadone doses did not exceed 30 mg.

4. A Texas Department of Health inspection on April 14, 1992 through April 15, 1992, found the following violations:

a. Failure to document a one year history of addiction;

b. Failure to document with the Texas Department of Health the duties and position of an employee who was a methadone addict at the facility;

c. Treatment plans, counseling reports, and progress notes were inadequate;

d. Clients testing negative for methadone were given take home doses;

e. Failure to put on probation clients who tested positive for drugs or negative for methadone;

f. Failure to properly participate in the State control registry;

g. Failure to properly identify multiple clients by proper identification;

h. No licensed counselors were employed at the time of the inspection;

i. Discrepancies relating to the identities of facility employees;

j. Allowing third parties to pick up home doses of methadone for clients;

k. Dispensing Valium for detoxification of clients addicted to Valium;

l. No justification or documentation as to the need or reason for Valium to addict clients;

m. A prescription by Respondent for one client being used to dispense Valium to two clients;

n. Take home doses allowed without meeting the prerequisite regarding time requirements;

o. Indications of falsified records such as a pre-signed physical examination sheet by Respondent.

5. Respondent requested through counsel a hearing on the matters raised in the Order to Show Cause regarding both his Pinedale and Park Place, Houston, locations. Both cases were consolidated in light of the fact that Chemical Dependence Associates, while operating under two separate DEA certificates of registration at two separate addresses was owned and operated by the same individual, Respondent.

6. A federal hearing was held on January 11, 1993. On February 17, 1993, the Federal Administrative Law Judge issued an Opinion and Recommended Decision. The decision was forwarded to the administrator. It was the administrator's final order that:

> The Orders to Show Cause alleged the Respondent had engaged in various violations of DEA, FDA, and Texas State Regulations including falsification of medical records, inadequate testing documentation, dispensing methadone to an undercover agent for no legitimate medical purpose, failing to account for methadone received and dispensed, and failing to maintain proper documentation of treatment records. Before evidence was presented at the hearing, the government indicated that Respondent had relinquished control over both sites where the methadone clinics were located. The government maintained, therefore, that even if the administrator were to reinstate the DEA certificates of registration there would be no locations to register. As the government noted, registrations for narcotic treatment programs are issued to locations, not to individuals.

7. In response to a Motion for Summary Disposition, Respondent stipulated that should he seek any further employment with a

narcotic treatment program it would be as a program director or sponsor, a position which would require him to be the applicant for a DEA certificate of registration. The government agreed that if the Motion for Summary Disposition were granted, the DEA would take no action against Respondent's individual DEA certificate of registration as a practitioner based solely on the violations alleged in the Order to Show Cause. The government further agreed that it would not attempt to apply 21 CFR 1301.76(a), which restricts employment of individuals with revoked DEA registrations, against Respondent for any employment in a traditional office setting in which he would have access to controlled substances.

8. Based on these stipulations and in light of the fact that there was no longer any issue to be resolved at the hearing, the Administrative Law Judge granted the government's Motion for Summary Disposition. The Administrative Law Judge noted that where no question of fact is involved, or when the facts are agreed upon, and administrative proceeding including submission of evidence and cross-examination is not required.

9. The Administrative Law Judge recommended that the DEA certificates of registration be revoked subject to the conditions mentioned above.

10. The administrator adopted the Opinion and Recommended Decision of the Administrative Law Judge in its entirety. Accordingly, the administrator ordered that DEA certificates of registration issued to Chemical Dependence Associates of Houston, both Pinedale and Park Place locations were revoked, and any pending applications for registration were denied. The order was made effective July 12, 1993.

11. Through their own investigation and subsequent to the final decision by DEA administrator revoking the registration of

both locations, the Texas Department of Health Division of Food and Drugs adopted the Drug Enforcement Administration' Order and Decision of the DEA Administrative Law Judge as Findings of Fact. The Texas Department of Health ratified the federal government's interpretation as referring only to registration of the two narcotic treatment programs and agreed that it did not affect Respondent's employment as a physician with access to controlled substances in a normal physician setting. The State registrations for both methadone clinic locations were permanently revoked.

III

It is further alleged that Respondent's actions as described in Counts 1-3 herein, individually and collectively, constitute grounds for the Board to revoke or suspend Respondent's Texas medical license or to impose any other authorized means of discipline upon Respondent pursuant to Sections 3.08(1), 3.08(4), 3.08(4)(A), 3.08(18), and 3.08(21) of the Act.

IV

Section 3.08(1) of the Act authorizes the Board to discipline a licensed Texas physician for submission of a false or misleading statement, document, or certificate to the board in an application for examination or licensure; the presentation to the board of any license, certificate, or diploma that was illegally or fraudulently obtained; the practice of fraud or deception in taking or passing an examination.

Section 3.08(4) of the Act authorizes the Board to discipline a licensed Texas physician for unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public.

Section 3.08(4)(A) of the Act authorizes the Board to discipline a licensed Texas physician for committing any act that

is in violation of the laws of the State of Texas if the act is connected with the physician's practice of medicine.

Section 3.08(18) of the Act authorizes the Board to discipline a licensed Texas physician for professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

Section 3.08(21) of the Act authorizes the Board to discipline a licensed Texas physician for suspension, revocation, restriction, or other disciplinary action by another state of a license to practice medicine, or disciplinary action by the uniformed services of the United States, based upon acts by the licensee similar to acts described in this section. A certified copy of the record of the state taking the action is conclusive evidence of it.

V

Respondent's actions as set forth in Counts 1-3 herein, are individually and collectively grounds for cancellation, revocation, or suspension of Respondent's license to practice medicine in the State of Texas pursuant to Sections 3.08, 4.01, and 4.12 of the Act.

VI

Section 4.01 of the Act authorizes the cancellation, revocation, suspension and probation of a physician's license for a violation of the Act or a rule of the Board or for any cause for which the Board is authorized to refuse to admit persons to its examination and to issue a license and renewal license.

VII

Section 4.12 of the Act authorizes a range of disciplinary actions against a licensed physician for committing any of the conduct set forth in Section 3.08 of the Act.

VIII

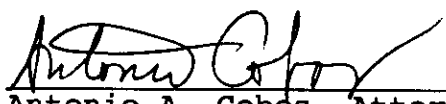
Respondent's violations of Sections 3.08(1), 3.08(4), 3.08(4)(A), 3.08(18), and 3.08(21) of the Act, as described in Counts 1-3, above, are grounds for the Board to enter an order imposing other means of discipline upon Respondent pursuant to Section 4.12 of the Act.

IX

Respondent's actions as set forth in Counts 1-3 herein, are grounds individually and collectively for the revocation or suspension of Respondent's Texas medical license or the imposition of other means of discipline as provided for in Section 4.12 of the Act.

WHEREFORE, PREMISES CONSIDERED, it is requested that a hearing on this Complaint be held and that an Order be entered to revoke or suspend Respondent's medical license, and in the event Respondent's medical license is not revoked or suspended, it is prayed that other means of discipline be imposed.

Respectfully submitted,



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THE STATE OF TEXAS §
§
COUNTY OF TRAVIS §

SUBSCRIBED AND SWORN to before me by the said Antonio A. Cobos on this the 28th day of July, 1995.

JOAN HENNEN
Notary Public, State of Texas
My Comm. Expires 5-24-98

Joan Hennen
Notary Public, State of Texas

Filed with the Texas State Board of Medical Examiners on this the 28th day of July, 1995.

Bruce A. Levy MD JD
Bruce A. Levy, M.D., J.D.
Executive Director
Texas State Board of Medical Examiners

CERTIFICATE OF SERVICE

I certify that on this 28th day of July, 1995, a true and correct copy of the foregoing Complaint has been served on the following individuals at the locations and in the manner indicated below:

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