

## **Texas Medical Board Press Release**

### **FOR IMMEDIATE RELEASE**

October 30, 2013

Media contact: Jarrett Schneider, 512-305-7018  
Customer service: 512-305-7030 or 800-248-4062

### **TMB disciplines 36 physicians at October meeting, adopts rule changes**

At its October 18, 2013 meeting, the Texas Medical Board disciplined 36 licensed physicians and issued one cease and desist order. The disciplinary actions included fourteen orders related to quality of care violations, eight orders related to unprofessional conduct, two orders related to non-therapeutic prescribing, one order based on other states' actions, one suspension, four voluntary surrenders, three orders related to peer review actions, one order related to Texas Physicians' Health Program violations, one order related to inadequate medical records, and one pain clinic action.

The Board did not issue physician licenses at its October meeting.

### **RULE CHANGES ADOPTED**

#### **Chapter 193. Standing Delegation Orders**

The Texas Medical Board adopted the repeal of §§193.1-193.10 and 193.12 and the replacement with new §§193.1-193.20 in Chapter 193, Standing Delegation Orders. A majority of the new sections of Chapter 193 were adopted to conform Chapter 193 with changes made to the Texas Occupation Code Annotated Chapter 157, Subchapter B, concerning delegation to advanced practice registered nurses and physician assistants, by Senate Bill 406, 83<sup>rd</sup> Legislature, Regular Session (2013).

Rule changes are effective November 7, 2013 and will be published in the Friday, November 1, 2013 issue of the Texas Register: <http://www.sos.state.tx.us/texreg/index.shtml>. (Note: Click on links under Current Issue on right side of webpage.)

### **CHAPTER 193. STANDING DELEGATION ORDERS**

#### **§193.1 - Purpose**

This section describes the intended purpose of Chapter 193 and sets forth its statutory basis.

#### **§193.2 - Definitions**

This section provides definitions for important terms and phrases used in Chapter 193. New terms and phrases defined include: prescriptive authority agreement, device, facility based practice site, health professional shortage areas (HSPA), hospital, medication order, nonprescription drug, physician group practice, practice serving a medically underserved area, prescribe or order a drug or device, and prescription drug.

#### **§193.3 - Exclusion from the Provisions of this Chapter**

This section sets forth certain limited exclusions to the operation of the Chapter 193.

#### **§193.4 - Scope of Standing Delegation Orders**

This section describes the scope of standing delegation orders and incorporates new terms and definitions consistent with the changes to Chapter 157 of the Occupations Code.

#### **§193.5 - Physician Liability for Delegated Acts and Enforcement**

This section sets forth the applicable limitation on the liability of physicians based solely on signing a prescriptive authority agreement or delegation order. This section further states that delegating physicians remain responsible to the Board and their patients for acts performed under the physician's delegated authority.

#### **§193.6 - Delegation of Prescribing and Ordering Drugs and Devices**

This section sets forth the general requirements and limitations related to the delegation and prescribing and ordering of drugs or devices. This section also prohibits the delegation of the prescriptive authority for Schedule II drugs, except in facility based practices under Section 157.054 of the Occupations Code. Prescribing under prescriptive authority agreements eliminates former requirements for site based supervision.

#### **§193.7 - Prescriptive Authority Agreements Generally**

This section provides that physicians may delegate to advanced practice registered nurses and physician assistants the act of prescribing or ordering a drug or device through a prescriptive authority agreement and limits the combined number of advanced practice registered nurses and physician assistants with whom a physician may enter into a prescriptive authority agreement to seven. The section sets forth an exclusion to the limit of seven prescriptive authority agreements for prescriptive authority agreements when exercised in facility based practices in hospitals or long term care facilities, subject to certain limitations, and in practices serving medically underserved populations. Prescribing under prescriptive authority agreements pursuant to this section eliminates former requirements for site based supervision.

#### **§193.8 - Prescriptive Authority Agreements: Minimum Requirements**

This section sets forth minimum requirements for valid prescriptive authority agreements, including requirements for periodic face to face-to-meetings with the supervising physicians to discuss patient care and improvement of patient care.

#### **§193.9 - Delegation of Prescriptive Authority at Facility Based Practice Sites**

This section describes the requirements for delegating the prescribing or ordering of a drug or device at a facility-based practice site. This section states that the limitations on the number of advanced practice registered nurses and physician assistants delegated to under prescriptive authority agreements do not apply to a physician whose practice is facility-based under Chapter 193, subject to certain limitations. This section also addresses requirements for physician supervision and states that the constant physical presence of a physician is not required.

#### **§193.10 - Registration of Delegation and Prescriptive Authority Agreements**

This section describes the requirements for physicians to register information with the Board regarding prescriptive authority agreements entered into with advanced practice registered nurses and physician assistants. This section also states that the Board shall maintain and exchange information with the Texas Board of Nursing and Physician Assistant Board as well as creating and making available to the public, an online list of physicians, advanced practice registered nurses, and physician assistants who have entered into prescriptive authority agreements.

### **§193.11 - Prescription Forms**

This section provides that prescription forms shall comply with applicable rules adopted by the Board of Pharmacy.

### **§193.12 - Prescriptive Authority Agreements**

This section provides the Board authority to enter, with reasonable notice, a site where a party to a prescriptive authority agreement is practicing, to inspect and audit records or activities related to the implementation and operation of the agreement.

### **193.13 - Delegation to Certified Registered Nurse Anesthetists**

This section authorizes the delegation of the ordering of drugs and devices to a certified nurse anesthetist in a licensed hospital or ambulatory surgical center, for the purpose of the nurse anesthetist administering an anesthetic or anesthesia-related service ordered by a physician.

### **§193.14 - Delegation Related to Obstetrical Services**

This section describes the authority, requirements, and limitations, related to delegating to physicians assistants offering obstetrical services and advance practice registered nurses recognized by the Texas State Board of Nurse Examiners as nurse midwives, the act or acts of administering controlled substances related to intra-partum and post-partum care.

### **§193.15 - Delegated Drug Therapy Management**

This section describes the authorization for, and requirements, and limitations, related to the delegation by physicians to pharmacists of drug therapy management.

### **§193.16 - Delegated Administration of Immunizations or Vaccinations by a Pharmacist under Written Protocol**

This section describes the authorization for, requirements, and limitations, related to the delegation of the administration of immunizations and vaccinations to a pharmacist.

### **§193.17 - Nonsurgical Medical Cosmetic Procedures**

This section describes the duties and responsibilities of a physician who performs or who delegates the performance of nonsurgical medical cosmetic procedures.

### **§193.18 - Pronouncement of Death**

This section authorizes physicians to receive information from Texas licensed vocational nurses through electronic communication for the purposes of making a pronouncement of death.

### **§193.19 - Collaborative Management of Glaucoma**

This section sets forth the minimum standards for the collaborative treatment of glaucoma.

### **§193.20 - Immunization of Persons Over 65 by Physician's Offices**

This section sets forth requirements that physicians providing ongoing primary or principal care to persons over 65 (elderly persons) to offer, to the extent possible, pneumococcal and influenza vaccines to each elderly person receiving care at the office.

## **DISCIPLINARY ACTIONS**

### **QUALITY OF CARE**

#### **Agim, Onyinye Amara, M.D., Lic. No. N2360, Houston**

On October 18, 2013, the Board and Onyinye Amara Agim, M.D., entered into an Agreed Order requiring Dr. Agim to complete at least 16 hours of CME, divided as follows: 8 hours in ethics and 8 hours in risk management (including supervision of mid-level providers) and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Agim did not adequately supervise the employees under her direction at the clinic, including the advanced practice nurse and had no written protocols in place during her supervision.

#### **Barrow, Justin Boone, M.D., Lic. No. K8607, College Station**

On October 18, 2013, the Board and Justin Boone Barrow, M.D., entered into an Agreed Order requiring Dr. Barrow to within one year complete at least 8 hours of CME in evaluation of chest pain. The Board found Dr. Barrow failed to appropriately evaluate and treat a patient for chest pain.

#### **Carreras, Jose R., M.D., Lic. No. G8678, Mission**

On October 18, 2013, the Board and Jose R. Carreras, M.D., entered into a Mediated Agreed Order requiring Dr. Carreras to 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. Carreras failed to meet the standard for one patient in his surgical care by not performing a complete examination and establish plan of care prior to his surgical intervention.

#### **Gleason, Patrick Langham, M.D., Lic. No. L6913, Corpus Christi**

On October 18, 2013, the Board and Patrick Langham Gleason, M.D., entered into an Agreed Order requiring Dr. Gleason to have his practice monitored by another physician for four monitoring cycles; within one year complete at least 12 hours of CME, divided as follows: four hours in medical record-keeping, four hours in risk management, and four hours in post-operative complications; and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Gleason failed to use proper diligence in his treatment of one patient and failed to safeguard against potential complications that led to the vascular injury and death of said patient.

#### **Hogan, Matthew James, M.D., Lic. No. H5777, Atlanta**

On October 18, 2013, the Board and Matthew James Hogan, M.D., entered into a Mediated Agreed Order requiring Dr. Hogan to within one year complete eight hours of CME in diagnosing cardiopulmonary emergencies and eight hours in medical record keeping; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Hogan failed to meet the standard of care in regards to one patient by failing to adequately evaluate the patient for a pulmonary embolism.

#### **Lester, R. Anton, III, D.O., Lic. No. F3204, Tyler**

On October 18, 2013, the Board and R. Anton Lester, III, D.O., entered into an Agreed Order requiring Dr. Lester to have his practice monitored by another physician for 12 monitoring cycles; within one year complete at least 16 hours of CME, divided as follows: eight hours in risk management and eight hours in ethics; not prescribe, dispense, administer or authorize controlled substances or dangerous drugs to himself for his own use or in his name for use by patients; separate from patient records, Dr. Lester shall maintain a log consisting of a record of every sample of controlled substances or dangerous drugs provided to patients in chronological order by date issued; and pay an administrative penalty of \$3,000 within 90 days. The Board found Dr. Lester's medical records were inadequate with the treatment of one patient and that Dr. Lester admitted to prescribing in his name in order to provide medications to his patients.

#### **Lewis, Adolphus Ray, D.O., Lic. No. H2532, Fort Worth**

On October 18, 2013, the Board and Adolphus Ray Lewis, D.O., entered into an Agreed Order requiring Dr. Lewis to have his practice monitored by another physician for eight monitoring cycles; 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. Lewis failed to meet the standard of care in his treatment of a patient's skin ulcers and maintained inadequate medical records.

**Miller, Dwayne, C., M.D., Lic. No. H0638, Comanche**

On October 18, 2013, the Board and Dwayne C. Miller, M.D., entered into an Agreed Order requiring Dr. Miller to within one year complete at least 16 hours of CME, divided as follows: 8 hours in medical recordkeeping and 8 hours in heart failure/blockage. The Board found Dr. Miller failed to meet the standard of care in the treatment of one patient when he failed to obtain an echocardiogram after complications developed following the placing of a cardiac pacemaker and failed to seek assistance when complications developed during the procedure.

**Mittal, Piyush, M.D., Lic. No. L7816, Lubbock**

On October 18, 2013, the Board and Piyush Mittal, M.D., entered into an Agreed Order requiring Dr. Piyush to complete at least 16 hours of CME, divided as follows: 8 hours in risk management and 8 hours in medical record-keeping. The Board found Dr. Piyush failed to meet the standard of care in the treatment of a patient by not maintaining continuity of care in the transfer of a patient between hospital facilities.

**CORRECTED ORDER 10/31/13: Noble, DeCarlo, M.D., Lic. No. L5851, Denton**

On October 18, 2013, the Board approved a Final Order requiring Dr. Noble to have his practice monitored by another physician for eight monitoring cycles; and within one year complete at least 36 hours of CME, divided as follows: eight hours in high risk obstetrics and gynecology, eight hours in medical recordkeeping, eight hours in risk management, and eight hours in ethics. The action was based on the findings of an administrative law judge who heard the case at the State Office of Administrative Hearings.

**Park, Jin Sup, M.D., Lic. No. E8797, Houston**

On October 18, 2013, the Board approved a Final Order publicly reprimanding Dr. Park and requiring Dr. Park to within 180 days complete the Clinical Competence Assessment, including Phase I and Phase II, offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program; within one year and three attempts pass the Special Purpose Examination (SPEX) and the Medical Jurisprudence Examination (JP Exam); have his practice monitored by a physician for eight cycles; and obtain 32 hours continuing medical education, divided as follows: eight hours in performing liver biopsies, eight hours in reading diagnostic mammograms, eight hours in medical record keeping and eight hours in risk management; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Park failed to meet the standard of care in his treatment of two patients, and failed to keep adequate medical records with respect to one of those patients. The action was based on the findings of an administrative law judge who heard the case at the State Office of Administrative Hearings.

**Robledo, Jaime De Jesus, M.D., Lic. No. K6916, Katy**

On October 18, 2013, the Board and Jaime De Jesus Robledo, M.D., entered into an Agreed Order requiring Dr. Robledo to have his practice monitored by another physician for four monitoring cycles; 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. Robledo failed to meet the standard of care and non-therapeutically prescribed controlled substances to one patient without adequately documenting his examination of the patient and his rationale for treatment.

**Wieck, Bryan Robert, M.D., Lic. No. J0361, Wichita Falls**

On October 18, 2013, the Board and Bryan Robert Wieck, M.D., entered into an Agreed Order requiring Dr. Wieck to within one year and three attempts complete the Medical Jurisprudence Examination (JP Exam); within 90 days submit a copy of his physician assistants and advance nurse practitioners written protocols; and within one year complete at least 16 hours of CME, divided as follows: 8 hours in pharmacology in the treatment of psychiatric patients and 8 hours in supervision and delegation. The Board found Dr. Wieck failed to adequately supervise his delegate, an NP and psychiatric nurse, in her care of two patients. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

**Xu, Jianzhang, M.D., Lic. No. J7253, Houston**

On October 18, 2013, the Board and Jianzhang Xu, M.D., entered into an Agreed Order requiring Dr. Xu to within one year complete at least 16 hours of CME, divided as follows: 8 hours in identifying drug seeking behavior and 8 hours

medical record keeping. The Board found Dr. Xu prescribed substances to a patient without appropriate indications and/or documentation reflecting appropriate indications and failed to recognize the patient's request for hydrocodone, alprazolam, and promethazine-codeine cough syrup as possible drug seeking behavior.

## **UNPROFESSIONAL CONDUCT**

### **Dickson, John Ervin, M.D., Lic. No. J7470, San Antonio**

On October 18, 2013, the Board and John Ervin Dickson, M.D., entered into an Agreed Order requiring Dr. Dickson to within 90 days complete all required hours of CME regarding his license renewal period of September 1, 2010, to August 31, 2012, with at least 2 hours in medical ethics and/or professional responsibility as required by Board rule; within one year complete at least 16 additional hours of CME, divided as follows: eight hours medical ethics, four hours management of anger and other disruptive behaviors, and four hours physician-patient communications; within one year and three attempts complete the Medical Jurisprudence Examination (JP Exam); and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Dickson engaged in unprofessional and abusive conduct towards one patient and his staff by making embarrassing, insulting or demeaning comments and that Dr. Dickson failed to obtain or document the required number of hours of CME credits regarding the license renewal audit.

### **Elemuren-Ogunmuyiwa, Iyabo Abiola, M.D., Lic. No. K4050, Harker Heights**

On October 18, 2013, the Board and Iyabo Abiola Elemuren-Ogunmuyiwa, M.D., entered into an Agreed Order publicly reprimanding Dr. Elemuren-Ogunmuyiwa and requiring Dr. Elemuren-Ogunmuyiwa to have her practice monitored by another physician for eight monitoring cycles; and within one year complete at least eight hours of in-person CME in the topic of proper billing practices. The Board found Dr. Elemuren-Ogunmuyiwa engaged in unprofessional conduct for improper billing. Specifically, Dr. Elemuren-Ogunmuyiwa was under investigation concerning her Tri-Care patient charts.

### **Free, Marcus Kyle, M.D., Lic. No. L0799, Sandusky, MI**

On October 18, 2013, the Board and Marcus Kyle Free, M.D., entered into a Mediated Agreed Order requiring Dr. Free to undergo an independent medical evaluation by a Board-designated psychiatrist and follow all recommendations for care and treatment. The Board found Dr. Free committed unprofessional conduct relating to a civil matter between him and his spouse.

### **Holmes, Michael Wesley, M.D., Lic. No. E7118, Beaumont**

On October 18, 2013, the Board and Michael Wesley Holmes, M.D., entered into an Agreed Order requiring Dr. Holmes to within 30 days tender a letter of apology, issue a refund to his patient; and pay an administrative penalty of \$1,000 within 60 days. The Board found Dr. Holmes failed to reimburse a patient for an over-payment and failed to respond to the patient's request for a written explanation of the patient's bill.

### **Hume, Thaddeus William, M.D., Lic. No. F0526, Houston**

On October 18, 2013, the Board and Thaddeus William Hume, M.D., entered into an Agreed Order requiring Dr. Hume to complete within one year and three attempts the Medical Jurisprudence Examination (JP Exam); complete within one year at least 16 hours of CME, divided as follows: 8 hours in ethics and 8 hours risk management; and pay an administrative penalty of \$2,000 within 60 days. The Board found Dr. Hume admitted that he supplied incorrect answers on his May 2010 licensure renewal form after being indicted in U.S. District Court for the Southern District of Texas approximately two months prior to his negative response to a question asking if he had ever been "arrested, fined (over \$250), charged with or convicted of a crime, indicted, imprisoned, placed on probation, or placed on deferred adjudication," since his most recent licensure with the Board and that based on the 2010 indictment, Dr. Hume was subject of peer review and disciplinary action taken by St. Joseph's Medical Center.

### **Hurly, James Matthew, M.D., Lic. No. J7996, Amarillo**

On October 18, 2013, the Board and James Matthew Hurly, M.D., entered into an Agreed Order requiring Dr. Hurly to complete the anger management course offered by the University of California San Diego Physician Assessment and Clinical Education (PACE) program, or an equivalent; and pay an administrative penalty of \$2,000 within 60 days. The

Board found Dr. Hurly pled guilty and received deferred adjudication for Misdemeanor Class A Assault Causing Bodily Injury.

**Rodriguez, Armand R., M.D., Lic. No. G0021, San Antonio**

On October 18, 2013, the Board and Armand R. Rodriguez, M.D., entered into an Agreed Order publicly reprimanding Dr. Rodriguez and requiring Dr. Rodriguez to limit his work as a physician to no more than 40 hours per week. The Board found Dr. Rodriguez diverted Demerol at a surgery center for his own personal use, was confronted by staff at the center about the diversion, admitted to it and resigned his privileges. Dr. Rodriguez sought inpatient treatment related to his Demerol use soon after resigning his privileges at the center.

**Skiba, William Edward, M.D., Lic. No. H2785, Houston**

On October 18, 2013, the Board and William Edward Skiba, M.D., entered into an Agreed Order requiring Dr. Skiba to undergo an independent medical evaluation by a Board-designated psychiatrist and follow all recommendations for care and treatment. The Board found Dr. Skiba self-reported a deferred disposition of a misdemeanor charge of disorderly conduct and indecent exposure.

**NONTHERAPEUTIC PRESCRIBING**

**Lee, Kang Sun, M.D., Lic. No. K6088, Corpus Christi**

On October 18, 2013, the Board and Kang Sun Lee, M.D., entered into an Agreed Order publicly reprimanding Dr. Lee and requiring Dr. Lee to surrender within seven days his DEA and DPS Controlled Substances Registration Certificates; limit his practice to a group or institutional setting; have his practice monitored by another physician for eight monitoring cycles; within one year and three attempts complete the Medical Jurisprudence Examination (JP Exam); within one year complete the prescribing 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 medical record keeping; and pay an administrative penalty of \$15,000 within six months. The Board found Dr. Lee practiced medicine and supervised mid-level practitioners at two unregistered pain clinics in Houston, Texas, that operated as illegal pill mills; failed to adequately supervise his mid-levels who failed to meet the standard of care, non-therapeutically prescribed controlled substances, and failed to maintain adequate medical records in their care and treatment of patients.

**Sparkman, Chris Alan, M.D., Lic. No. L5571, The Woodlands**

On October 18, 2013, the Board and Chris Alan Sparkman, M.D., entered into a Mediated Agreed Order publicly reprimanding Dr. Sparkman and requiring Dr. Sparkman to refrain from engaging in the practice of pain management; shall not possess, administer, dispense, or prescribe any Schedule II controlled substances; limit his medical practice to a group or an institutional setting; have his practice monitored by another physician for eight monitoring cycles; within one year and three attempts complete the Medical Jurisprudence Examination (JP Exam); and pay an administrative penalty of \$15,000. The Board found Dr. Sparkman practiced medicine at an unregistered pain clinic that was owned by non-physicians and functioned as a "pill mill" for controlled substances. Dr. Sparkman failed to meet the standard of care, failed to maintain adequate medical records, and non-therapeutically prescribed controlled substances to patients at the clinic. The order resolves a formal complaint filed at the State Office of Administrative Hearings.

**OTHER STATES' ACTIONS**

**Sanders, Thomas Joe, M.D., Lic. No. G0055, Reno, NV**

On October 18, 2013, the Board and Thomas Joe Sanders, M.D., entered into an Agreed Order requiring Dr. Sanders to cease practicing in Texas until such a time as he personally appears before the Board and provides clear and convincing evidence that he is competent to safely practice medicine. The Board found Dr. Sanders was disciplined by the Nevada Medical Board for diverting hydrocodone for personal use resulting in the voluntary surrender of his DEA controlled substance registration.

## **SUSPENSION**

### **Terrell, Gregory Scott, M.D., Lic. No. K1695, Tyler**

On October 18, 2013, the Board and Gregory Scott Terrell, M.D., entered into an Agreed Order of Suspension, suspending Dr. Terrell's Texas medical license until such time as he appears before the Board and provides clear and convincing evidence that he is competent to safely practice medicine. The Board found Dr. Terrell was arrested on July 31, 2013 for diversion of controlled substances for another person's use.

## **VOLUNTARY SURRENDER**

### **Craig, Randall Gordon, M.D., Lic. No. G9084, Tyler**

On October 18, 2013, the Board and Randall Gordon Craig, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Craig voluntarily and permanently surrendered his Texas medical license. The Board found Dr. Craig pled guilty to and was convicted of a misdemeanor offense for failing to file a tax return. Dr. Craig requested that the voluntary surrender of his medical license be accepted in lieu of further disciplinary proceedings.

### **Nakissa, Nasser, M.D., Lic. No. G6355, San Antonio**

On October 18, 2013, the Board and Nasser Nakissa, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Nakissa voluntarily and permanently surrendered his Texas medical license in lieu of further disciplinary proceedings. Dr. Nakissa was under investigation related to allegations that he engaged in non-therapeutic prescribing of drugs in violation of the Medical Practice Act. This order resolves a formal complaint filed at the State Office of Administrative Hearings.

### **Rao, Turlapati R., M.D., Lic. No. F5004, Lubbock**

On October 18, 2013, the Board and Turlapati R. Rao, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Rao voluntarily and permanently surrendered his Texas medical license in lieu of further disciplinary proceedings. The Board found Dr. Rao surrendered his hospital privileges at two facilities while subject to peer review.

### **Routh, Lisa Carole, M.D., Lic. No. H2742, Houston**

On October 18, 2013, the Board and Lisa Carole Routh, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Routh voluntarily surrendered her Texas medical license. Dr. Routh was under investigation related to allegations that she violated the standard of care in her treatment of patients; failed to cooperate with Board staff; and engaged in substance abuse. Dr. Routh voluntarily surrendered her medical license due to her medical condition and in lieu of further disciplinary proceedings.

## **PEER REVIEW ACTIONS**

### **Cantu, Dennis David, M.D., Lic. No. F1430, Laredo**

On October 18, 2013, the Board and Dennis David Cantu, M.D., entered into an Agreed Order publicly reprimanding Dr. Cantu and requiring Dr. Cantu to use a chaperone any time he examines a female patient; within one year and three attempts complete the Medical Jurisprudence Examination (JP Exam); within one year complete at least eight hours of CME in risk management; and pay an administrative penalty of \$3,000 within 60 days. The Board found Dr. Cantu was granted a leave of absence by Laredo Medical Center following the filing of a police report by hospital staff alleging inappropriate conduct with a patient. Two statements were submitted by eye witnesses involving Dr. Cantu's alleged boundary violations, though Dr. Cantu denied engaging in any sexual contact with the patient.

### **Gladden, Jeffrey R., M.D., Lic. No. H4934, Plano**

On October 18, 2013, the Board and Jeffrey R. Gladden, M.D., entered into an Agreed Order requiring Dr. Gladden to within one year and three attempts complete the Medical Jurisprudence Examination (JP Exam); and within one year complete at least 24 hours of CME, divided as follows: 8 hours in risk management, 8 hours in supervision of midlevel providers, and 8 hours in ethics. The Board found Dr. Gladden was the subject of a peer review which found Dr. Gladden

failed to arrange coverage for his patients, failed to provide care to admitted hospital patients, failed to properly supervise his nurse practitioner, and had his hospital privileges suspended for 90 days as a result.

**Shah, Mrugeshkumar K., M.D., Lic. No. L6174, Carrollton**

On October 18, 2013, the Board and Mrugeshkumar K. Shah, M.D., entered into an Agreed Order requiring Dr. Shah to have his practice monitored by another physician for eight monitoring cycles; within one year complete at least 12 hours of CME, divided as follows: four hours in medical ethics, four hours in risk management, and four hours in medical recordkeeping. The Board found Dr. Shah had his privileges revoked due to his continued failure to timely complete his standard operating reports and failure to provide updated credentialing information.

**TXPHP VIOLATION**

**Whitt, Theresa Ann, M.D., Lic. No. J0360, Beeville**

On October 18, 2013, the Board and Theresa Ann Whitt, M.D., entered into an Agreed Order requiring Dr. Whitt to undergo an independent medical evaluation by a Board-designated psychiatrist and follow all recommendations for care and treatment and abstain from the consumption of prohibited substances. The Board found Dr. Whitt violated provisions of her 2012 Remedial Plan because she violated her contract to complete the Texas Physicians' Health Program (TXPHP).

**INADEQUATE MEDICAL RECORDS**

**Salameh, Raja Nicolas, M.D., Lic. No. G9654, McAllen**

On October 18, 2013, the Board and Raja Nicolas Salameh, M.D., entered into an Agreed Order requiring Dr. Salameh have his practice monitored by another physician for eight monitoring cycles; and within one year complete at least 8 hours of CME in the topic of risk management. The Board found Dr. Salameh maintained inadequate medical records for a patient to support his care and treatment of the patient.

**CEASE AND DESIST**

**Brooks, Amber, D.C., No Medical License, Dallas**

On September 25, 2013, the Board entered a Cease and Desist Order regarding chiropractor Amber Brooks, D.C., prohibiting her from engaging in the practice of medicine. The Board found Dr. Brooks engaged in the unlicensed practice of medicine by making offers on her website for treatments that exceed the scope of the practice of chiropractic.

**PAIN MANAGEMENT CLINIC ACTIONS**

**Dallas Medical Consultants, Cert. No. PMC00342, Dallas**

On October 18, 2013, the Board and and Robert John Koval, M.D., entered into an Agreed Order of Voluntary Surrender in which Dr. Koval surrendered his Pain Management Clinic Certification for Dallas Medical Consultants in lieu of further disciplinary proceedings. The order requires Dr. Koval to immediately cease operating Dallas Medical Consultants as a pain clinic in Texas and withdraw any and all PMC applications, if any, currently pending before the Board.

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*To view disciplinary orders, visit the TMB website, click on "Look Up A Doctor," accept the usage terms, then type in a doctor's name. Click on the name shown in the search results to view the doctor's full profile. Within that profile is a button that says "View Orders."*