LICENSE NO. D-3082

IN THE MATTER OF	BEFORE THE
THE LICENSE OF	
FRANCISCO JOSE RODRIGUEZ, M.D.	TEXAS MEDICAL BOARD

MEDIATED AGREED ORDER

On the 4th day of November, 2011, came on to be heard before the Texas Medical Board (the "Board"), duly in session, the matter of the license of Francisco Jose Rodriguez, M.D. ("Respondent").

On July 22, 2010, Respondent appeared in person, with counsel Ace Pickens, at an Informal Show Compliance Proceeding and Settlement Conference ("ISC") in response to a letter of invitation from the staff of the Board. The Board's representatives were John D. Ellis, a member of the Board, and Kathy C. Flanagan, M.D., a member of a District Review Committee ("Panel"). Lee Bukstein represented Board staff.

The matter did not settle at the ISC, and the Board filed a formal complaint at the State Office of Administrative Hearings ("SOAH").

On January 13, 2011, Respondent appeared in person, with counsel Ace Pickens, at an ISC in response to a letter of invitation from the staff of the Board. The Board's representatives were John D. Ellis, a member of the Board, and Kathy C. Flanagan, M.D., a member of a District Review Committee ("Panel"). Lee Bukstein represented Board staff. The matter did not settle at the ISC.

Prior to these matter going to trial, the parties agreed to mediation. The mediation was held on October 20, 2011. Respondent appeared in person with counsel, Richard Ellis. The Board was represented by Kathy C. Flanagan, M.D., a member of a District Review Committee, and Lee Bukstein, Staff Attorney.

Upon the recommendation of the Board's representatives and with the consent of Respondent, the Board makes the following Findings and Conclusions of Law and enters this Mediated Agreed Order.

BOARD CHARGES

Board staff charged that Respondent failed to properly evaluate and treat Patient A for bipolar disorder while at Methodist Specialty & Transplant Hospital and that Respondent had increased Patient A's dose of Effexor without adequate documentation.

Board staff also charged that Respondent: failed to document an adequate clinical evaluation of Patient B; prescribed Xanax for Patient B for an extended period of time without adequately documenting a clinical rationale; prescribed concomitant Xanax, Provigil, and Lunesta without adequately documenting his rationale; and that he had failed to adequately advise Patient B about potential drug interactions.

Board Staff charged that Respondent failed to properly change Patient C's medications. The ISC Panel found no violation regarding the change in medications. Board Staff also charged that Respondent had failed to maintain adequate medical records and had improperly terminated the patient's care.

BOARD HISTORY

Respondent has not received a prior disciplinary order from the Board.

Upon the recommendation of the Board's representatives and with the consent of Respondent, the Board makes the following Findings and Conclusions of Law and enters this Agreed Order.

FINDINGS

The Board finds the following:

1. General Findings:

   a. Respondent received all notice required by law. All jurisdictional requirements have been satisfied. Respondent waives any defect in notice and any further right to notice or hearing under the Medical Practice Act, Title 3, Subtitle B, Texas Occupations Code (the "Act") or the Rules of the Board.

b. Respondent currently holds Texas Medical License No. D-3082. Respondent was originally issued this license to practice medicine in Texas on June 21, 1966. Respondent is also licensed to practice in New York and the District of Columbia.

c. Respondent is primarily engaged in the practice of psychiatry. Respondent is board certified by the American Board of Psychiatry and Neurology, a member of the American Board of Medical Specialties.

d. Respondent is 75 years of age.

2. Specific Panel Findings:

Patient A:

a. Respondent. Patient A was hospitalized due to psychological problems at Methodist Hospital from January 23, 2010, through January 25, 2010. Patient A was transferred on January 25, 2010, to Methodist Specialty & Transplant Hospital. Respondent was the attending psychiatrist for Patient A at Methodist Specialty & Transplant Hospital through the Patient's discharge on January 30, 2010.

b. Respondent evaluated and managed a patient who presented with complaints of depression and suicidal ideation.

c. Respondent noted at the time of admission that the Patient was hospitalized due to her suicide attempt via overdose, current depression and history of depression. Respondent also noted a history of a prior suicide attempt and recent heavy consumption of red wine. Respondent's diagnosis was Major Depressive Disorder, severe. At the time of the Patient's discharge, an appointment with another psychiatrist was scheduled for February 24, 2010. Respondent prescribed Effexor XR 150 mg BID and Xanax 0.5 mg prn. After Patient A was no longer under Respondent's care, Patient A subsequently attempted suicide again and was re-hospitalized for psychiatric treatment.

d. Respondent did not document any information to show that he considered the possibility of diagnosis of Bipolar disorder (e.g., pertinent negatives for Bipolar disorder or screening questions for prior symptoms of mania or hypomania) nor did he document that he had ruled out that diagnosis.

e. Respondent failed to document any discussion with the Patient about the possibility of an underlying Bipolar disorder or to caution her that if such disorder was present, the increase in her antidepressant could precipitate a manic episode and a worsening of symptoms. Respondent also failed to document that the modifiable risk factors for suicide (e.g. alcohol use) noted in the psychosocial assessment were addressed by him.

Patient B:

f. Respondent saw Patient B beginning 2006 through May 2009. Respondent prescribed Xanax, Darvocet, Lexapro and Zomig.

g. Respondent failed to document an original initial evaluation for Patient B that justified the treatment with sedative-hypnotics. Respondent failed to document a rationale for continuation and maintenance treatment with sedative-hypnotics.

h. Respondent prescribed Xanax for an extended time without documenting the justification with particular clinical circumstances.

i. In 2009, Respondent initiated treatment of Patient B with Provigil, a drug usually prescribed to promote wakefulness, without documenting the justification with particular clinical circumstances.

j. Patient B obtained prescriptions, including hydrocodone, from other providers during this time.

k. On May 8, 2009, Patient B was admitted to Methodist Specialty and Transplant Hospital under the care of the Respondent for a diagnosis of major depression aggravated by psychosocial stressors from work and because of her eviction from her temporary residence at the home of her sister.

l. Respondent did not document his assessment to determine whether Patient B was abusing drugs.

m. From May 2009 to December 2009, Respondent prescribed Lunesta without documenting the justification with particular clinical circumstances.

n. Respondent failed to adequately document that he had advised Patient B about the dangers of drug interactions for the drugs that he was prescribing simultaneously.

o. Respondent failed to maintain his documentation of his treatment of Patient A and Patient B in a legible manner.

Patient C:

p. Respondent failed to maintain adequate medical records for Patient C that were complete, contemporaneous and legible. The medical records lacked documentation of: a discussion of risks, including Tardive Dyskinesia, and benefits of Thorazine; alternative medication treatments; reasons for the medication and the dosages given; and periodic monitoring for the potential emergence of side effects of the prescribed medication.

q. Respondent failed to document appropriate evaluation and management of Patient C who presented with anxiety symptoms and auditory hallucinations.

r. On August 3, 2009, Patient C refused to follow Respondent's recommendations and switch medications. Respondent then informed the Patient and his spouse that he was terminating his care of the Patient immediately. Respondent reiterated this termination of care by sending a letter to Respondent that day that referenced the availability of the Center for Health Care Services.

s. Respondent discontinued treatment without addressing Patient C's current medication needs and without indicating that Respondent would continue to remain available to the Patient for a specified period of time while the Patient secured a new physician.

3. Mitigating Factors:

In determining the appropriate sanctions in this matter, the Panel considered the following mitigating factors:

a. Patient C's spouse interfered with the physician-patient relationship.

b. Respondent has already improved his medical recordkeeping practices and is implementing additional plans to improve his medical recordkeeping.

c. Respondent has cooperated in the investigation of the allegations related to this Agreed Order. Respondent's cooperation, through consent to this Agreed Order, pursuant to the provisions of Section 164.002 the Act, will save money and resources for the State of Texas. To avoid further investigation, hearings, and the expense and inconvenience of litigation, Respondent agrees to the entry of this Agreed Order and to comply with its terms and conditions.

CONCLUSIONS OF LAW

Based on the above Findings of Fact, the Board concludes that:

1. The Board has jurisdiction over the subject matter and Respondent pursuant to the Act.

2. Section 164.051(a)(3) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's violation of a Board rule, specifically Board Rules: 165.1, requiring the maintenance of adequate medical records;

3. Section 164.051(a)(6) of the Act authorizes the Board to take disciplinary action against Respondent based on Respondent's failure to practice medicine in an acceptable professional manner consistent with public health and welfare, and further defined by Board Rules: 190.8(1)(A), failure to treat a patient according to the generally accepted standard of care; 190.8(1)(C), failure to use proper diligence in one's professional practice; 190.8(1)(D), failure to safeguard against potential complications; 190.8(1)(H), failure to disclose reasonable alternative treatments; and 190.8(1)(J), termination of patient care without providing reasonable notice to the patient.

4. Section 164.053(a)(6) of the Act authorizes the Board to take disciplinary action against Respondent based upon Respondent's prescribing, administering or dispensing dangerous drugs in a manner inconsistent with public health and welfare.

5. Section 164.001 of the Act authorizes the Board to impose a range of disciplinary actions against a person for violation of the Act or a Board rule.

6. Section 164.002(a) of the Act authorizes the Board to resolve and make a disposition of this matter through an Agreed Order.

ORDER

Based on the above Findings and Conclusions of Law, the Board ORDERS that Respondent shall be subject to the following terms and conditions:

1. For 12 monitoring cycles (defined below) following the date of the entry of this Order, Respondent's practice shall be monitored by a physician ("monitor"), in accordance with

§164.001(b)(7) of the Act. A "monitoring cycle" begins when the Compliance Division selects patient records for review, and concludes when Respondent receives the monitor's report for that group of records. The Compliance Division of the Board shall designate the monitor and may change the monitor at any time for any reason. The monitor shall have expertise in a similar specialty area as Respondent. The Compliance Division shall provide a copy of this Order to the monitor, together with other information necessary to assist the monitor.

a. As requested by the Compliance Division, Respondent shall prepare and provide complete legible copies of selected patient medical and billing records ("selected records"). The Compliance Division shall select records for at least 30 patients seen by Respondent during each three-month period following the last day of the month of entry of this Order ("reporting period"). The Compliance Division may select records for more than 30 patients, up to 10 percent of the patients seen during a reporting period. If Respondent fails to see at least 30 patients during any three-month period, the term of this Order shall be extended until Respondent can submit a sufficient number of records for a monitor to review. The monitor shall perform the following duties:

1) Personally review the selected records;
2) Prepare written reports documenting any perceived deficiencies and any recommendations to improve Respondent's practice of medicine or assist in the ongoing monitoring process. Reports shall be submitted as requested by the Compliance Division; and
3) Perform any other duty that the Compliance Division determines will assist the effective monitoring of Respondent's practice.

b. The Compliance Division shall provide to Respondent a copy of any deficiencies or recommendations submitted by the monitor. Respondent shall implement the recommendations as directed by the Compliance Division.

c. The monitor shall be the agent of the Board, but shall be compensated by the Respondent through the Board. Such compensation and any costs incurred by the monitor shall be paid by Respondent to the Board and remitted by the Board to the monitor. Respondent shall not charge the compensation and costs paid to the monitor to any patients.

2. Within 18 months from the date of the entry of this Order, Respondent shall enroll in and successfully complete the medical recordkeeping course offered by University of

California San Diego Physician Assessment and Clinical Education (PACE) program or an equivalent course approved in advance by the Executive Director. To obtain approval for a course other than PACE courses, Respondent shall submit in writing to the Compliance Division of the Board information on the course that includes description of the course content, faculty, course location, and dates of instruction. Respondent shall submit documentation of attendance and successful completion of this requirement to the Compliance Division of the Board on or before the expiration of the time limit set forth for completion of the course. The course requirements set forth in this paragraph shall be in addition to all other continuing medical education ("CME") required for licensure maintenance.

3. Within 18 months from the date of the entry of this Order, Respondent shall obtain, in addition to any CME required for licensure renewal, at least a total of 16 hours of CME approved for Category I credits by the American Medical Association in the subject of psychopharmacology. These courses must be approved in writing in advance by the Executive Director or their designee. To obtain approval for the course, Respondent shall submit in writing to the Compliance Division of the Board information on the course, to include at least a reasonably detailed description of the course content and faculty, as well as the course location and dates of instruction. Respondent shall submit documentation of attendance and successful completion of this requirement to the Compliance Division of the Board on or before the expiration of the time limit set forth for completion of the course.

4. Respondent shall pay an administrative penalty in the amount of $1,000 within 60 days of the date of the entry of this Order. The administrative penalty shall be paid in a single payment by cashier's check or money order payable to the Texas Medical Board and shall be submitted to the Board for routing so as to be remitted to the Comptroller of Texas for deposit in the general revenue fund. Respondent's failure to pay the administrative penalty as ordered shall constitute grounds for further disciplinary action by the Board, and may result in a referral by the Executive Director of the Board for collection by the Office of the Attorney General.

5. Respondent shall comply with all the provisions of the Act and other statutes regulating the Respondent's practice.

6. Respondent shall fully cooperate with the Board and the Board staff, including Board attorneys, investigators, compliance officers, consultants, and other employees or agents of the Board in any way involved in investigation, review, or monitoring associated with

Respondent's compliance with this Order. Failure to fully cooperate shall constitute a violation of this order and a basis for disciplinary action against Respondent pursuant to the Act.

7. Respondent shall inform the Board in writing of any change of Respondent's office or mailing address within 10 days of the address change. This information shall be submitted to the Registration Department and the Compliance Department of the Board. Failure to provide such information in a timely manner shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act. Respondent agrees that 10 days notice of a Probationer Show Compliance Proceeding to address any allegation of non-compliance of this Agreed Order is adequate and reasonable notice prior to the initiation of formal disciplinary action. Respondent waives the 30-day notice requirement provided by §164.003(b)(2) of the Medical Practice Act and agrees to 10 days notice, as provided in 22 Texas Administrative Code §187.44(4).

8. Any violation of the terms, conditions, or requirements of this Order by Respondent shall constitute unprofessional conduct likely to deceive or defraud the public, or to injure the public, and shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act.

9. Respondent shall be permitted to supervise and delegate prescriptive authority to physician assistants and advanced practice nurses and to supervise surgical assistants.

10. The above referenced conditions shall continue in full force and effect without opportunity for amendment, except for clear error in drafting, for one year following the date of the entry of this Order. If, after the passage of the one year period, Respondent wishes to seek amendment or termination of these conditions, Respondent may petition the Board in writing. The Board may inquire into the request and may, in its sole discretion, grant or deny the petition without further appeal or review. Petitions for modifying or terminating may be filed only once a year thereafter.

RESPONDENT WAIVES ANY FURTHER HEARINGS OR APPEALS TO THE BOARD OR TO ANY COURT IN REGARD TO ALL TERMS AND CONDITIONS OF THIS AGREED ORDER. RESPONDENT AGREES THAT THIS IS A FINAL ORDER.

THIS ORDER IS A PUBLIC RECORD.

I, FRANCISCO JOSE RODRIGUEZ, M.D., HAVE READ AND UNDERSTAND THE FOREGOING AGREED ORDER. I UNDERSTAND THAT BY SIGNING, I WAIVE CERTAIN RIGHTS. I SIGN IT VOLUNTARILY. I UNDERSTAND THIS AGREED ORDER CONTAINS THE ENTIRE AGREEMENT AND THERE IS NO OTHER AGREEMENT OF ANY KIND, VERBAL, WRITTEN OR OTHERWISE.

DATED: 10/20-11, 2011.

FRANCISCO JOSE RODRIGUEZ, M.D.
Respondent

SIGNED AND ENTERED by the presiding officer of the Texas Medical Board on this 4th day of November, 2011.

Irvin E. Zeitler, Jr., D.O., President
Texas Medical Board