B-9641

IN THE MATTER OF THE COMPLAINT	)(	BEFORE THE
FRANK LANIER DUNN, M.D.,	)(	TEXAS STATE BOARD
RESPONDENT	)(	OF MEDICAL EXAMINERS

ORDER

On this the 16th day of June, 1992, came to be heard for final action by the Texas State Board of Medical Examiners ("the Board"), in session, the matter of the complaint against Frank Lanier Dunn, M.D. ("the Respondent"). The Board was represented by Antonio A. Cobos. Respondent was represented by Egon Tausch, Heritage Plaza Building, 434 South Main, Suite 209, San Antonio, Texas 78204. The Hearing Examiner was Wade Wilson, Esq.

The Board's Complaint alleged that the Respondent violated Section 3.08(18) and Section 3.08(4) of the Medical Practice Act of Texas.

The matter was heard in public hearing on December 9, 1991, and concluded on December 11, 1991. Written arguments were submitted to the Hearing Examiner after the hearing.

After consideration of the Proposed Decisions of Issues submitted to the Board by the Hearing Examiner, and argument of counsel, the Board makes the following Finding of Facts and Conclusions of Law:

FINDINGS OF FACT

1. Respondent, Frank Lanier Dunn, M.D., is a physician duly licensed by the Board. Respondent holds medical license B-9641.

2. The Board has jurisdiction over the subject matter and Respondent. The Board provided all notices required by law and the rules of the Board. All jurisdictional requirements have been satisfied.

3. Official notice was taken of the Medical Practice Act, Art. 4495, T.R.C.S.; the Board's Administrative Rules, 22 T.A.C. et. seq. and the Texas Controlled Substances Act, Health and Safety Code, Chapter 481.

4. Respondent knowingly and competently waived his Fifth Amendment rights under the United States Constitution. The Examiner did not allow a blanket waiver of rights but allowed Respondent to invoke a privilege of self-incrimination at any time during the hearing. The Examiner noted that criminal charges against Respondent were then pending.

5. Richard Dean Heimbach, M.D. is a duly licensed Texas physician who has practiced in Texas since 1972. Dr. Heimbach served in the Air Force for 20 years, during which time he completed a residency in aerospace medicine and a Ph.D. in radiation biology. Dr. Heimbach is Board of Medical Specialties certified in aerospace medicine and has a full-time hyperbaric practice in San Antonio, Texas. Dr. Heimbach sees 40-50 patients per day, belongs to a number of professional organizations and has a number of publications, mainly in hyperbaric medicine.

6. Dr. Heimbach has authored a number of chapters in textbooks on various subjects in hyperbaric medicine going back to 1977, including a chapter for a new textbook in hyperbaric medicine which will be edited by Dr. Eric Kenwald out of Milwaukee, Wisconsin.

7. Dr. Heimbach is well qualified to express opinions on the subject of hyperbaric medicine and its indications.

8. Hyperbaric oxygen treatment consists of enclosing a patient in a chamber (either single or multi-patient) in which atmospheric pressure is increased from anywhere up to six times normal atmospheric pressure. One hundred percent oxygen may also be given to the patient to breathe depending on the pressure used.

9. The theory behind hyperbaric oxygen treatment is that there are certain disease states which are either initiated by or made worse by a decreased oxygen tension in some part of the body. One can then increase oxygen tension to that part of the body to normal or near normal oxygen tension and reverse the pathological process taking place.

10. Hyperbaric oxygen therapy should be administered in a

controlled environment for safety reasons. Doubling of one atmospheric pressure (30 lbs./inch) is equivalent to the pressure released by the detonation of a 50 megaton thermonuclear weapon directly overhead.

11. Patients who are to undergo hyperbaric treatment are screened for certain types of lung diseases because upon release of pressure after hyperbaric treatment, air can be trapped and cause a patient to have a lung rupture.

12. A lung rupture may cause a cerebral air embolism with a bolus of air that goes to the brain and can very rapidly kill a patient.

13. Hyperbaric treatment chambers should be established as part of hospital facilities, should maintain cleanliness and should be certified as usable by the American Society of Mechanical Engineers.

14. There are approximately 300 hyperbaric treatment facilities in the U.S. of which essentially all of them are in hospital settings.

15. Patient R.L. was seen by Respondent for treatment of AIDS which is a viral infection in which the virus attacks the immune system. AIDS makes a patient very susceptible to a number of infectious diseases or neoplasms any one of which may eventually kill the patient.

16. Hyperbaric oxygen treatment is not indicated for the treatment of AIDS. There is no evidence to support the use of hyperbaric oxygen treatment for AIDS.

17. Patient R.L. was treated by Respondent from March 23, 1988 to March 28, 1988. During this time period Respondent administered hyperbaric oxygen treatment to R.L. for his AIDS illness.

18. On March 25, 1988, Respondent administered hyperbaric oxygen treatment to patient R.L. who later became unresponsive and went into respiratory arrest.

19. The autopsy report of R.L. was consistent with a diagnosis of death from air embolism. Air embolism is one of the potential dangers of exposure to the hyperbaric pressure environment. Patients with AIDS, such as R.L., are very susceptible to pulmonary disease, particularly pneumocystis which can set up a patient for the kind of pulmonary pathology which would in turn lead to air trapping, lung rupture then air embolus.

20. An air embolus is a bolus or bubble or multiple bubbles of air which enters the arterial side of circulation. This air then blocks circulation of blood to the brain and the patient essentially has a stroke. This type of stroke is caused by a blockage of air rather than a blood clot as in normal strokes.

21. Patient R.L. died as a result of a pulmonary embolus secondary to Respondent's hyperbaric oxygen treatment.

22. The use of hyperbaric oxygen treatment for R.L.'s illness of AIDS was nontherapeutic in nature and in the manner prescribed.

23. The medical records of R.L. are inadequate in that Respondent failed to conduct an adequate physical exam, history or proper laboratory studies.

24. Respondent's care and treatment of patient R.L. as stated in above Findings of Fact 15-23 constitutes a professional failure to practice medicine in a manner consistent with public health and welfare.

25. In 1986, Respondent treated patient G.S. with hyperbaric oxygen treatment for her transient ischemic attacks. Transient ischemic attacks are transient in that they manifest themselves as brain dysfunctions over a period of time not to exceed 24 hours. They are relieved spontaneously, but are thought to be prodromal or heralding a full blown stroke in the relatively near future.

26. Hyperbaric oxygen treatment is not indicated for the treatment of transient ischemic attacks.

27. Respondent failed to conduct an adequate history, physical or laboratory work to support his diagnosis of transient ischemic attacks for patient G.S.

28. Respondent's administration of hyperbaric oxygen treatments to patient G.S. for transient ischemic attacks was nontherapeutic in nature.

29. Respondent's care and treatment of patient G.S. and the documentation of such care and treatment as stated in Findings of Fact 25-28 is a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

30. From April 27, 1987 to April 28, 1987, Respondent administered hyperbaric oxygen treatment to patient B.S. for hydrogen

sulfide inhalation.

31. Hydrogen sulfide is a very toxic gas, which if exposed to, may be treated with hyperbaric oxygen treatment if the treatment is given hours after exposure. Patient B.S. was poisoned over one year before April, 1987.

32. There is no evidence that hyperbaric oxygen treatment is beneficial months after exposure to hydrogen sulfide gas.

33. Respondent failed to conduct an adequate physical history or laboratory findings for the treatment of patient B.S.

34. Respondent's administration of hyperbaric oxygen treatment to patient B.S. was nontherapeutic in the manner prescribed.

35. Respondent's care and treatment of patient B.S. as found in Findings of Fact 30-34, constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

36. From August 8, 1987 to January 10, 1988, Respondent administered hyperbaric oxygen treatments to patient M.P. for cancer of her left lung on the rationale that cancer cells are unable to tolerate high concentrations of oxygen.

37. Hyperbaric oxygen treatment is not indicated for the treatment of cancer of any type, including lung cancer.

38. Respondent administered 30 cc of ozone to patient M.P. There is no therapeutic indication whatsoever in medicine today for the use of ozone injections.

39. Respondent failed to conduct an adequate physical, history or laboratory work to justify his treatment of patient M.P. and/or failed to document an adequate physical, history or laboratory findings.

40. Respondent's hyperbaric oxygen treatment of patient M.P. as found in Findings of Fact 36-37 was nontherapeutic in nature.

41. Respondent's care and treatment of patient M.P. as found in Findings of Fact 36-40 constitutes professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

42. From September 29, 1987 to November 20, 1987, Respondent administered hyperbaric oxygen treatment to patient I.B. for arterial occlusion and cerebrovascular spasm. An arterial occlusion occurs

when the blood flow to the brain is decreased or obstructed which can lead to brain dysfunction. Cerebrovascular spasms are constrictions of blood vessels as a result of constriction of the muscular coat in an area which narrows the blood vessel to a point where the blood flow is obstructed.

43. Hyperbaric oxygen treatment is not indicated for the treatment of arterial occlusions or cerebrovascular spasms. Respondent's administration of hyperbaric oxygen treatment to patient I.B. was nontherapeutic in nature.

44. Respondent failed to conduct an adequate physical examination on patient I.B. and/or failed to document an adequate physical examination.

45. Respondent's care and treatment of patient I.B. as found in Findings of Fact 42-44 constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

46. From July 8, 1988 to September 14, 1988, Respondent administered hyperbaric oxygen treatment to patient S.P. for dementia. Dementia is a form of brain dysfunction which results in a significant decrease in intellectual functioning by the patient.

47. Hyperbaric oxygen treatment is not indicated for the treatment of dementia. All available studies demonstrate that the patients who were treated with hyperbaric oxygen treatment are not better off than those who are not treated with hyperbaric oxygen treatment. Respondent's use of hyperbaric oxygen treatment for S.P.'s dementia was nontherapeutic in nature.

48. Respondent failed to conduct an adequate physical examination on this patient, S.P., and/or failed to document an adequate physical or findings.

49. Respondent's care and treatment of patient S.P. as found in Findings of Fact 46-48 constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

50. Respondent's care and treatment of patients R.L., G.S., B.S., M.P., I.B. and S.P. indicates a pattern of inadequate documentation of the patients' condition as well as improper uses of hyperbaric oxygen

treatment for disorders for which the patients were treated.

51. Respondent, through his use of hyperbaric oxygen treatment presents a danger to his patients and the public.

52. A drug audit was performed on Respondent's practice by Helen Kaupang, a Diversion Investigator with the Drug Enforcement Administration on November 9, 1990, which was concluded on December 4, 1990.

53. The audit covered eight classes of drugs Respondent had ordered over a two year period. It was requested that Respondent provide all records of order forms, invoices for controlled substances, dispensing records and theft/loss/destruction records.

54. The audit of Respondent's drug purchases and disposals covered the drug Obetrol, a Schedule II Controlled Substance and an amphetamine. Respondent failed to account for 22% of his dispensing and prescribing of Obetrol.

55. Respondent dispensed Obetrol to patients M.H. and M.S. without executing a triplicate prescription as required under the Texas Controlled Substances Act. Respondent "loaned" the Obetrol, 50 20 mg dosages to patient M.H. on November 5, 1990, for her diabetes insipidus. Respondent "loaned" 15 Obetrol 20 mg to patient M.S. on November 5, 1990, for weight control. These two patients were to return the Obetrol to Respondent as soon as they were able to purchase it at the drugstore. Respondent later offered to execute a triplicate prescription for these two patients when confronted by Board Investigator Pam Ingram and D.E.A. Investigator Helen Kaupang on November 9, 1990.

56. There are several pharmacies located in Kerrville, Texas, Respondent's locale of practice. Respondent also prescribed Obetrol for a patient residing in California, S.H., from November, 1987 to August, 1990. Over 900 dosage units were sent in the mail to patient S.H. from November, 1987 to August, 1990. Respondent does not hold a California license and stated he would rather break California laws than the laws of Texas.

57. In regard to the drug audit of November 9, 1990, Respondent failed to produce biennial inventories, complete invoices, D.E.A. order forms or complete triplicate prescription books.

58. Kenneth Matthews, M.D. is a licensed Texas physician who practices in the area of psychiatry. Dr. Matthews conducts an educational program for physicians on prescribing of controlled substances and prescribing problems. Dr. Matthews is American Board of Specialties certified in psychiatry.

59. Respondent treated patient D.G. from October 29, 1987 to October 25, 1990, and who was a heroin addict. Patient D.G. was prescribed opiate analgesic medications, Lorcet and Vicodin, (controlled substances) for D.G.'s headaches. Respondent failed to use milder medications such as aspirin or Tylenol before trying these medications.

60. On October 29, 1987, Respondent prescribed to patient D.G. a combination of Valium, 10 mg., #100, Xanax, 1.0 mg., #40 and Halcion, #30.

61. On September 10, 1990, Respondent received a letter from patient D.G. requesting hydrocodone #100 and diazepam 10 mg., #100, for which Respondent wrote a prescription. Respondent failed to conduct a physical examination on this patient prior to ordering the above prescriptions.

62. On October 4, 1990 and October 25, 1990, patient D.G. asked Respondent for medications for which Respondent prescribed 100 Lorcet Plus for both dates.

63. Valium, Xanax and Halcion are benzodiazepines, are addictive drugs and classified as controlled substances. Hydrocodone/Lorcet is an analgesic controlled substance and is also addictive.

64. Respondent's prescribing of controlled substances to patient D.G. from October 29, 1987 to October 25, 1990 constitutes nontherapeutic prescribing in that the patient was a known substance abuser. Respondent failed to adequately conduct laboratory tests and failed to ascertain the nature of D.G.'s illness.

65. Respondent failed to document tests, referral information or consultations to support his treatment of patient D.G. Such a failure is a deviation from the standard of care.

66. Respondent knew or should have known that D.G. was a habitual user of narcotic drugs or controlled substances as early as October 29, 1987 when he documented D.G. was a habitual heroin addict.

Respondent prescribed controlled substances (Lorcet/Valium, Halcion, Xanax, Librium) to D.G. after October 29, 1987 and failed to notify the Board of said prescribing.

67. From June 27, 1990 to November 7, 1990, Respondent treated patient D.V. whom he diagnosed with attention Deficit Disorder ("ADD"). ADD is a disorder generally of childhood, the treatment of which frequently involves the use of Ritalin, Dexedrine or Cylert to help an individual with attention problems. To confirm a diagnosis of ADD one should seek information about problems in elementary, middle and high school. There should also be psychological testing to determine intelligence and an EEG to determine whether there is any kind of seizure disorder in a patient. Respondent failed to perform or seek out these tests.

68. Dextroamphetamine is a Schedule III Controlled substance and is an addictive drug. On the following dates Respondent mailed dextroamphetamine to patient D.V.:

a. June 27, 1990, 15 mg., #30
b. August 4, 1990, 15 mg., #100
c. August 28, 1990, 15 mg., #100
d. August 30, 1990, 5 mg., #100
e. October 19, 1990, 15 mg., #100
f. November 7, 1990, 15 mg., #100

Respondent failed to record any regular or periodic examination to justify sending out the above prescriptions.

69. Respondent's care and treatment of D.V. as found in Findings of Fact 67-68 constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

70. On April 24, 1990, Respondent diagnosed patient P.S. with an anxiety reaction for which he prescribed 100 Valium tablets. The amount of Valium prescribed to this patient exceeded good medical practice in that this patient was seen on an initial visit and the diagnosis of anxiety disorder was not sufficiently supported by the medical records.

71. Respondent's care and treatment of patient P.S. constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

72. On July 20, 1988, Respondent began treating patient S.K. and characterized this patient as strung out on speed and having a history of 11 years of heroin use. Respondent on this date prescribed Valium and Dalmane, both Class V Controlled Substances and both addictive medications. Respondent prescribed Valium 10 mg., #100 and Dalmane, 30 mg., #50 which is an excessive amount and below the standard of care for this patient.

73. Throughout 1988 and 1990, Respondent continued prescribing Valium, Dalmane, Vicodin and Nubain injections to S.K. Respondent knew or should have known this patient was a habitual user of narcotic drugs or controlled substances as early as July 20, 1988, yet Respondent prescribed controlled substances to this patient and failed to notify the Board of said prescribing.

74. Respondent failed to keep medical records for patients S.K, D.V. and H.P. throughout all of 1989, despite the fact that he was treating these patients and prescribing or dispensing controlled substances.

75. Respondent failed to adequately document any laboratory tests, referral or consultation information for this patient. Such a failure is below the standard of care.

76. Respondent's care and treatment of patient S.K., as found in Findings of Fact 72-75, constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

77. Respondent failed to produce medical records for patient H.P. whom he treated in 1989 for a malignancy of the spine. Respondent prescribed benzodiazepines and Lorcet Plus for this patient. Respondent's failure to keep records on the care and treatment of this patient constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

78. On March 23, 1990, Respondent diagnosed patient R.B. with chronic osteomyelitis. Chronic osteomyelitis is an infection of the bone where blood supply to the bone is less than to other parts of the body and is difficult to treat. To confirm a diagnosis of chronic osteomyelitis, blood cultures documenting the presence of a particular bacteria as well as x-rays are obtained. Respondent failed to include

documentation of x-rays, reports of radiologists and laboratory information.

79. Respondent prescribed to patient R.B. Valium 10 mg. #100, Vicodin (a pain medication) #100 and Obetrol. Obetrol is a stimulant medication that fits loosely under the rubric of antidepressive medications. Obetrol is an addictive drug which is subject to abuse and was used in the 1960's and 1970's for weight reduction. Prescribing Obetrol for weight reduction is not within the standard of care since 1980.

80. On June 12, 1990, Respondent dispensed to R.B., Vicodin #100, Valium #100 and Obetrol #20. Respondent prescribed the Obetrol for weight loss.

81. On June 18, 1990, Respondent dispensed Obetrol #10, and Vicodin #100 to R.B.

82. Respondent's simultaneous dispensing of Obetrol, a stimulant, with Vicodin, an analgesic, was below the standard of care.

83. Respondent's care and treatment of patient R.B. constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare in that Respondent simultaneously dispensed Obetrol and Vicodin, dispensed Obetrol for weight loss, failed to document x-ray reports, blood cultures or laboratory results and failed to consult with an infectious disease or orthopedic specialist.

84. On March 21, 1990, Respondent diagnosed patient J.P. with subluxation of the sacral-lumbar joint with stenosis of the lower spinal column. Stenosis of the lower spinal column refers to a situation where the vertebra, the bricks which hold up the body and spine, become crooked from each other and cause pain and difficulty of movement. Stenosis of the lower spinal column is confirmed by x-rays. Respondent failed to include x-ray reports within patient J.P.'s records.

85. Respondent prescribed to J.P. Vicodin, Valium and Phentermine, a stimulant medication much like Dexedrine and Obetrol, on March 21, 1990, March 23, 1990, April 6, 1990, April 19, 1990, May 9, 1990, May 15, 1990 and July 11, 1990. Without appropriate information from orthopedists or radiographic evidence of this

patient's difficulties, such prescribing was inappropriate and constituted a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

86. From May 8, 1990 to October 30, 1990, Respondent prescribed/ dispensed over 1000 mls. of Nubain, 620 unit dosages of Vicodin/Lorcet Plus, an unspecified amount of Talwin and 4 unit dosages of Percocet. The medical records of J.P. fail to disclose any sort of referral or consultation. Such a failure is a deviation from the standard of care.

87. Respondent failed to produce records on patient S.H. whom he diagnosed with Attention Deficit Disorder. Over 500 unit dosages of Obetrol were dispensed to this patient between November, 1987 and September, 1988. Between November, 1989 and August, 1990, Respondent dispensed over 400 unit dosages of Obetrol to this patient. Respondent's failure to produce medical records documenting what illness was being treated and whether laboratory or other information was sought, constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

88. From January, 1990 to August, 1990, Respondent prescribed over 450 unit dosages of Obetrol to patient M.H. for this patient's diabetes insipidus. Diabetes insipidus occurs when the pituitary gland does not adequately control the output of water through the kidneys causing the person to urinate copious amounts. It is treated with various kinds of diuretics to slow down the amount of water passing through the kidneys. Obetrol is not recommended as a treatment for diabetes insipidus. Respondent's prescribing of Obetrol for this patient constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

89. On November 5, 1990, Respondent loaned Obetrol to patient M.H. without executing a triplicate prescription. Loaning of controlled substances is below the standard of care and constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

90. From May 25, 1990 to July 15, 1990, Respondent dispensed Obetrol #25 to patient M.S. for weight loss. This patient had a

family history of hypertension, strokes and heart attacks. The patient also had elevated blood pressure which is aggravated by stimulant medication. Prescribing Obetrol for weight loss constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

91. On August 30, 1990, Respondent prescribed to patient M.S., Nubain 10 ccs, Vicodin #60 and Dexedrine #30. Such a combination constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

92. On November 5, 1990, Respondent loaned Obetrol to patient M.S. without executing a triplicate prescription. Loaning of controlled substances constitutes a professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

93. Respondent, through his practice of general medicine presents a danger to the public.

94. In May of 1963, Respondent was committed to the California State Hospital by the Orange County Court and his license was suspended by the California Board of Medical Examiners. In September, 1965, a petition for reinstatement was granted by the California Board.

95. In February of 1973, Respondent's California License was revoked, said revocation stayed, and the Respondent was placed on 10 years probation. The probation was terminated and his license was revoked in June of 1976 based upon Respondent's conviction of 2 counts of contributing to the delinquency of a minor in June of 1974. Respondent took two minor males to Tiajuana, Mexico to obtain B-17 injections for the Respondent's self-diagnosed brain tumors. Respondent was partially clad in female clothing and under the influence of alcohol, Antabuse and Procaine which Respondent explained seemed to bring out the female aspect of his personality.

96. In July of 1963, Respondent's Arizona medical license was revoked based upon allegations of mental incompetence. In January of 1967, his license was restored by the Arizona Board. His license was again revoked in December of 1973.

97. On April 20, 1991, Respondent's Texas medical license was

suspended by the Executive Committee of the Board. Respondent knew of the Board's suspension of his license yet continued to practice medicine after he was notified the week of April 22, 1991. On July 22, 1991, Respondent prescribed 120 Vicodin tablets to patient D.S. Respondent, by his continued practice of medicine while his license was suspended, violated Sections 3.08(12) and 3.07(a) of the Medical Practice Act.

CONCLUSIONS OF LAW

1. Section 3.08(4)(E) and Section 4.12 of the Medical Practice Act provides for disciplinary action against a licensee for prescribing or administering a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment is administered or prescribed.

2. Section 3.08(4)(B) and Section 4.12 of the Medical Practice Act provides for disciplinary action against a licensee for failing to keep complete and accurate records of purchases and disposals of drugs listed in the Texas Controlled Substance Act (Art. 4476-15 V.T.C.S.) or of controlled substances scheduled in the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et. seq.

3. Section 3.08(4)(E) and Section 4.12 of the Medical Practice Act provides for disciplinary action against a licensee for writing prescriptions for or dispensing to a person known to be a habitual user of narcotic drugs, controlled substances or dangerous drugs or to a person the physician should have known was a habitual user of the narcotic drugs, controlled substances or dangerous drugs.

4. Section 3.08(18) and Section 4.12 of the Medical Practice Act provides for disciplinary action against a licensee for professional failure to practice medicine in an acceptable manner consistent with public health and welfare.

5. Section 3.08(21) and Section 4.12 of the Medical Practice Act provides for disciplinary action against a licensee for suspension, revocation or restriction by another state of a license to practice medicine based upon acts by the licensee similar to acts described in Section 3.08 of the Medical Practice Act.

6. Section 3.08(12) and Section 4.12 of the Medical Practice Act provides for disciplinary action against a license for impersonating a licensed practitioner.

7. The Respondent by his actions, conduct and behavior has violated Sections 3.08(4)(E), 3.08(18), 3.08(4)(B), 3.08(12), 3.08(4)(C) and 3.08(21) of the Medical Practice Act of Texas.

8. The Respondent's violation of Sections 3.08(4)(E), 3.08(18), 3.08(4)(B), 3.08(12), 3.08(4)(C) and 3.08(21) of the Act are grounds for cancellation, revocation or suspension of the Respondent's license to practice medicine in the State of Texas pursuant to Section 4.12 of the Act.

IT IS THEREFORE ORDERED, ADJUDGED AND DECREED that Respondent's license to practice medicine is hereby REVOKED. All costs of appeal are assessed against Respondent.

SIGNED AND ENTERED this 16th day of June, 1992.

Barbara J. Coe
Vice President, Texas State Board
of Medical Examiners

TC.AO 4558