

LICENSE NO. F-5036

IN THE MATTER OF
THE LICENSE OF
GUSTAV RICHARD SCHMIEGE, JR., M.D.

BEFORE THE
TEXAS MEDICAL BOARD

AGREED ORDER

On the 21st day of August, 2008⁹, came on to be heard before the Texas Medical Board (the "Board"), duly in session, the matter of the license of Gustav Richard Schmiede, Jr., M.D. ("Respondent").

On August 15, 2008, Respondent appeared in person, without counsel, at an Informal Show Compliance Proceeding and Settlement Conference in response to a letter of invitation from the staff of the Board. The Board's representatives were Timothy Webb, J.D., a member of the Board, and Janet Tornelli-Mitchell, M.D., a member of a District Review Committee. Lee Bukstein represented Board staff.

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

FINDINGS OF FACT

The Board finds that:

1. 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.
2. Respondent currently holds Texas Medical License No. F-5036. Respondent was originally issued this license to practice medicine in Texas on June 13, 1979. Respondent is also licensed to practice in the states of California, Florida, New York and Pennsylvania.

3. 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.

4. Respondent is 76 years of age.

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

6. Respondent first saw patient KW in March 2005. After an additional visit on April 7, 2005, Respondent wrote a prescription for Effexor XR.

7. At the next documented visit on January 19, 2007, Respondent's office notes are all in checklist format with illegible handwritten comments in the margins. Respondent wrote "SHOP" at the top of the evaluation, but there is no explanation of the acronym until notes for later office visits. At the end of the checklist (with check boxes) format progress note for the January 19, 2007, visit, the Respondent notated his diagnosis of Bipolar disorder and Attention Deficit Disorder (ADD). Respondent completed a "disability statement" on which he checked a box marked "the disability is permanent." Respondent prescribed Seroquel, Cymbalta and Depakote.

8. On the progress notes for the office visit on January 26, 2007, nothing is actually checked on the checklist. However, the Respondent wrote some information across the page, "nothing getting worse", as well as additional, but illegible comments. Respondent prescribed Adderall for KW.

9. On the progress notes for the office visit on February 2, 2007, Respondent wrote some information across the page, "a little hypomanic", "watch out", and "likes A" as well as additional, but illegible comments. Respondent again prescribed Adderall for KW. At the next visit on February 9, 2007, the following items are checked on the checklist: "depressed mood", "decreased energy", "hopelessness", "elevated mood", "impulsiveness", "speeding thoughts", "oppositional", "somatic complaints", "irritability", "mixed thoughts", "insomnia", "inertia", "forgetfulness", "restlessness", "fear", and "withdrawn."

10. On the progress notes for the office visit on February 9, 2007, Respondent wrote some information across the page, "shaky", "dizzy", "hypomania", and "quit Add", as well as additional, but illegible comments. Respondent then prescribed Depakote ER and Ritalin.

11. At the next visit on February 23, 2007, the following items are circled on the checklist: "anxiety", "depression", and "loose association."

12. On the progress notes for the office visit on March 2, 2007, Respondent wrote some information across the page, "Depressed, despite meds", as well as additional, but illegible comments.

13. At the next visit on March 9, 2007, the following items are circled on the checklist: "depressed mood", "decreased energy", "worthlessness", "somatic complaints", "mixed thoughts", "insomnia", and "withdrawal."

14. On the progress notes for the office visit on April 5, 2007, Respondent wrote some information across the page, "depression", "withdrawal, and "not concentrating" , the acronym "SHOP" and additional, but illegible comments. Respondent also wrote a prescription for Adderall.

15. On April 17, 2007, Respondent again wrote a prescription for Adderall, but at an increased dose.

16. On May 3, 2007, Respondent wrote that SHOP means "not Suicidal, Homicidal, Organic, or Psychotic", and additional, but illegible comments. Respondent also noted that KW was stopping Seroquel because of metabolic syndrome, and he prescribed Geodon 80 mg three times per day.

17. KW had an extreme adverse reaction to taking the Geodon that included four visits to the emergency room of a nearby hospital. Although KW communicated this information to Respondent, he did not document her communication. KW decided to stop seeing Respondent.

18. On April 17, 2007, patient SM first saw Respondent on a referral from patient KW. Respondent's initial evaluation was "depression, focusing, organizing, and ANGRY" and "Beck 43, no insight." Respondent's other handwritten notes are illegible. Respondent's differential diagnosis included "Major Depression, rule out bipolar spectrum, and probable Adult ADD." Respondent prescribed Lexapro, Wellbutrin and Adderall.

19. At SM's follow-up visit on May 22, 2007, Respondent indicated that SM had taken two of the prescribed medications, (Adderall and Wellbutrin) but not the Lexapro.

20. During the time period that Respondent treated KW with drugs for her presumed psychological disorders of Bipolar Disorder and ADD, Respondent failed to adequately document the basis of his diagnosis and justification for the use of all the medications prescribed.

21. During the time period that Respondent treated SM with drugs for her presumed psychological disorder of ADD, Respondent failed to adequately document the basis of his diagnosis and justification for the use of all the medications prescribed.

22. Respondent failed to appropriately diagnose and treat KW's actual psychological condition.

23. 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)(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, as further defined by 22 Texas Administrative Code, §190.8(1)(C), failure to exercise diligence in the practice of medicine.

3. Respondent has committed a prohibited act or practice within the meaning of Sections 164.051(a)(3) by his violation of a Board Rule, specifically 22 Texas Administrative Code, §165.1 which requires the maintenance of adequate medical records.

4. 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. Such sanctions include: revocation, suspension, probation, public reprimand, limitation or restriction on practice, counseling or treatment, required educational or counseling programs, monitored practice, public service, and an administrative penalty.

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

6. Section 164.002(d) of the Act provides that this Agreed Order is a settlement agreement under the Texas Rules of Evidence for purposes of civil litigation.

ORDER

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

1. Respondent shall limit Respondent's medical practice, including any office and inpatient practice, to a group or an institutional setting approved in advance in the discretion of the Executive Director of the Board. After the entry of this Order, Respondent shall inform the Director of Compliance for the Board in writing of Respondent's current practice setting. Any change in Respondent's practice setting must be approved in advance by the Executive Director of the Board. Respondent shall provide a copy of this Order to the group or institutional setting administrator.

2. For a period of one year beginning on 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. 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 monitor shall review a random selection of patient medical 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.

b. 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.

c. 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.

d. 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.

3. Within one year of the date of the entry of this Order, Respondent shall obtain by attendance in-person, in addition to any other requirement for license renewal or other Continuing Medical Education ("CME") required in this Order, 10 hours of CME approved for Category I credits by the American Medical Association in the area of medical record keeping. Upon completion of the required CME, Respondent shall submit proof to the Board of successful completion of the CME. A copy of attendance certificates or a detailed report that can be readily verified by the Board shall satisfy this requirement.

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

5. 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. Respondent shall inform the Board in writing of any change of Respondent's mailing or practice address within 10 days of the address change. This information shall be submitted to the Permits Department and the Director of Enforcement for 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.

6. 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. 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).

7. The time period of this Order shall be extended for any period of time that (a) Respondent subsequently resides or practices outside the State of Texas, (b) Respondent's license is subsequently canceled for nonpayment of licensure fees, or (c) this Order is stayed or enjoined by Court Order. If Respondent leaves Texas to live or practice elsewhere, Respondent shall immediately notify the Board in writing of the dates of Respondent's departure from and subsequent return to Texas. When the period of extension ends, Respondent shall be required to comply with the terms of this Order for the period of time remaining on the extended Order. Respondent shall pay all fees for reinstatement or renewal of a license covering the period of extension.

8. Respondent shall inform the Board in writing of any change of Respondent's mailing or practice address within 10 days of the address change. This information shall be submitted to the Permits Department and the Director of Enforcement for 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.

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 12 months following the date of the entry of this Order. If, after the passage of the 12-month 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, GUSTAV RICHARD SCHMIEGE, JR., 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.

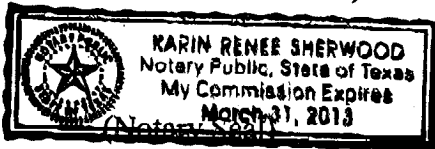
DATED: July 8, 2009.

Gustav Richard Schmiege, Jr.
GUSTAV RICHARD SCHMIEGE, JR., M.D.
Respondent

STATE OF _____
COUNTY OF _____

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SWORN TO AND ACKNOWLEDGED BEFORE ME, the undersigned Notary Public, on this 8 day of July, 2009.



Karin R. Sherwood
Signature of Notary Public

SIGNED AND ENTERED by the presiding officer of the Texas Medical Board on this 21 day of August, 2009.

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