

HEARING CONDUCTED BY THE
TEXAS STATE OFFICE OF ADMINISTRATIVE HEARINGS
SOAH DOCKET NO. 503-10-3509.MD
LICENSE NO. F-8432

IN THE MATTER OF
THE COMPLAINT AGAINST
JESUS ANTONIO CAQUIAS, M.D.

BEFORE THE
TEXAS MEDICAL BOARD

FINAL ORDER

During an open meeting at Austin, Texas, the Texas Medical Board ("Board") finds that after proper and timely notice was given, the above-styled case was heard by Administrative Law Judge Sharon Cloninger and Administrative Law Judge Pratibha J. Shenoy ("ALJs") of the State Office of Administrative Hearings ("SOAH"). ALJs Cloninger and Shenoy presided over the case, and prepared a Proposal For Decision on Summary Disposition ("PFD") on August 3, 2012, that contained Findings of Fact and Conclusions of Law. The PFD was properly served on all parties, and all parties were given an opportunity to file exceptions and replies as part of the record herein. Board Staff timely filed exceptions on September 10, 2012, and Respondent timely filed a response to Board Staff's exceptions on October 10, 2012. On October 17, 2012, ALJs Cloninger and Shenoy confirmed all of the findings and conclusions in their previous Proposal For Decision and included one additional Finding of Fact 4A that confirmed that Respondent was subject to the provisions of Board Rule 200.

The Board, after review and due consideration of the PFD, adopts the Findings of Fact and Conclusions of Law of the ALJs.

FINDINGS OF FACT

1. Jesus Antonio Caquias (Respondent) holds Texas Medical License No. F-8432, originally issued by the Texas Medical Board (Board) on December 3, 1980.
2. Respondent's medical license was in full force and effect at all times relevant to this proceeding.
3. Respondent became a Doctor of Integrative Medicine in 2003.

4. Respondent practices medicine in the Brownsville, Texas, area.
- 4A. Respondent's diagnosis and treatment of Patients A, B, C, and E was the practice of alternative and complementary medicine and subject to the requirements of Chapter 200 of Title 22 of the Texas Administrative Code, including Board Rule 200.3 (Practice Guidelines for the Provision of Complementary and Alternative Medicine).
5. From February 2006 to March 2009, Respondent worked on a part-time contract basis as a physician for the Center for Autistic Spectrum Disorders and Nutrigenomics (CARE Clinics) in Austin, Texas, where he provided and supervised medical diagnosis and treatment for autistic children and adult patients.
6. Respondent was the CARE Clinics' medical director from August 2006 to December 2007.
7. Patients traveled from other states for treatment at the CARE Clinics.
8. Four of the patients treated by Respondent at the Austin CARE Clinics are Patients A, B, C, and E.
9. Patient D was treated at the CARE Clinics in Tampa, Florida, and possibly treated by Respondent at the CARE Clinics in Austin.
10. The CARE Clinics in Austin closed in January 2009, after insurance companies stopped reimbursing the healthcare provider. The CARE Clinics re-opened on a limited basis in March 2009.
11. Respondent's last day of work at the CARE Clinics was March 6, 2009.
12. The Austin CARE Clinics closed permanently on July 15, 2009, following a Federal Bureau of Investigation (FBI) and Internal Revenue Service (IRS) raid in which dozens of boxes of documents were removed from the clinic.
13. The Board entered an Agreed Order on June 22, 2006 (2006 Order), due to Respondent's failure to maintain adequate medical records in his position as "gatekeeper" for the Cameron County indigent patient program.
 - a. The 2006 Order required Respondent to submit charts to a chart monitor quarterly for 2 years.
 - b. The 2006 Order required Respondent to attend the University of California San Diego Physician Assessment and Clinical Education medical recordkeeping program within 1 year.
 - c. The 2006 Order required Respondent to resign from his position as "gatekeeper" for the Cameron County indigent patient program.

14. The Board entered an Agreed Order on April 13, 2007, requiring Respondent to cease misleading advertising and pay an administrative penalty of \$5,000.

Incomplete Copies of Medical Records

15. The medical records in evidence for Patients A, B, C, and E are not complete sets of Respondent's medical records for those patients.
16. The medical records in evidence cannot be checked against the original charts, because the original charts more than likely were destroyed or damaged by fire and water on February 18, 2010, after a pilot intentionally crashed his airplane into the Austin IRS building where the seized records were stored.
17. Around January 2009, staff (Staff) of the Board requested copies of the medical records for Patients A, B, and C.
18. Respondent did not control or own the medical records at the CARE Clinics.
19. CARE Clinics owner and custodian of records Kazuko Curtin responded to Staff's request for the medical records of Patients A, B, and C in April 2009, a month after Respondent's last day at work there.
20. Ms. Curtin told Respondent she had sent the requested records to Staff, but Respondent, who was in Brownsville, Texas, did not review what she sent or ensure that complete sets of the records were delivered to Staff.
21. By the time Respondent realized incomplete sets of the records had been sent to Staff, it was too late for him to supplement the response, because the FBI and IRS had removed the records from the CARE Clinics.
22. The CARE Clinics premises were sealed after the July 2009 FBI and IRS raid and before Staff filed its initial Complaint against Respondent on March 31, 2010, leaving Respondent without the ability to access records, including any electronic records the FBI and IRS might have left onsite, to supplement Ms. Curtin's response to Staff's request for the records of Patients A, B, and C.
23. Ms. Curtin's custodian of records affidavits for Patients A and B state "already sent" in the space for the number of attached pages and "I am sorry I forgot to count before I sent," indicating the affidavits were not attached to the patients' records.
24. It is not clear as to when Staff requested the records for Patients D and E, whether Ms. Curtin responded to the request, or if the IRS or FBI provided the records for Patients D and E.
25. Ms. Curtin was not subpoenaed by either party and did not testify at the hearing.

26. During Respondent's time at the CARE Clinics, the recordkeeping was in transition from paper files to electronic files.
27. Respondent's regular practice was to take notes either on paper or on the computer while speaking with a patient, transferring any handwritten notes to the computer later.
28. Respondent documented physical examinations using a handwritten checklist, then added comments in the computerized records.
29. Electronically documenting physical examinations meets the standard of care.
30. Staff's expert witnesses, Victor Sierpina, M.D., and Robert S. Baratz, M.D., Ph.D., D.D.S., reviewed the records provided to them by Staff.
31. Staff's expert witnesses based their opinions on a review of incomplete medical records.
32. Respondent's expert witness Anna Davis, M.D., spent a day with Respondent at the CARE Clinics around 2008, and observed Respondent's treatment of patients, including physical examinations and maintenance of treatment records.
33. In 2011, Respondent's expert witness Kenneth P. Stoller, M.D., reviewed electronic records from the CARE Clinics (but not necessarily records for Patients A through E), and found them to be more complete than the records in evidence for Patients A through E, leading him to believe documents are missing from the records in evidence.
34. Respondent's expert witnesses opined that Respondent's records were incomplete as submitted by Staff, rather than inadequately prepared by Respondent.

Patient A

35. Respondent first saw adult Patient A on January 8, 2007, for severe migraine headaches.
 - a. Patient A reported a history of hypothyroidism, painful migraine headaches, body aches, chronic fatigue, and difficulty sleeping.
 - b. The medical records in evidence for Patient A do not contain documentation of an initial physical examination by Respondent.
 - c. Respondent signed an "amino supplement schedule" for Patient A.
36. In subsequent visits, Respondent recorded and interpreted Patient A's metal levels, based on speculative effects of those levels on Patient A's symptoms.
 - a. Respondent ordered laboratory tests to diagnose various mineral and vitamin abnormalities in Patient A.

- b. Regarding these visits, the only documentation in the medical records in evidence are short recommendations such as “no deficiency detected, repeat test” or “vitamin B’s IV recommended, Detoxification IV recommended.”
 - c. The medical records in evidence for the subsequent visits contain no patient history or documentation of physical examinations.
 - d. The medical records in evidence do not contain documentation of Respondent’s assessments, monitoring of headaches, or discussions with Patient A.
 - e. The medical records in evidence do not contain documentation of Respondent’s therapeutic rationale, monitoring, or results for his medical treatment of Patient A.
37. On December 1, 2006, Patient A received an intravenous infusion of “Vitamin B complex, McGuff vitamin C, methylcobalamin, heparin, procaine, folic acid, Vitamin B6 and magnesium sulfate 50%.”
- a. Documentation of the volume of liquid and the amount of each substance infused is not in the medical records in evidence.
 - b. On December 2, 16, and 17, 2006, Patient A received similar infusions that included lithium, and the volumes of liquid and the amount of each substance infused are not documented in the medical records in evidence.
 - c. Respondent’s supervision of the care, including intravenous infusions, rendered to Patient A is not documented in the medical records in evidence.
38. Significant documentation by Respondent and other CARE Clinics’ personnel for Patient A’s treatment was done but is missing from the record in this case.
39. Respondent’s documentation of assessments, monitoring, observations, and discussions with Patient A were usually or often kept electronically.
40. Patient A’s electronic records from the Care Clinics are not in evidence.

Patient B

41. Patient B, age 19, was taken to Respondent by her parents for an initial visit on February 26, 2007.
- a. Patient B’s parents provided Respondent with her developmental and medical histories, which included difficulty with auditory processing, being easily distracted and disoriented, and with a list of her psychotropic medications.
 - b. Respondent’s initial physical examination of Patient B is documented in the medical records in evidence only by a check-off type of physical examination record, and several items were not marked.

- c. The failure to mark items on this check-off form could indicate that the particular conditions listed and unmarked were not evaluated by Respondent or his staff, but it is just as likely that Respondent or his staff entered notes about the physical examination in the electronic records which are not in evidence.
42. Respondent recommended that Patient B take a long list of vitamins, probiotics, anti-oxidants, and Valtrex 500 mg BID, and undergo IV treatments.
43. Over the next 2 years, Respondent saw Patient B once or twice a month. The medical records in evidence contain only non-specific documentation about those visits, such as "symptoms improved" or "tremendous progress in cognitive and social skill."
- a. The medical records in evidence contain no documentation of any physical examinations during this time, but Patient B was given a physical examination on every visit.
 - b. The vast majority of the notes in the medical records in evidence deal with assessment of vitamin or mineral deficiency or excess and recommendation for a large number of vitamin or mineral supplements.
 - c. Respondent's therapeutic rationale, monitoring, or results for his medical treatment of Patient B are not in the medical records in evidence.
44. The medical records in evidence show that Patient B received approximately 12 intravenous infusions, initially with the McGuff B complex, lithium, methylcobalamin, and vitamin C combination. In September 2008, Respondent added anti-oxidative IV therapy and phosphatidylcholine phenylbutyrate IV therapy for Patient B.
- a. Documentation of the volumes of the infusions and the amount of each substance infused were not included in the medical records in evidence.
 - b. Mr. B observed his daughter's intravenous therapies and, every time, saw the labels from the infusion bags being pasted to the back of the treatment sheets and kept in the medical records.
45. Documentation of Respondent's supervision of the care rendered to Patient B is not included in the medical records in evidence.
46. Documentation of Respondent's assessments, monitoring, observations, or discussions with Patient B or her family is not included in the medical records in evidence.
- 1.
47. The records in evidence do not include Respondent's electronic records for Patient B.
48. Respondent's documentation of assessments, monitoring, observations, and his discussions with Patient B's family were usually or often kept electronically.

49. Respondent discussed and documented the therapeutic rationale of Patient B's treatment with Mr. B, and discussed the risks and benefits of his medical treatment plan with Mr. B.
50. Respondent performed physical examinations on Patient B, but documentation of those exams is not in evidence.
51. In February 2009, Patient B's chart was about 15 inches thick, as compared to the 4 inches of medical records in evidence.
52. In Patient B's approximately 100 visits to the CARE Clinics, a pre-treatment questionnaire was always filled out, but only about 20 of the questionnaires are in the medical records in evidence.
53. Mr. B or his wife signed about 100 consent forms for their daughter, but none of the consent forms are in the records in evidence.
54. Mr. B has in his possession copies of lab tests, gene tests, vitamin/mineral/supplement recommendations, and dietary recommendations for Patient B, which are not in the medical records in evidence.
55. Mr. B saw Respondent taking notes and referring to computer records when they discussed Patient B's treatment.
56. The last time Respondent saw Patient B was on March 6, 2009, his final day of work at the CARE Clinics.

Patient C

57. Respondent first saw Patient C on July 28, 2006, when she was 3 years old.
58. Patient C had been diagnosed by another provider as having autistic spectrum disorder accompanied by severe expressive receptive language disorder.
59. Before their first visit at the CARE Clinics, Patient C's mother, Ms. C, completed a 10- to 15-page packet describing Patient C's current symptoms and detailing the prior treatments obtained for her.
60. During their first visit to the CARE Clinics, Ms. C met with Respondent and another staff member for between one and one-and-a-half hours and they discussed Patient C's medical condition as well as the various therapies offered by the clinic.
61. Ms. C and her husband first opted to treat Patient C with supplements and a topical chelation cream.
62. Ms. C and her husband discussed other treatment options with Respondent, including the risks and benefits of intravenous chelation therapy for a child as young as Patient C.

63. In consultation with Respondent, Mr. and Ms. C decided to try IV chelation on a trial basis for Patient C.
64. After the chelation treatments began, Ms. C felt Patient C had "steady gains in all areas," leading Ms. C to continue IV chelation treatments.
65. Patient C underwent intravenous chelation at the Austin CARE Clinics approximately 25 times, and in total made approximately 50 visits to the clinic.
66. When the Tampa CARE Clinics opened, Ms. C began taking Patient C there, since it was closer to their North Carolina home. Patient C made approximately six visits to the Tampa CARE Clinics before that facility closed.
67. Ms. C saw Respondent every time she brought her daughter to the Austin CARE Clinics for treatment and sometimes would see Respondent between three and ten times during each treatment.
68. At the start of every visit, Ms. C completed seven or eight forms, including a pre-treatment form and a consent form that listed the risks and benefits of intravenous chelation.
69. Respondent would do a physical exam of Patient C each time she went to the clinic, usually checking her ears, throat, and abdomen while a nurse would check Patient C's pulse. Patient C's vital signs were recorded, and urine and blood samples were taken and checked before Patient C was prepared for her chelation treatment.
70. Before each chelation treatment, Ms. C had an opportunity to talk to Respondent to discuss Patient C's progress and any concerns.
71. During each appointment with Patient C, Respondent took notes that he later transcribed into electronic records.
72. Each time Patient C received IV chelation, Ms. C observed the clinic staff removing the infusion ingredient label from each infusion bag and pasting it onto a form that was placed in Patient C's records.
73. Respondent would sit with Ms. C and Patient C to monitor the progress of the chelation several times during each treatment.
74. Respondent would again meet with Ms. C after the intravenous infusion was finished, before they left the clinic for the day.
75. During each visit, Respondent would, in conjunction with Ms. C, prepare a document outlining the medications or supplements Patient C was taking, how they should be adjusted, and any other notations for treatment prior to the next visit.

76. Ms. C kept copies of many, but not all of Patient C's medical records. These records form a stack of paper at least 8 inches in thickness, which is several times thicker than the records in evidence for Patient C.

Patient D

77. The CARE Clinics opened a satellite clinic in Tampa, Florida, in June 2008.
78. Many of the nurses at the Austin CARE Clinics obtained Florida nursing licenses before the Tampa clinic opened.
79. Patient D was a patient at the Tampa CARE Clinics.
80. It is not clear whether Patient D was ever seen at the Austin CARE Clinics.
81. Some patients obtained treatment at both the Austin and Tampa CARE Clinics.
82. For patients who obtained treatment at both the Austin and Tampa CARE Clinics, each patient's medical chart would be transferred between the clinics depending on the patient's current location.
83. Respondent initialed test results from laboratory tests conducted for Patient D.
84. Respondent does not recall whether Patient D was his patient at the Austin CARE Clinics.
85. Nurse Ann Barnaby worked primarily at the Austin CARE Clinics.
86. Ms. Barnaby was a licensed nurse in Texas at all times while she worked with Respondent at the Austin CARE Clinics.
87. Respondent gave Ms. Barnaby permission to use Respondent's signature stamp, but only if she called and obtained his approval first.
88. Ms. Barnaby used Respondent's signature stamp to authorize tests and prescriptions for Patient D, whom she believed to be an Austin CARE Clinics patient seeking a refill of a medication already prescribed by Respondent.
89. Respondent first learned that Ms. Barnaby had improperly used his signature stamp when Staff notified him of the charges related to Patient D.
90. Ms. Barnaby used Respondent's signature stamp for Patient D without Respondent's knowledge or authorization.

91. Prior to learning of the charges related to Patient D, Respondent had no reason to doubt Ms. Barnaby's trustworthiness.
92. Respondent adequately supervised the Austin CARE Clinics staff to safeguard against his signature stamp being misused in the activities of the Florida CARE Clinics.

Patient E

93. Patient E is an adult who received medical care at the CARE Clinics on various occasions between November 2007 and September 2008.
94. Patient E presented at the CARE Clinics with sleep apnea, memory loss, confusion, low energy, headaches, and problems with decision-making and motivation.
95. For many years, Patient E was employed as a plumber. He worked with lead and was exposed to lead fumes.
96. Patient E received intravenous chelation treatments at the CARE Clinics to treat heavy metal toxicity diagnosed by Respondent.
97. Eileen Reilly-Mitchell, RN, FNP, worked at the CARE Clinics from 2007 until the clinic closed.
98. Respondent and Ms. Reilly-Mitchell spoke with Patient E about the risks and benefits of chelation treatment, including the risks of cardiac issues, renal problems, and exacerbation of existing symptoms.
99. Respondent developed a treatment plan for Patient E in consultation with Patient E.
100. Patient E received and completed pre-treatment forms, consent forms, and initial history forms, and underwent and received the results of laboratory tests.
101. During each appointment with Patient E, Respondent took notes of physical exams and treatments that he later transcribed into electronic records.
102. Each time Patient E received IV chelation, CARE Clinics staff removed the infusion ingredient label from each infusion bag and pasted it onto a form that was placed in Patient E's records.
103. Respondent performed physical examinations of Patient E at 1- to 2-month intervals during the course of Patient E's chelation treatments.
104. Respondent ordered and monitored the results of diagnostic laboratory tests for Patient E during the course of Patient E's chelation treatments.

105. On September 17, 2008, Patient E's laboratory results indicated a very high level of lithium in his blood.
106. Respondent received intravenous lithium during chelation treatments at the CARE Clinics.
107. The high levels of lithium in Patient E's blood were not shown to be the result of treatments he received at the CARE Clinics.

Procedural History

108. On March 31, 2010, Staff filed its initial Complaint against Respondent and referred the case to the State Office of Administrative Hearings (SOAH).
109. Pursuant to the parties' joint request, the Administrative Law Judges (ALJs) referred the case to mediation on May 19, 2010.
110. The parties reached a mediated settlement agreement on September 7, 2010, but later determined a second round of mediation was necessary to address issues that arose at a second Informal Settlement Conference.
111. The additional issues are contained in Staff's First Amended Complaint, filed February 9, 2011.
112. The parties requested a second referral to mediation on March 1, 2011, and the ALJs referred the case to mediation on March 4, 2011.
113. On June 24, 2011, Staff requested to withdraw from mediation and the mediators returned the case to the ALJs on June 27, 2011.
114. Staff filed its Second Amended Complaint on July 14, 2011.
115. On January 3, 2012, Staff sent Respondent a Notice of Adjudicative Hearing incorporating the Second Amended Complaint.
116. The Notice of Adjudicative Hearing contained a statement of the time, place, and nature of the hearing as well as a statement of the legal authority and jurisdiction under which the hearing was to be held, a reference to the particular sections of the statutes and rules involved, and a short, plain statement of the matters asserted.
117. The hearing on the merits was held on February 13-16 and February 23, 2012, before ALJs Pratibha J. Shenoy and Sharon Cloninger. Staff was represented by attorneys Lee Bukstein and Wendy Pajak. Attorneys R. W. Armstrong and Laurie Guerra represented Respondent.
118. The record in this matter closed on June 4, 2012, upon the ALJs' receipt of the parties' written closing arguments and Staff's reply.

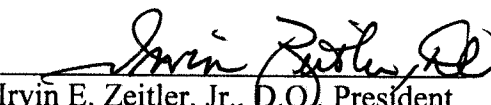
II. CONCLUSIONS OF LAW

1. The Board has jurisdiction over this matter pursuant to Tex. Occ. Code Title 3, Subchapter B.
2. SOAH has jurisdiction over the hearing in this proceeding, including the authority to issue a proposal for decision with proposed findings of fact and conclusions of law, pursuant to Tex. Gov't Code ch. 2003.
3. Notice of the complaint and of the hearing on the merits was provided as required by Tex. Occ. Code § 164.006 and by the Administrative Procedure Act, Tex. Gov't Code §§ 2001.051 and 2001.052.
4. Based on the above Findings of Fact regarding Patient D, Respondent did not fail to adequately supervise the Austin CARE Clinics staff to safeguard against the misuse of his signature stamp in the activities of the Florida CARE Clinics. Tex. Occ. Code §§ 164.051(a)(6) and 164.053(a)(8), and 22 Tex. Admin. Code § 190.8(1)(C).
5. Based on the above Conclusions of Law, Respondent is not subject to disciplinary action under Tex. Occ. Code § 164.051(a)(1) based on Respondent's commission of an act prohibited under Tex. Occ. Code § 164.052.
6. Based on the above Findings of Fact as to Patients A, B, C, and E, Respondent did not violate 22 Tex. Admin. Code § 165.1 by failing to maintain adequate medical records and is not subject to disciplinary action pursuant to Tex. Occ. Code § 164.051(a)(3).
7. Based on the above Findings of Fact as to Patients A, B, C, D, and E, Respondent did not violate 22 Tex. Admin. Code § 200.3 by failing to follow guidelines for the practice of complementary and alternative medicine, and is not subject to disciplinary action under Tex. Occ. Code § 164.051(a)(3).
8. Based on the above Findings of Fact as to Patient E, Respondent did not commit a prohibited act or practice within the meaning of Tex. Occ. Code §§ 164.052(a)(5) and 164.053(a)(5) by prescribing or administering a drug or treatment that is nontherapeutic in nature or nontherapeutic in the manner the drug or treatment was administered or prescribed.
9. Based on the above Findings of Fact with respect to Patient E, Respondent did not fail to practice medicine in an acceptable professional manner consistent with public health and welfare. Specifically, Respondent did not fail to treat Patient E according to the generally accepted standard of care as described at 22 Tex. Admin. Code § 190.8(1)(A); did not act with negligence in performing medical services, as set out in 22 Tex. Admin. Code § 190.8(1)(B); did not fail to use diligence in his practice, under 22 Tex. Admin. Code § 190.8(1)(C); and did not fail to safeguard against potential complications, as required by 22 Tex. Admin. Code § 190.8(1)(D).

10. The Board has the sole and exclusive authority to impose sanctions for violations of the Medical Practice Act or a Board rule, and to issue a Final Order. Tex. Occ. Code § 164.007(a); 22 Tex. Admin. Code § 187.37(d)(2); and 22 Tex. Admin. Code ch. 190 *et seq.*

The Board hereby adopts the Findings of Fact and Conclusions of Law as proposed by the ALJs and ORDERS the Staff's Complaint is DISMISSED.

SIGNED AND ENTERED by the presiding officer of the Texas Medical Board on this 30 day of November 2012.


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