



STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303

Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

June 13, 2002

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Robert Bogan, Esq.
& Robert Maher, Esq.
NYS Department of Health
Hedley Park Place – 4th Floor
Troy, New York 12180

Anthony Trojani, Esq.
700 Paredes Avenue
Suite 107
Brownsville, Texas 78521

Ernesto Cantu, M.D.
c/o Ronald Sanchez
SID Antonio County Jail
200 North Comal
San Antonio, Texas 78207

RE: In the Matter of Ernesto Cantu, M.D.

Dear Parties:

Enclosed please find the Determination and Order (No. 02-194) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

Five days after receipt of this Order, you will be required to deliver to the Board of Professional Medical Conduct your license to practice medicine together with the registration certificate. Delivery shall be by either certified mail or in person to:

Office of Professional Medical Conduct
New York State Department of Health
Hedley Park Place
433 River Street - Fourth Floor
Troy, New York 12180

If your license or registration certificate is lost, misplaced or its whereabouts is otherwise unknown, you shall submit an affidavit to that effect. If subsequently you locate the requested items, they must then be delivered to the Office of Professional Medical Conduct in the manner noted above.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

Request for review of the Committee's determination by the Administrative Review Board stays penalties other than suspension or revocation until final determination by that Board. Summary orders are not stayed by Administrative Review Board reviews.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

A handwritten signature in black ink, appearing to read "Tyrone T. Butler". The signature is written in a cursive style with a large initial 'T'.

Tyrone T. Butler, Director
Bureau of Adjudication

TTB:cah
Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER
OF
ERNESTO CANTU, M.D.

DETERMINATION
AND
ORDER
BPMC #02-194

COPY

A Notice of Referral Proceeding and Statement of Charges, both dated March 28, 2002, were served upon the Respondent, **ERNESTO CANTU, M.D.** **FRED LEVINSON, M.D.**, Chairperson, **ERNST A. KOPP, M.D.** and **MR. JOHN D. TORRANT**, duly designated members of the State Board for Professional Medical Conduct, served as the Hearing Committee in this matter pursuant to Section 230(10)(e) of the Public Health Law. **STEPHEN L. FRY, ESQ.**, Administrative Law Judge, served as the Administrative Officer.

A hearing was held on May 23, 2002, at the Offices of the New York State Department of Health, Hedley Park Place, 433 River Street, Troy, New York. The Department appeared by **DONALD P. BERENS, JR., ESQ.**, General Counsel, by **ROBERT BOGAN, ESQ.** and **PAUL ROBERT MAHER, ESQ.**, of Counsel. The Respondent did not appear at the hearing.

Evidence was received and transcripts of these proceedings were made.

After consideration of the entire record, the Hearing Committee issues this Determination and Order.

STATEMENT OF CASE

This case was brought pursuant to Public Health Law Section 230(10)(p). The statute provides for an expedited hearing where a licensee is charged solely with a violation of Education Law Section 6530(9). In such cases, a licensee is charged with misconduct based upon a prior criminal conviction in New York or another jurisdiction, or upon a prior administrative adjudication regarding conduct which would amount to professional misconduct, if committed in New York. The scope of an expedited hearing is limited to a determination of the nature and severity of the penalty to be imposed upon the licensee.

In the instant case, the Respondent is charged with professional misconduct pursuant to Education Law Sections 6530(9)(b) and (d), based upon actions constituting violations of subdivisions (2), (3), (4), (11), (15), (16), (20), (25), (32), and (35). A copy of the Notice of Referral Proceeding and Statement of Charges is attached to this Determination and Order as Appendix 1.

WITNESSES

| | |
|---------------------|------|
| For the Petitioner: | None |
| For the Respondent: | None |

FINDINGS OF FACT

The following Findings of Fact were made after a review of the entire record in this matter. Numbers below in parentheses refer to exhibits, denoted by the prefix "Ex.". These citations refer to evidence found persuasive by the Hearing Committee in arriving at a particular finding. Conflicting evidence, if any, was considered and rejected in favor of the

cited evidence. All Hearing Committee findings were unanimous unless otherwise specified.

1. **ERNESTO CANTU, M.D.**, the Respondent, was authorized to practice medicine in New York State on October 5, 1979, by the issuance of license number 139880 by the New York State Education Department (Ex. 4).

2. On December 8, 2000, the Texas State Board of Medical Examiners (hereinafter "Texas Board"), by an Agreed Order (hereinafter "Texas Order 1"), publicly reprimanded Respondent and limited his license for three years under terms and conditions, based upon his failure to comply with recordkeeping guidelines (Ex. 5). Among the terms and conditions imposed was a requirement that Respondent obtain a monitoring physician within 60 days of the effective date of the order and that he obtain 50 hours of continuing medical education (CME), including at least 10 hours in chronic pain management, 10 hours in addictionology and 5 hours in medical record-keeping.

3. On October 12, 2001, the State of New York, Department of Health, Board for Professional Medical Conduct (the "New York Board") filed a Notice of hearing and Statement of Charges against Respondent, in a proceeding, like the instant proceeding, based upon Public Health Law §230(10)(p). On November 9, 2001, a Consent Agreement and Order, previously signed by Respondent, was approved which disposed of the October 12, 2001 Notice and Charges. In this Order, Respondent agreed to imposition of a Censure and Reprimand; an indefinite suspension of his license to practice medicine with indefinite probation, to be tolled until he returned to New York to

practice and fully complied with all of the terms of Texas Order 1. Respondent also agreed that he would be required to demonstrate his competence to practice medicine safely before returning to New York State to practice, and stipulated that in the event he was charged with professional misconduct in the future, the agreement and order would be admitted into evidence in that proceeding (Ex. 6).

4. On December 7, 2001, the Texas Board, by Agreed Order (hereinafter "Texas Order 2"), suspended Respondent's medical license for no less than one year (with extensive and stringent requirements for lifting of the suspension), based upon his failure to conform to minimal standards of acceptable medical practice; allowing staff to perform duties/procedures without appropriate qualifications; failure to maintain records of prescribed/dispensed substances; writing false or fictitious prescriptions; conduct likely to deceive or defraud the public; inappropriate prescribing of controlled substances prescribing of controlled substances for non-therapeutic purposes; prescribing, dispensing and selling controlled substances to addicts; allowing a non-physician to hold herself out as a licensed physician; failure to comply with the terms of the Texas Order 1, described in fact-finding 2, above; and failure to properly secure drugs and paraphernalia. The Texas Board specifically concluded that the cited violations were so serious in extent and degree that Respondent's continued practice of medicine would constitute a continuing threat to the public welfare (Ex. 5).
5. On April 2, 2002, Respondent was personally served with the Notice of Hearing, Statement of Charges and copy of the Health Department Hearing Rules at his then current residence, the County Jail in San Antonio, Texas (Ex. 1). In the Notice of Hearing, Respondent was specifically advised that he had to file an answer to each of

the charges and allegations therein no later than 10 days prior to the hearing, or the charges and allegations would be deemed admitted, pursuant to Public Health Law §230(10)(p). Respondent was also advised that adjournment requests had to be made in writing to the Bureau of Adjudication at least 5 days prior to the hearing, that adjournment requests are not routinely granted, that failure to obtain an attorney within a reasonable time prior to the hearing was not grounds for an adjournment, and that the hearing would be held whether or not Respondent appeared (Ex. 1).

6. This hearing was scheduled for May 23, 2002 at 10:00 A.M.. At no time prior to that date did Respondent request an adjournment of the hearing, nor did Respondent file an answer at any time.
7. One of the Department's attorneys, Paul Robert Maher, stated at the hearing that on May 14, 2002, he made a phone call to the County jail in San Antonio and attempted to speak with Respondent about the upcoming hearing. Respondent declined to speak with Mr. Maher.
8. On the date of the hearing, at 9:22 A.M., the Administrative Law Judge received a fax of a letter from an attorney indicating that Respondent was incarcerated at the County Jail in San Antonio and requesting an adjournment of the hearing until Respondent could resolve the criminal proceedings against him. This request was carefully considered by the Administrative Law Judge and the Hearing Committee and denied.

HEARING COMMITTEE CONCLUSIONS

The hearing Committee concludes that the conduct resulting in the Texas Board's disciplinary actions against Respondent constitute misconduct under the laws of New York State, pursuant to New York Education Law §6530(9). The violations, had they occurred in

New York, would have constituted misconduct in accordance with the following definitions of misconduct:

1. New York Education Law §6530(2) (practicing the profession fraudulently);
 2. New York Education Law §6530(3) (negligence on more than one occasion);
 3. New York Education Law §6530(4) (gross negligence);
 4. New York Education Law §6530(11) (permitting an unlicensed person to perform duties requiring a license);
 5. New York Education Law §6530(15) (failure to comply with an Order of the Board);
 6. New York Education Law §6530(16) (willful failure to comply with federal, state, or local laws rules, or regulations governing the practice of medicine);
 7. New York Education Law §6530(20) (moral unfitness);
 8. New York Education Law §6530(25) (delegating responsibilities to a person when the licensee knows that such person is not qualified to perform them);
 9. New York Education Law §6530(32) (failure to maintain adequate records);
- and
10. New York Education Law §6530(35) (ordering treatment not warranted by the condition of the patient).

VOTE OF THE HEARING COMMITTEE

SPECIFICATIONS

FIRST SPECIFICATION

Respondent violated New York Education Law §6530(9)(b) by having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York state, constitute professional misconduct under the laws of New York state.

VOTE: SUSTAINED (3-0)

SECOND SPECIFICATION

Respondent violated New York Education Law §6530(9)(d) by having had disciplinary action taken after a disciplinary action was instituted by a duly authorized professional disciplinary agency of another state, where the conduct resulting in the disciplinary action would, if committed in New York state, constitute professional misconduct under the laws of New York state.

VOTE: SUSTAINED (3-0)

HEARING COMMITTEE DETERMINATION

Before the merits of this case are discussed, the issue of Respondent's adjournment request must be taken up. The Hearing Committee and the Administrative Law Judge determined, after careful consideration of the issue, that the request should be denied. Respondent was personally served with the Notice of Hearing, Statement of Charges and copy of the hearing requirements over a month and a half prior to the hearing date, and was specifically advised that any adjournment request had to be filed at least five days prior to the hearing date. Respondent did not do this, nor did he file the answer to the charges required by the statute. In addition, Respondent declined to speak with the Department's attorney on the phone regarding his participation in the hearing.

Respondent's adjournment attempt was not timely. His last minute attempt to obtain an adjournment (less than 40 minutes before the hearing was scheduled to start) was viewed by the Administrative Law Judge and the Hearing Committee as nothing more than a delaying tactic, and was denied.

The Hearing Committee also notes that Respondent's presentation at this hearing would have been, had he attended, "strictly limited to evidence and testimony relating to the nature and severity of the penalty to be imposed upon the licensee" (Public Health Law §230(10)(p)). The findings made by the Arizona Board, and agreed to by Respondent, are binding on the Hearing Committee. The Hearing Committee concludes that even had Respondent appeared personally, no evidence he could have presented would have mitigated against the sanction of revocation of his license ordered below.

At the time Texas Order 2 was issued, Respondent was on probation pursuant to Texas Order 1. He was required, among other things, to obtain a practice monitor and to obtain specified continuing medical education. Respondent was also on indefinite license suspension in New York State, with a requirement that he demonstrate his competence to safely practice medicine before his license could be restored.

The findings to which Respondent agreed in Texas Order 2 were extremely numerous and startlingly serious. In addition to findings that he had failed to obtain the practice monitor and continuing education required by Texas Order 1, Order 2 detailed an array of findings that included violations involving the fraudulent sale, dispensing and use of controlled substances by himself and/or his girlfriend. These violations are so numerous and startling that the entire Texas Order 2 is attached to this Decision and Order as Appendix 2.

It is apparent from Texas Order 2, especially when viewed in the context of Respondent's status in Texas and New York at the time, that Respondent has completely and utterly abandoned his responsibilities to the public and the medical profession. No matter what good qualities Respondent may possess and no matter what brought about the violations at issue, revocation of his license is the only appropriate response to

Respondent's misconduct, and Respondent's appearance at this hearing could not possibly have changed this result.

ORDER

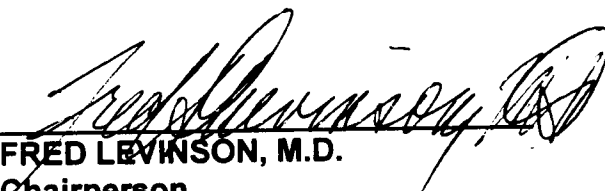
IT IS HEREBY ORDERED THAT:

1. The medical license of **ERNESTO CANTU, M.D.** is hereby **REVOKED**.

The **ORDER** shall be effective upon service on the Respondent or the Respondent's attorney by personal service or by certified or registered mail.

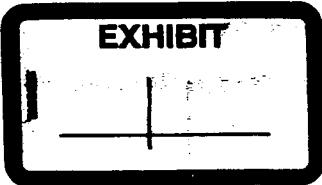
DATED: Middletown, New York

June 12, 2002


FRED LEVINSON, M.D.
Chairperson

ERNST A. KOPP, M.D.
MR. JOHN D. TORRANT

APPENDIX 1



IN THE MATTER
OF
ERNESTO CANTU, M.D.
CO-02-02-0721-A

NOTICE OF
REFERRAL
PROCEEDING

TO: ERNESTO CANTU, M.D.
C/O Ronald Sanchez
SID 490263
San Antonio County Jail
200 North Comal
San Antonio, TX 78207

PLEASE TAKE NOTICE THAT:

An adjudicatory proceeding will be held pursuant to the provisions of N.Y. Pub. Health Law § 230(10)(p) and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The proceeding will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct (Committee) on the 23rd day of May 2002, at 10:00 in the forenoon of that day at the Hedley Park Place, 5th Floor, 433 River Street, Troy, New York 12180.

At the proceeding, evidence will be received concerning the allegations set forth in the attached Statement of Charges. A stenographic record of the proceeding will be made and the witnesses at the proceeding will be sworn and examined.

You may appear in person at the proceeding and may be represented by counsel. You may produce evidence or sworn testimony on your behalf. Such evidence or sworn testimony shall be strictly limited to evidence and testimony relating to the nature and severity of the penalty to be imposed upon the licensee. Where the charges are based on the conviction of state law crimes in other jurisdictions, evidence may be offered that would show that the conviction would not be a crime in New York state. The Committee also may limit the number of witnesses whose testimony will be received, as well as the length of time any witness will be permitted to testify.

If you intend to present sworn testimony, the number of witnesses and an estimate of the time necessary for their direct examination must be submitted to the New

York State Department of Health, Division of Legal Affairs, Bureau of Adjudication, Hedley Park Place, 5th Floor, 433 River Street, Troy, New York, ATTENTION: HON. TYRONE BUTLER, DIRECTOR, BUREAU OF ADJUDICATION, (hereinafter "Bureau of Adjudication") as well as the Department of Health attorney indicated below, on or before May 3, 2002.

Pursuant to the provisions of N.Y. Public Health Law §230(10)(p), you shall file a written answer to each of the Charges and Allegations in the Statement of Charges no later than ten days prior to the hearing. Any Charge of Allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such an answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. You may file a brief and affidavits with the Committee. Six copies of all such papers you wish to submit must be filed with the Bureau of Adjudication at the address indicated above on or before May 3, 2002, and a copy of all papers must be served on the same date on the Department of Health attorney indicated below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

The proceeding may be held whether or not you appear. Please note that requests for adjournments must be made in writing to the Bureau of Adjudication, at the address indicated above, with a copy of the request to the attorney for the Department of Health, whose name appears below, at least five days prior to the scheduled date of the proceeding. Adjournment requests are not routinely granted. Claims of court engagement will require detailed affidavits of actual engagement. Claims of illness will require medical documentation. Failure to obtain an attorney within a reasonable period of time prior to the proceeding will not be grounds for an adjournment.

The Committee will make a written report of its findings, conclusions as to guilt, and a determination. Such determination may be reviewed by the Administrative Review Board for Professional Medical Conduct.

**SINCE THESE PROCEEDINGS MAY RESULT IN A DETERMINATION
THAT SUSPENDS OR REVOKES YOUR LICENSE TO PRACTICE**

MEDICINE IN NEW YORK STATE AND/OR IMPOSES A FINE FOR
EACH OFFENSE CHARGED. YOU ARE URGED TO OBTAIN AN
ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
March 28, 2002



PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct

Inquiries should be addressed to:

Robert Bogan
Associate Counsel
New York State Department of Health
Office of Professional Medical Conduct
433 River Street – Suite 303
Troy, New York 12180
(518) 402-0828

STATE OF NEW YORK

DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

IN THE MATTER

OF

ERNESTO A. CANTU, M.D.
CO-02-02-0721-A

STATEMENT

OF

CHARGES

ERNESTO A. CANTU, M.D., the Respondent, was authorized to practice medicine in New York state on October 5, 1979, by the issuance of license number 139880 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. On or about December 8, 2000, the Texas State Board of Medical Examiners (hereinafter "Texas Board"), by an Agreed Order (hereinafter "Texas Order 1"), PUBLICLY REPRIMANDED Respondent and LIMITED his license for three (3) years under terms and conditions, based on his failure to comply with recordkeeping guidelines.

B. On or about December 7, 2001, the Texas Board by Agreed Order (hereinafter "Texas Order 2"), SUSPENDED Respondent's medical license for no less than one (1) year, based on failure to conform to minimal standards of acceptable medical practice, allowing staff to perform duties/procedures without appropriate qualifications, failure to maintain records of prescribed/dispensed substances, writing false or fictitious prescriptions, conduct likely to deceive or defraud the public, inappropriate prescribing, prescribing for non-therapeutic purposes, prescribing/dispensing/selling to addicts, allowing a non-physician to hold herself out as a licensed physician, failure to comply with the terms of the Texas Order, described in Paragraph A above, failure to comply with an order of the Texas Board, and failure to properly secure drugs and paraphernalia

C. The conduct resulting in the Texas Board disciplinary action against Respondent would constitute misconduct under the laws of New York state, pursuant to the following sections of New York state Law:

1. New York Education Law §6530(2) (practicing the profession fraudulently);
 2. New York Education Law §6530(3) (negligence on more than one occasion);
 3. New York Education Law §6530(4) (gross negligence);
 4. New York Education Law §6530(11) (permitting an unlicensed person to perform duties requiring a licensee);
 5. New York Education Law §6530(15) (failure to comply with an Order of the Board);
 6. New York Education Law §6530(16) (willful failure to comply with federal, state, or local laws rules, or regulations governing the practice of medicine);
 7. New York Education Law §6530(20) (moral unfitness);
 8. New York Education Law §6530(25) (delegating responsibilities to a person when the licensee knows that such person is not qualified to perform them);
 9. New York Education Law §6530(32) (failure to maintain adequate records);
- and/or
10. New York Education Law §6530(35) (ordering treatment not warranted by the condition of the patient).

SPECIFICATIONS

FIRST SPECIFICATION

Respondent violated New York Education Law §6530(9)(b) by having been found guilty of improper professional practice or professional misconduct by a duly authorized professional disciplinary agency of another state where the conduct upon which the finding was based would, if committed in New York state, constitute professional misconduct under the laws of New York state, in that Petitioner charges:

1. The facts in Paragraphs A, B, and/or C.


SECOND SPECIFICATION

Respondent violated New York Education Law §6530(9)(d) by having his license to practice medicine suspended or having other disciplinary action taken after a duly authorized

professional disciplinary agency of another state, where the conduct resulting in the suspension or other disciplinary action would, if committed in New York state, constitute professional misconduct under the laws New York state, in that Petitioner charges:

2. The facts in Paragraphs A, B, and/or C.

DATED: *March 22*, 2002
Albany, New York


PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional Medical Conduct

APPENDIX 2

| | | |
|---|----------------------------|--|
| IN THE MATTER OF THE LICENSE OF ERNESTO CANTU, M.D. | § § § § § § | BEFORE THE DISCIPLINARY PANEL OF THE TEXAS STATE BOARD OF MEDICAL EXAMINERS |
|---|----------------------------|--|

AGREED ORDER

On this the 7th day of December 2001, came on to be heard before the Texas State Board of Medical Examiners (hereinafter "the Board"), duly in session the matter of the license of Ernest Cantu, M.D. (hereinafter "Respondent"). Respondent, after consultation with his attorney, agrees to the entry of this Order, and waives his rights to notice and hearing under; TEX. GOV'T CODE ANN. §§ 2001.051-54 (Vernon 2000); Tex. Occ. Code (Vernon 2000), Chapter 164; and the Rules of the State Board of Medical Examiners (22 TEX. ADMIN. CODE Chapter 187).

FINDINGS OF FACT

1. The Respondent, ERNESTO CANTU, M.D., holds Texas medical license F-7416.
2. The Respondent's Texas medical license was in full force and effect at all times and dates material and relevant to this Application.
2. The Board has jurisdiction over the subject matter and Respondent. Respondent received all notice that may be required by law and by the rules of the Board. All jurisdictional requirements have been satisfied under TEX. OCC. CODE ANN. §§ 151.001-165.160 (Vernon 2000) (the "Act"). By entering into this Agreed Order, Respondent waives any defect in the notice and any further right to notice or hearing under the Act; TEX. GOV'T CODE ANN. §§ 2001.051-54 (Vernon 2000); and the Rules of the State Board of Medical Examiners (22 TEX. ADMIN. CODE Chapter 187). All jurisdictional requirements have been satisfied.
4. The Respondent is fifty seven (57) years of age.
5. The Respondent graduated from the University Autonoma De Guadalajara, Jalisco, Mexico in 1978.

6. Respondent obtained his Texas medical license in 1980.
7. The Respondent is not Board certified.
8. The Respondent has no hospital privileges.
9. The Respondent maintains two offices in San Antonio. One is a diet clinic, and the other is a general medicine clinic.
10. The Respondent is currently on probation with the Board as a result of an Agreed Order he entered into in December 2000.
11. Respondent entered into a financial relationship with PillBox Pharmacy. The PillBox Pharmacy ran an Internet site and provided controlled substances and dangerous drugs to individuals in Texas, throughout the United States and abroad. Patients would contact the PillBox Pharmacy Internet site and representatives of the site would schedule a telephone consultation with Respondent. Respondent was paid \$45.00 for each approved prescription. Respondent was only paid for consultations where prescriptions were written. PillBox Pharmacy collected the fees and forwarded the fees to Respondent.
12. Pharmacy records from the PillBox Pharmacy were obtained by the Board for the period of January 1, 2000 to July 2001. These records consisted of 3,628 pages and show the Respondent issued well over 10,000 prescriptions for controlled substances and dangerous drugs through the PillBox Pharmacy during this period, including patients in Texas, throughout the United States and abroad. Respondent prescribed these drugs without establishing a proper physician-patient relationship, without performing a mental or physical exam, using appropriate diagnostic or laboratory testing, or providing a means to monitor medication response to determine either adverse or beneficial outcomes.
13. Payment records from the PillBox Pharmacy show that during a typical 5 day period of March 8, 2001 to March 14, 2001 Respondent was paid \$9,495.00 by the PillBox Pharmacy for consults performed.
14. Respondent permitted his girl friend Anne Malley (who Respondent refers to as his "common law wife") to represent herself as Dr. Anne Cantu and provide the telephone consultations with patients in connection with the internet prescribing of controlled substances and dangerous drugs via the PillBox Pharmacy website discussed in Count I above. Anne Malley, aka Dr. Anne Cantu, aka Anne Corro is not a licensed health care provider of any kind.

15. Respondent prescribed patient A. S. of O'Fallon Illinois, a patient he never met or examined Narco (Hydrocodone) (100 tablets) on 1/3/01, 3/2/01, 3/29/01 and 5/31/01 via the PillBox Pharmacy. Patient subsequently was admitted to the emergency room on June 6, 2001 after overdosing on narcotics.

16. Respondent prescribed patient T. N. of San Francisco California, a patient he never met or examined, prescriptions for Darvocet-N (100 tablets) on 10/24/00, 11/13/00, 12/6/00, and 12/29/00 (X2), via the PillBox Pharmacy. T. N.'s treating psychiatrist, from San Francisco, California, stated that he has treated the patient T. N. for the past 7 years for major depression and opiate dependence. He stated that T.N. is currently addicted to Darvocet and developing liver damage secondary to the high ingestion of the acetaminophen in the Darvocet.

17. Respondent prescribed patient K.T., of Gardendale Alabama, a patient he never examined or met Lortab (hydrocodone) (90 tablets) and Xanax (90 tablets) on 6/05/01 via the PillBox Pharmacy.

18. K.T.'s husband stated his wife (K.T.) is addicted to Lortab and Xanax and is undergoing treatment for her addiction.

19. Respondent issued fictitious prescriptions for injectable Demerol in the name of D.H., a patient of Respondent. D.H. states he has never received a prescription for Demerol, nor has he been administered Demerol by the Respondent. The fictitious prescriptions were for the purpose of obtaining Demerol for Respondent's girl friend, Anne Malley and/or the Respondent himself.

20. Respondent issued fictitious prescriptions for injectable Demerol in the name of R.K., a patient of Respondent. R.K. states he has never received a prescription for Demerol, nor has he been administered Demerol by the Respondent, in fact R.K. states he is extremely allergic to Demerol. The fictitious prescriptions were for the purpose of obtaining Demerol for Respondent's girl friend, Anne Malley and/or the Respondent himself.

21. Respondent issued a fictitious prescription for injectable Demerol in the name of M.F., a patient of Respondent. Respondent requested M.F. pick up the Demerol for him. When M.F. found out that the prescription was in his [M.F.'s] name he questioned the Respondent why he was prescribing Demerol in his name, Dr. Cantu responded by telling M.F. that Demerol was

“good stuff” and that he ought to try it. The fictitious prescription was for the purpose of obtaining Demerol for Respondent’s girl friend, Anne Malley and/or the Respondent himself.

22. Respondent issued fictitious prescriptions for injectable Demerol in the name of Debra Macias, Respondent’s medical assistant. The fictitious prescriptions were for the purpose of obtaining Demerol for Respondent’s girl friend, Anne Malley and/or the Respondent himself.

23. Respondent permitted an unlicensed medical assistant, Debra Macias to see and treat bariatric patients in his clinic while he was not present. Ms. Macias would take the weight and blood pressure of patients and would administer vitamin B-12 injections and/or Lasix injections to patients as well as call the pharmacy to authorize refill of their diet prescriptions without a physician at the clinic

24. Respondent has prescribed large amounts of Demerol as well as Ambien, Valium and Vicodin to his common-law wife, Anne Malley for her migraine headaches, manic depression and anxiety. Respondent stated that Anne Malley was also being treated by a neurologist Gerardo Zavala, MD., who also treated Anne Malley with large amounts of Demerol. Dr. Zavala provided a letter stating he does not consider Anne Malley his patient as he only saw her twice the last time being in December 8, 2000 and that she was non-compliant. Dr. Zavala also stated that he is in disagreement with Respondent’s treatment plan that includes the use of large amounts of injectable Demerol

25. October 18, 2000, the Respondent signed an Agreed Order based on Respondent’s violation of Board Rule 170, Authority of Physician to Prescribe for the Treatment of Pain. Respondent’s license was limited for a period of three years under various terms and conditions. These conditions include:

- a. Paragraph one on page two (2) of the Order required Respondent to obtain a monitoring physician within 60 days of the effective date of the order.
- b. Paragraph four (2) on page three (3) of the Order required Respondent to obtain fifty (50) hours of continuing medical education (CME) approved for Category I credits per year of which at least ten (10) hours in chronic

pain management, ten (10) hours in addictionology and five (5) hours in medical record-keeping.

- c. Paragraph four (4) on page three (3) of the Order instructs Respondent that he must comply with all provision of the Act and other statutes regulating the practice of medicine. (*See Tab Four*).
- d. Paragraph six (6) on page three (3) of the Order states any violation of the terms, conditions, or requirements of the Order by Respondent shall constitute a basis for disciplinary action by the Board against Respondent pursuant to the Act.

26. Respondent has failed to obtain a monitoring physician approved by the Executive Director in violation of the Agreed Order.

27. Respondent has failed to provide any documentation showing he has completed the required CME in violation of the Agreed Order.

28. Respondent has failed to cooperate with Board investigators by failing to provide requested documents and information in violation of the Agreed Order.

29. Respondent was served with a subpoena duces tecum on October 16, 2001 which required him to produce medical records of named patients and other information within two weeks of receipt of the subpoena duces tecum. Respondent has not complied with the subpoena.,

30. Respondent was served with a second subpoena duces tecum on October 23, 2001 which required him to produce medical records of certain named within two weeks of receipt of the subpoena duces tecum. Respondent has not complied with the subpoena

31. On October 31, 2001 two investigators and a compliance officer for the Board, and a Department of Public Safety Officer interviewed Respondent and conducted an inspection of his clinic.

32. Respondent was asked to produce his triplicate book and copies of triplicate prescriptions for the past two years. Respondent was only able to produce triplicate prescriptions for three patients. Pharmacy records Respondent then indicated that the triplicate prescriptions were at his other office. The investigators and the Respondent then went to the Respondent's other office, but Respondent was still unable to produce any other triplicate prescriptions.

Respondent then stated the triplicate prescriptions were in a storage unit, but went onto state he could not remember where the storage unit was.

33. Inspection of the Respondent office was conducted. It was noted that stock medication, syringes, samples and unlabeled partially used multi-dose vials of medication were lying about on an open counter. There was no apparent locked storage facility for medication at the facility.

34. During the October 31, 2001 interview with Respondent discussed in Count Fifteen above, the Board investigator asked to see the medical records of the patients whose records were previously subpoenaed. Respondent was only able to produce three of the 34 records subpoenaed. The Pillbox pharmacy records showed Respondent had prescribed Demerol to these three patients, however, none of the three medical records produced by the Respondent had any notations indicating they had ever been prescribed or administered Demerol.

35. There is probable cause to believe Respondent was altering and/or manufacturing medical records of patients D.A., R.K., D.H., and R.T.

36. Records from the PillBox Pharmacy showed Respondent had prescribed Demerol to D.A., R.K., DH., and R.T.

37. Respondent had been served with a subpoena on October 16, 2001 to produce his medical records of D.A., R.K., D.H.

38. Respondent's medical assistant, Debbra Macias stated that Respondent had requested that she locate the patient charts of D.A., R.K., D.H., and R.T and make copies of progress note forms and that he (Respondent) was taking these charts home with him to "fix" them.

39. On October 26, 2001 Federal authorities conducted a search of Respondent's residence and automobile. Records for D.A., R.K., DH., and R.T. were found.

40. Medical records of D.H. showed he had been prescribed injectable Demerol, and there were 15 progress notes denoting visits between August 2000 and September 2001.

41. D.H. provided a sworn statement that he had never been prescribed or administered Demerol, and that he had only seen the Respondent one or two times in the past two years.

42. Respondent's medical records for R.K. and D.A show no documentation that either if them were ever prescribed Demerol. However, patient prescription profiles from the

PillBox Pharmacy show Demerol was prescribed in the names of these patients (see Exhibits 4, 5, and 6).

43. Hand-written notes including pages with columns headed with the initials of the patients D.A., R.K., D.H., and R.T were found clearly showing Respondent was in the process of altering the medical records of R.K. R.T. and D.A., just as he had altered D.H.'s medical records.

44. There is probable cause to believe that Respondent abused Demerol and/or that he has knowingly aided his girl friend, Anne Malley, in abusing Demerol.

45. On October 26, 2001 Federal authorities conducted a search of Respondent's residence and automobile. 96 empty vials of Demerol 100mg were found in the subject's residence and in the trash as well as used syringes and other drug paraphernalia. Photographs will be available for review at the hearing.

46. In addition to the fictitious prescriptions for, and diversions of Demerol discussed in Counts six through ten above, Respondent's medical assistant, Inasia Flesher, kept a log for the time period of April 14, 2000 through May 8, 2000 of confrontations between Anne Malley, unusual behavior of the Respondent and names and dates of Demerol prescribed by Respondent to his medical staff, and picked up by his medical staff and delivered to Anne Malley or Respondent. Entries in this log include:

- 4/15/00; Debbie Macias went to Village Oaks Pharmacy to get Demerol for Anne Malley. The prescription was in the name of Debbie Macias.
- 4/17/00; Amany [sp] went to the Pill box Pharmacy and picked up a prescription for 20 ampoules of Demerol. The prescription was in the name of Anne Malley.
- 4/18/00; Amany [sp] went to the PillBox Pharmacy and picked up a prescription for 20 ampoules of Demerol. The prescription was in the name of Denise Armstrong.
- 4/19/00; Amany [sp] went to the PillBox Pharmacy and picked up a prescription for 16 ampoules of Demerol. The prescription was in the name of Romeo Torres.
- 4/21/00; Rosemary was asked by Anne Malley to call in a prescription for 30 tablets of Vicodin in her name at Walgreen's.
- 4/22/00; Amany [sp] went to the PillBox Pharmacy and picked up a prescription for 16 ampoules of Demerol and syringes. The prescription was in the name of Denise Armstrong.
- 4/29/00; the entry on this date describes an incident where she felt that the subject was under the influence of drugs. He was banging into walls and didn't know what he was talking about. She advised him to go home and he

left but came back shortly after screaming that he just got into an auto accident.

- 5/1/00; Amany [sp] was sent to the pharmacy to pick up Demerol 16 ampoules. The prescription was in the name Anne Malley. The Pharmacy only had 3 ampoules in stock.
- 5/3/00; Amany [sp] was sent to the pharmacy to pick up the remainder of the prescription.
- 5/5/00; Oak Dale Pharmacy called the office requesting the birth date of Debbie Macias stating that the subject has called in a prescription for her for Demerol and that needed her birth date for their records.

47. Pharmacy records show Respondent prescribed large amounts of Demerol to his girl friend, Anne Malley, under various names including Anne Cantu, Anne Corro. Pick up logs from the PillBox Pharmacy show the respondent prescribed Demerol in large amounts to employees and patients of Respondent, which were picked up by Anne Malley. Some of these employees and patients have provided written statements that they never received the Demerol.

48. Respondent neither admits nor denies the Findings of Fact Nos. 11 through 16. However, in the interest of resolving this matter agrees to the entry of this Order.

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

CONCLUSIONS OF LAW

Based on the above Findings of Fact the Board makes the following Conclusions of Law:

1. The Respondent's actions and/or omissions as described herein in Counts one and two, collectively and individually constitute violations of Sections 164.051(a)(1), 164.051(a)(6), 164.052(a)(4), 164.052(a)(5), 164.053(a)(1), 164.053(a)(2), 164.053(a)(3), 164.053(a)(5), 164.053(a)(6), 164.053(a)(8), 164.053(a)(9) and 165.155(a) of the Act. These violations are to the extent and degree that Respondent's continuation in the practice of medicine constitutes a continuing threat to the public welfare, pursuant to Section 164.059 of the Act.

2. Respondent is subject to action by the Board under Sections 164.051(a)(6) due to Respondent's failure to practice medicine in an acceptable professional manner consistent with public health and welfare.

3. Respondent is subject to action by the Board due to his commission of a prohibited act or practice within the meaning of Sections 164.051(a)(1) and 164.052(a)(5) of the Act based upon unprofessional or dishonorable conduct that is likely to deceive or defraud the public or injure the public.

4. Respondent is subject to action by the Board due to his commission of a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(5) of the Act by 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.

5. Respondent is subject to action by the Board due to his commission of a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(6) due to his prescribing or administering dangerous drugs or controlled substances in a manner inconsistent with public health and welfare.

6. Respondent is subject to action by the Board due to his commission of a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(4) due to his writing of false or fictitious prescriptions.

7. Respondent is subject to action by the Board due to his commission of a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(1) due to his violation of laws connected with the practice of medicine.

8. Respondent is subject to action by the Board due to his commission of a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(2) due to his failure to keep complete and accurate records of purchases and disposals of controlled substances and dangerous drugs.

9. Respondent is subject to action by the Board due to his commission of a prohibited act or practice within the meaning of Sections 164.052(a)(5) and 164.053(a)(3) due to his writing prescriptions for a person who he knew, or should have known was an abuser of narcotic drugs, controlled substances or dangerous drugs.

10. Respondent is subject to action by the Board due to his commission of a prohibited act or practice within the meaning of Sections 164.051(a)(5) and 164.053(a)(8) due to his failure to supervise adequately the activities of those acting under the supervision of the physician.

11. Respondent is subject to action by the Board due to his commission of a prohibited act or practice within the meaning of Sections 164.051(a)(5) and 164.053(a)(9) due to his delegation of professional medical responsibilities or acts to a person if the delegating physician knows or has reason to know that the person is not qualified by training, experience, or licensure to perform the responsibility or acts.

12. Respondent is subject to action by the Board due to his commission of a prohibited act or practice within the meaning of 165.155(a) of the Act by employing or agreeing to employ, paying or promising to pay, or rewarding or promising to reward any person, firm, association, partnership, or corporation for securing or soliciting a patient or patronage.

13. Respondent's prescription of medications including controlled substances and dangerous drugs without performing an adequate clinical evaluation or establishing a proper physician-patient relationship establishes that Respondent's continuation in the practice of medicine constitutes a continuing threat to the public welfare as defined by Section 164.059(b) of the Act which allows the Disciplinary Panel of the Board to temporarily suspend Respondent's license pursuant to Section 164.059(c) of the Act.

14. 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's Texas license is hereby SUSPENDED, for no less than one (1) year and until such time as Respondent requests in writing to have the suspension stayed or lifted, and personally appears before the Board and provides sufficient evidence and information which in the discretion of the Board adequately indicates that Respondent is physically, mentally, and otherwise competent to safely practice medicine. Such evidence and information shall include at a minimum, but shall not be limited to, evidence of no less than one (1) year sobriety, and complete legible copies of medical records and reports of psychological and neuropsychiatric evaluations, including a 96-hour inpatient evaluation, performed within one hundred and twenty (120) days from the time Respondent request a termination of suspension, conducted by or under the direction of a psychiatrist certified by the American Board of Medical Specialties in

Psychiatry, approved in writing in advance by the Executive Director of the Board, addressing Respondent's current mental and physical status and clearly indicating that Respondent is able to safely practice medicine. Such records, reports, and evaluations shall specifically address any potential or actual impairment of Respondent due to substance abuse or an organic mental condition, and shall address any tendencies toward compulsive behavior, relapse, recidivism, or recurrence in regard to the possibility of actions, conditions, or misconduct similar to that described in the preceding findings of fact. A copy of this Order shall be provided by Respondent to the approved psychiatrist as a reference for the evaluations, and as authorization for the psychiatrist to provide to the Board any and all records and reports related to the evaluations conducted pursuant to this paragraph. Respondent shall execute any and all releases for medical records necessary to effectuate the provisions of this paragraph.

Upon an adequate showing before the Board that Respondent is able to safely practice medicine, the suspension of Respondent's license may be stayed for a time period and under the terms and conditions as determined by the Board to the extent necessary to adequately protect the public.

While suspended, the Respondent shall continued to be monitored by the Board. Respondent shall submit himself for appropriate examinations, including screening for alcohol or drugs either through a urine, blood, or a hair specimen, at the request of a representative of the Board, without prior notice, to determine chemically through laboratory analysis that Respondent is free of prohibited drugs and alcohol. Respondent shall pay for costs of these chemical analyses, A positive screen for drugs or alcohol, or refusal to submit to random screenings shall constitute a violation of this Order and may result in further disciplinary action pursuant to the Act.

If Respondent violates any term or condition of the Order, as determined by the Executive Director, Board staff will file a complaint with the State Office of Administrative Hearings seeking revocation of Respondent's medical license.

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, EARNESTO CANTU, 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.

E. A. Cantu M.D.
EARNESTO CANTU, M.D.
RESPONDENT

STATE OF Texas §
COUNTY OF Brewer §

BEFORE ME, the undersigned Notary Public, on this day personally appeared EARNESTO CANTU, M.D. known to me to be the person whose name is subscribed to this instrument, an Agreed Order, and who after being by me duly sworn, on oath, stated that he executed the same for all purposes expressed therein.

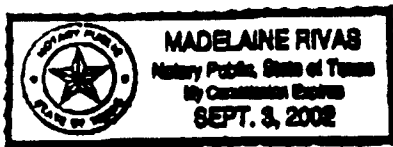
Given under my hand and official seal and office this 4th day of December 2001.

(Notary Seal)


Madelaine Rivas
Signature of Notary Public

Madelaine Rivas
Printed or typed name of Notary Public

My commission expires: 09-03-02



SIGNED AND ENTERED by the presiding officer of the Texas State Board of Medical Examiners on this 7th day of December 2001.

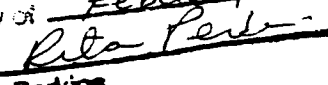


Lee S. Anderson, M.D.
President, Texas State Board of
Medical Examiners

**STATE OF TEXAS
COUNTY OF TRAVIS**

I, Rita Perkins, certify that I am an official assistant
custodian of records for the Texas State Board
of Medical Examiners, and that this is a true and correct
copy of the original, as it appears on file in this office.

Witness my official hand and seal of the Board
this 27 day of February, 2002



Rita Perkins
Public Information