Adverse Actions Report January 2022 – February 2022

The digital edition of the *Forum* presents a two-month report of recent adverse actions. This report does not include non-adverse action such as reentry agreements or relief of consent order obligations. To view all public actions, visit www.ncmedboard.org/BoardActions.

Name/license #/location	Date of action	Cause of action	Board action
ANNULMENTS			
NONE			
SUMMARY SUSPENSIONS			
NONE			
REVOCATIONS			
LEAK, Byron Christopher, MD (201001423) Charlotte, NC	02/09/2022	Automatic revocation of medical license due to felony conviction for distribution of Oxycodone	Revocation
SUSPENSIONS			
ARTIS, Karlus Cornelius, MD (000034782) Roanoke Rapids, NC	01/31/2022	From December 2015 to June 2020 MD prescribed multiple controlled substances to a patient who is an immediate family member. MD prescribed Schedule II and IV narcotics as well as a Schedule IV amphetamine. MD was able to produce records for five episodes of prescribing to this patient. MD documented patient history, vital signs, physical examinations, diagnosis, and intervention prior to prescribing to the patient. The patient's medical records lacked evidence of urine drug screens, failure to query the North Carolina Controlled Substances Reporting System (NCCSRS), no controlled substance agreement, and no informed consent. The NCCSRS listed at least seven prescriptions for controlled substances to the patient for which MD could produce	Indefinite Suspension immediately stayed except for three months with term and conditions. MD shall successfully complete the ProBE course and may not prescribe, administer, distribute, and/or dispense controlled substances except from his current medical practice. MD shall schedule an appointment with the North Carolina Professionals Health Program (NCPHP) and follow all recommendations including submitting to further assessments.

		no record.	
KONOSWARAN, Suresh Aravinth, MD (201400260) Greensboro, NC	01/06/2022	In February 2021, MD entered into a Consent Order with the Board in which he was reprimanded and required to have a trained female chaperone present while providing in-person medical care to female patients. The Consent Order was based on allegations that MD inappropriately touched a patient's breasts. In July 2021, MD, self-reported to the Board that there had been an additional complaint made by a female patient (Patient A) alleging that MD made numerous inappropriate phone calls of a personal nature to Patient A. MD resigned from his employer in July 2021. During the investigation into Patient A's allegations, the Board was informed of two additional patients' (Patient B and Patient C) complaints regarding MD. Patient B alleged that during a virtual visit, MD asked her to remove her top and bra. About an hour after the first visit, MD initiated another virtual visit with Patient B in which he again asked her to lift her shirt. Patient C alleged that MD frequently called her to ask her about her personal life. Further, Patient C stated that during a virtual visit, MD asked her to lift her shirt.	Indefinite suspension
MACKIE, Crystal Monique, MD (202001935) Norfolk, VA	01/3/2022	MD was first issued a limited emergency license to practice medicine by the	Indefinite suspension

		Board in May 2020. She practiced family medicine in Charlotte. On March 10, 2021, the Board received a complaint from the Chief Medical Officer of the health clinic where MD began working on March 2, 2021. On March 09, 2021, the clinic received a call from a Complainant voicing concerns that her nineteen-year-old intellectually challenged son was written a prescription for Oxycodone. The Complainant noted her son was not a patient of the clinic and had no idea how he would have gotten to the clinic because he does not drive. The clinic checked and found no record of Complainant's son ever being treated at either of its two locations. The clinic obtained a copy of the prescription from the pharmacy. The prescription was written on one of the prescription notes kept at the clinic. MD's license, DEA number, and cell phone number were handwritten on the prescription. She had no explanation how Complainant's son had obtained a prescription with her identifying information. Complainant's nineteen-year-old son was interviewed. He advised he had walked to a 7-Eleven convenience store near his home and was stopped by a female in a silver SUV. The lady requested assistance in getting a prescription filled	

		for her and offered to pay him for his help. After he agreed, the lady wrote his name and address information on the prescription, drove him to his residence to get his ID, and took him to a pharmacy where the prescription was filled. He returned to the SUV and gave the lady the prescription medication. He was then taken back to his residence. MD was assessed by the North Carolina Professionals Health Program (NCPHP) in March 2021. Following the assessment, MD attended and successfully completed an in-patient treatment program for alcohol use disorder. In August 2021 MD signed a five-year contract with NCPHP and was deemed safe to practice by NCPHP.	
NIETO, Rafael, MD (201301102) Charlotte, NC	01/13/2022	The Board received a complaint regarding MD from Patient A in September 2020. MD owns and operates IZAR Wellness Institute (IZAR), a medical spa in Charlotte. Patient A was first contacted by MD through the IZAR Facebook page with an offer of free medical spa services. In exchange for the free services, MD would be provided with two tickets to the Mrs. North Carolina Pageant and listed as a sponsor for Patient A. On Patient A's request, MD also agreed to provide medical spa services to Patient A's friend, Patient B. On July 18,	Indefinite suspension; immediately stayed with conditions

		2020, MD performed several medical spa services on Patients A and B during an after-hours visit to IZAR. Patients A and B arrived at IZAR at approximately 5:30 p.m. and did not leave until after midnight. MD provided dinner and sparkling wine to Patients A and B. MD performed dermal filler injection procedures on Patients A and B. MD numbed the lips of Patients A and B and then allowed Patients A and B to assist with each other's procedures by holding and then removing the needle under his instructions. MD performed colonic hydrotherapy treatment on Patient A. Patient A undressed and put on a gown for this procedure. Although Patient B was in the room during this procedure, no other chaperone was present. MD offered Patients A and B a condominium in Charlotte where they could spend the night rather than drive home. MD asserts that he offered Patients A and B a place to spend the night due to the late hour. MD did not prepare notes or medical records regarding the services performed on Patients A and B.	
LIMITATIONS/CONDITIONS			
WILLIAMS, Dwight Morrison, MD (200001370) Asheboro, NC	01/07/2022	In December 2019, the Board received a complaint from a pharmacist questioning MD's prescribing practices. The During the course of its	Consent Order; Within 30 days MD to engage CPEP to develop an Educational Intervention plan

		investigation, the Board obtained medical records for three patients which were sent for review by an independent medical expert who felt that many aspects of MDs' care were within the acceptable standard of care. However, many aspects of MD' care were below the minimum acceptable standard of care. These criticisms focused on MD' medical record keeping and treatment of patients with pain who were receiving controlled substance medications. MD obtained and completed a comprehensive competency assessment examination by the Center for Personalized Education for Professionals (CPEP). CPEP's assessment report indicated that MD demonstrated several deficiencies and educational needs related to medical knowledge, clinical judgment, and medical record documentation. CPEP is willing to develop an Educational Intervention plan for MD.	
REPRIMANDS			
FINLEY, Molly Ann, DO (202004314) San Tan Valley, AZ	01/03/2022	DO was first issued a Limited License for Disasters or Emergencies by the Board in October 2020. She practiced telemedicine. In June 2020, DO submitted an application for a license to practice osteopathy in Kentucky. In March 2021, the Commonwealth of Kentucky Board of Medical Licensure (Kentucky Board) denied DO's Application for	Reprimand

		Licensure. The Kentucky Board's denial was based on DO providing an incorrect response when completing her license application. Specifically, she failed to respond accurately to the following question: Have you ever been disciplined by any licensed hospital (including postgraduate training) or the medical staff of any licensed hospital, including removal, suspension, probation, limitation of hospital privileges or any other disciplinary action if the action was based upon what the hospital or medical staff found to be unprofessional conduct, professional incompetence, malpractice, or a violation of a provision(s) of a Medical Practice Act? DO responded in the negative. However, the Kentucky Board found that, in 2017, DO's medical staff membership at the Community Board of St. Joseph's Hospital and Medical Center in Phoenix, Arizona was revoked based on her failure to disclose two misdemeanor Driving Under the Influence convictions in her application for Medical Staff Membership. According to DO, the omission in the Kentucky application was an isolated and unintentional oversight. DO did fully disclose all requested information during her application process with North Carolina.	

GAUTHEIR, Michael Edward, MD (202002211) Virginia Beach, VA	01/21/2022	Action based on the action of another state medical board. MD practiced pain management in Virginia Beach, Virginia. In March 2021, the Virginia Board of Medicine executed an Order in which MD's license to practice was REPRIMANDED for allowing an employee who is not a licensed healthcare practitioner to assist him in performing fluoroscopic guided injection therapy procedures.	Reprimand
SALIM, Jawad Ahmed, MD (202200162) Charlotte, NC		MD applied for a license to practice medicine in North Carolina. In November 2019, MD entered a guilty plea related to criminal charges that he facilitated the submission of unlawful medical claims to Medicare. MD was sentenced to one day of imprisonment, twelve months of supervised release and was further ordered to pay restitution in the amount of $500,000.00. MD's Georgia medical license was reprimanded, assessed a $5,000.00 fine and he was required to complete continuing medical education in ethics.	License issued with reprimand
DENIALS OF LICENSE/APPROVAL			
SURRENDERS			
PUBLIC LETTERS OF CONCERN			
BROTZMAN, Wrenn Shoulars, PA-C (001010553**)** Goldsboro, NC	01/14/2022	PA began to treat patients seeking cosmetic and aesthetic procedures through her practice, Succulent Aesthetics, PLLC	Public Letter of Concern

		(the Practice), which was operated out of a dedicated space within her primary residence. The Board is concerned that PA began treating patients through the Practice without first filing an Intent to Practice with the Board and without documenting that she had obtained a supervising physician. This later conduct violates Board rules. The Board understands that PA had a verbal agreement with the supervising physician at the time she began providing services through the Practice and that she entered into a written supervision agreement with the supervising physician upon becoming aware of the Board's requirement. The Board is concerned that the supervising physician, although a board-certified emergency medicine physician, lacked specific experience and training in performing cosmetic procedures. Also, although the supervising physician was continuously available to PA for consultation related to the Practice, the Board is concerned that he never physically visited or inspected PA's home office location other than by a "virtual tour." For these reasons, the Board is concerned that the supervising physician was not properly trained to provide the required oversight of PA's practice as envisioned by the Board's	

		rules. Lastly, the Board notes that PA treated an immediate family member without making a medical record of that treatment, in violation of Board rules and standards of acceptable and prevailing medical practice.	
DHARIWAL, Manoj Kumar, MD (201801463) Port Charlotte, FL	01/14/2022	Action based on the action of another state medical board. In May 2021, MD entered into a Consent Order with the Connecticut Board in which he was assessed a $5,000 civil penalty. The Connecticut Board Order was based on concerns regarding MD's prescriptions of various medications through a telehealth platform. Specifically, the Connecticut Department of Public Health alleged that, on several occasions, MD's prescriptions to Connecticut residents failed to meet the standard of care because he either had no direct or indirect contact with patients, made diagnoses and/or prescribed medications without an adequate history and/or examination, inadequately documented care, or prescribed one or more medication without required patient counseling and/or monitoring the effects of the drug.	Public Letter of Concern
DIGBY, Ronald Wyman, MD (000021642) Gastonia, NC	01/28/2022	The Board is concerned that in August 2020 MD consumed a small amount of alcohol and presented to work. No patient harm occurred. He was referred to the North Carolina	Public Letter of Concern

		Professionals Health Program (NCPHP) for an assessment in September 2020, signed a monitoring agreement with NCPHP and entered inpatient treatment. MD completed inpatient treatment in May 2021 and began working with NCPHP on a return-to-work plan, which included abstinence from alcohol. However, MD consumed alcohol in June 2021, and inactivated his North Carolina medical license in July 2021.	
GORDON, Anthony Kent, MD (201802696) Houston, TX	01/14/2022	The Board is concerned that while MD lived in California, an ultrasound technician he previously employed asked him to interpret breast ultrasounds taken at a Georgia plastic surgery center, where the ultrasound technician worked, via teleradiology. In 2016, MD interpreted breast ultrasounds for Patients A through D and authored reports relating to his interpretations based upon the information provided by the referring physician. The Board expressed some concerns with regard to MD's documentation and follow-up recommendations set forth in the records for these Patients. The Board also expressed concern that some of the ultrasounds provided to MD lacked information and that he should have considered recommending that further studies be done based on such. The Board	Public Letter of Concern

		understands that MD's documentation on these Patients was appropriate and that any follow-up recommendations were within the purview of the referring physician. The Board notes that MD is no longer working in this type of framework or for the Georgia plastic surgery center.	
KELLY, Thomas Andrew, MD (000027216) Greensboro, NC	01/04/2022	The Board is concerned that MD's care of a 65-year-old male patient may have failed to conform to the standards of acceptable and prevailing medical practice in North Carolina. The patient presented to MD, in October 2018, for a cardiology consultation after having an echocardiogram at a separate location. Although MD did not have the actual images from that study, the echo report raised concern for significant aortic stenosis; however, the report included discordant data with only a moderately elevated gradient with reported normal left ventricular function, but the valve area suggested more severe aortic stenosis. Based on MD's recommendation and with the patient's informed consent, MD proceeded with an elective procedure to assess patient's level of cardiac function (cardiac catherization). The right cardiac catherization, the imaging of the heart's blood vessels (coronary	Public Letter of Concern

		angiography), and the assessment of the aortic root were all properly performed without complications. However, crossing the aortic valve was difficult and it appears the catheter was close to or adherent to the innermost layer of tissue that lines the chambers of the heart (endocardium). MD performed an imaging test to determine the heart function in patient's left ventricle (ventriculogram) with a high-pressure injector. Because of the position of the catheter within a small ventricular cavity, a vigorous left ventricular contraction resulted in some contrast leaking into the left ventricular wall. The patient's heart compressed due to the fluid collecting in the sac surrounding the heart (cardiac tamponade), and he went into cardiac arrest. Appropriate resuscitation efforts were performed, and the patient survived to undergo emergent surgery with Aortic Valve Replacement and relief of tamponade. However, the patient suffered severe anoxic brain injury and subsequently died. The Board had MD's treatment of the patient reviewed by an independent medical expert. The reviewing expert opined that MD's care of the patient may have fallen below the standard of care	

		in North Carolina. Specifically, while the reviewing expert opined that MD's overall approach and management of this patient met the standard of care, the expert criticized MD's failure to recognize possible catheter entrapment within a small ventricle which is ultimately what led to the poor outcome. Further, the reviewing expert opined that the ventriculogram may not have been necessary because the left ventricular function was already known, and therefore, added little clinical value. The Board is aware that MD has been licensed since 1983. The Board also notes MD has indicated that he has extensive experience in performing cardiac catheterizations and currently does not routinely perform ventriculograms, but when he does, he only uses hand injection of contrast after confirming proper position of the catheter in the ventricle.	
LANDA, Israel, MD (201300437) Goldsboro, NC		The Board is concerned that MD began serving as the supervising physician for a physician assistant's cosmetic practice (Practice) without first filing an Intent to Practice with the Board and without documenting the supervising physician relationship. MD did not document the supervisory arrangement with the physician assistant in writing until several months after	Public Letter of Concern

		the physician assistant began performing procedures. In addition, and despite expertise in the field of emergency medicine and experience in performing the types of injections and procedures that are generally used in the cosmetic medicine field, the Board remains concerned that MD lacked specific experience and training in the cosmetic procedures performed by the physician assistant. The Board is also concerned that MD did not physically visit or inspect the Practice other than through a virtual tour. Lastly, the Board notes the physician assistant treated an immediate family member and did not make a medical record of that treatment, in violation of Board rules and standards of acceptable and prevailing medical practice.	
MEYER, Albert Augustine, MD (000021588) Wilmington, NC	01/31/2022	The Board is concerned that MD's care of a patient may have failed to conform to the standards of acceptable and prevailing medical practice in North Carolina. The patient, a twenty-four-year-old female, thirty-nine weeks pregnant, presented to the hospital in July 2013 complaining of leakage of fluid and was found to be in active labor. During the second stage of labor, MD attempted a vacuum assisted vaginal delivery despite nonreassuring fetal heart tones. The decision was made for the patient to	Public Letter of Concern

		undergo an emergency cesarean section, performed by another physician, who delivered a male infant. Due to his condition, the infant was transferred to Duke University. The Board is concerned that MD failed to properly assess the patient in a timely fashion, failed to recognize the seriousness of the fetal heart tracing, and failed to seek assistance from the on-call obstetrician in a timely fashion. Additionally, MD failed to apply a fetal scalp electrode to monitor fetal well-being, even when asked by an assisting nurse. The Board also notes that MD did not specifically discuss the risks of a vacuum assisted vaginal delivery with the patient or document the position of the fetus prior to application of the vacuum.	
MISCELLANEOUS ACTIONS			
BUDZYN, Brian James, MD (201600018) Huntersville, NC	02/03/2022	MD has a history of alcohol use disorder. In December 2020, MD self-referred to the North Carolina Professionals Health Program (NCPHP) and began treatment for alcohol use disorder. In February 2021, MD requested that his North Carolina medical license be made inactive retroactively with an inactive date of December 30, 2020. MD has not practiced medicine since that time. In March 2021, MD signed a five-year	License reinstated with conditions via Consent Order. MD shall maintain current agreement with NCPHP and refrain from the use or possession of alcohol and all other mind- or mood-altering substances and all controlled substances

		monitoring agreement with the NCPHP. In August 2021, MD and the Board entered into a Consent Order in which his license was indefinitely suspended. MD later submitted his reinstatement application to the Board for a license to practice medicine. MD is in compliance with his NCPHP agreement and NCPHP supports the reinstatement of his medical license.	
O'CONNOR, Brian Joseph, PA-C (000102119) Charlotte, NC	02/10/2022	In August 2020, the Board executed a public letter of concern because PA called in prescriptions to a pharmacy for Plaquenil® (hydroxychloroquine) for himself and members of his immediate family. In March 2021, PA entered into a Consent Order with the Board, wherein PA's physician assistant license was indefinitely suspended for, among other things, prescribing controlled substances to a person with whom he had a significant personal and emotional relationship. PA has not practiced as a physician assistant since April 2021.	License reinstated; PA required to successfully complete ProBE course
CONSENT ORDERS AMENDED			
WON, John Sunghoon, MD (200601944) Elizabeth City, NC	01/06/2022	MD practiced maxillofacial surgery in Raleigh and Elizabeth City, North Carolina. In July 2021, MD	Amended Consent Order; MD may perform oral surgery; Restrictions placed on

		entered into a Consent Order with the Board in which his license to practice medicine was suspended for twelve months; however, the suspension was immediately stayed upon the condition that he does not perform oral surgery. The Consent Order was based on MD's failure to comply with the provisions of his May 2020 Consent Order by performing oral surgery on six patients between July 2020 and September 2020. MD submitted for a comprehensive assessment by the Center for Personalized Education for Professionals (CPEP) in August 2020. CPEP identified some areas of educational need and made the following recommendations: (1) establish a relationship with an experienced educational Preceptor in oral maxillofacial surgery; (2) review and commit to memory Advanced Cardiovascular Life Support (ACLS) protocols and algorithms and enrollment in an electrocardiogram (ECG) interpretation course; and (3) take steps to improve medical record documentation In September 2021, MD requested that the Board relieve him of the condition of his 2020 and 2021 Consent Orders that restricted him from performing oral surgery. At	medical license

		the November 2021 Board meeting, the Board reviewed MD's request and agreed to allow him to practice oral surgery with certain restrictions.	
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			