Adverse Actions Report July-August 2025

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			
AUDISHO, Sargon, MD (201802519) Chicago, IL	8/6/2025	MD's felony conviction for one count of Health Care Fraud.	Revocation of NC medical license
OENBRINK, Raymond Joseph, DO (200901584) Daytona Beach, FL	7/14/2025	An eight-year-old girl was first seen by MD for an evaluation for Chronic Inflammatory Response Syndrome. Patient was seen on subsequent occasions as jaundice and other symptoms developed. Despite evidence that Patient was experiencing liver failure, MD did not advise her parents to stop giving Tylenol, which is a hepatotoxic medication. Patient was later admitted to a hospital and an ultrasound confirmed she was suffering from an enlarged liver and spleen. Patient died with a cause of death listed as multi-system organ dysfunction due to macrophage activation syndrome due to juvenile idiopathic arthritis. The Board's expert testified that the lab results and physical findings documented by MD were unmistakable evidence of acute liver failure across all of its functions. The minimum standard of care	Revocation of NC medical license

		dictated that the severity of Patient's condition be imparted to her parents along with the recommendation that she required immediate evaluation at a hospital. MD's treatment plan fell far below the minimum standard of care.	
YOUNG, David Matthew, MD (201902461) Fredericksburg, TX	7/16/2025	MD's felony convictions for one count of Conspiracy to Commit Health Care Fraud and three counts of False Statements Relating to Health Care Matters.	Revocation of NC medical license
SUSPENSIONS			
WILLIAMSON, Bridget Alaire David, PA-C (001011566) Charleston, SC	7/10/2025	In March 2022, PA was reprimanded by the Board. The Board acted reciprocally in response to the Indiana Physician Assistant Committee's 2021 summary suspension of PA's license and indefinite probation. In February 2025, the Board ordered PA for an NCPHP examination. PA carries a diagnosis of an alcohol use disorder that is currently in remission.	Indefinite Suspension
LIMITATIONS/CONDITIONS			
WALLENBORN, Jacqueline, PA-C (001005299) Hendersonville, NC	8/29/2025	PA was charged in January 2020 with Driving While Consuming Alcohol. Following an assessment, she was diagnosed with alcohol use disorder and residential treatment was recommended. After her discharge from treatment PA entered into a monitoring contract with NCPHP to assist her with her recovery. In May 2020, the Board was informed that PA	PA license reinstated with terms and conditions

		had relapsed. She re-entered residential treatment and made her NC physician assistant license inactive. PA signed a new five-year monitoring contract with NCPHP but later withdrew from monitoring. In February 2021 PA's license was indefinitely suspended by the Board via Consent Order. In 2024, PA entered into a five-year monitoring contract with the South Carolina Recovering Professionals Program (SCRPP) and re-engaged with NCPHP for out-of-state monitoring to run concurrently with her SCRPP contract. PA is currently in compliance with the terms and conditions of her monitoring contracts with SCRPP and NCPHP, which are in effect until February 2029. NCPHP supports PA's reinstatement as a physician assistant.	
REPRIMANDS			
BAILEY, Dwight Merritt, DO (200501042) Charlotte, NC	8/29/2025	DO admits that he engaged in a third-party boundary violation with the relative of a patient. Board staff also discovered that on two occasions in 2023, DO prescribed gabapentin for his terminally ill pet dog. DO is not licensed in veterinary medicine and he did not indicate to the pharmacy that the prescription was for an animal.	Reprimand; DO shall complete the Professional/Problem-Based Ethics course
BRYNER, Jay Clifford, Jr., PA-C (001006163) Arden, NC	7/8/2025	The Board is concerned that in November 2024, PA wrote a prescription to a former psychiatric patient,	Reprimand

		for a controlled substance, using a prescription pad from his previous employer. When Patient presented the prescription, the pharmacist called the facility and was told PA no longer worked there. The prescription was not filled, thus resulting in the very delays in obtaining his refill that Patient anxiously sought to avoid.	
TSERING, Chock, MD (200100798) Monroe, NC	8/28/2025	The Board received a complaint from a provider citing concerns regarding MD's controlled substance prescribing. The Board also received information from NCDHHS that MD was a top opioid prescriber in the state. In response to this information, the Board had the records for seven of MD's patients reviewed by an independent expert. In all cases MD's treatment of the seven patients failed to meet or fell below the standard of care. The reviewing expert criticized MD's long-term prescribing of opioids and benzodiazepines being primarily conducted through phone visits without adequate clinical justification. In addition, medical records were largely repetitive, with minimal updates and no documentation of current pain levels, functional improvements, or specific	Reprimand; Shall cease prescribing Schedules II-IV controlled substances within 60 days

		pain symptoms, which are crucial for assessing the treatment's effectiveness. There was no evidence that MD consistently reviewed the North Carolina Controlled Substances Reporting System before prescribing opioids. A high-risk patient was not seen in person more than once a year and had only an annual UDS. MD also did not appropriately address abnormal UDS results.	
WALKER, Rogers Smith, MD (000027331) Little River, SC	8/19/2025	A 78-year-old male with a history of hypertension and mild atherosclerotic disease of the heart and vessels, presented to MD for left shoulder pain radiating down his left arm. His blood pressure was slightly elevated. MD ordered a CPK, PSA, and lipid profile. He diagnosed Patient with pain in his left shoulder and administered injections. Patient suffered a fatal heart attack three days after seeing MD. MD's failure to consider a cardiac cause for Patient's symptoms and his failure to administer an in-office ECG departed from the minimum standard of care.	Reprimand; Shall complete four hours CME in acute myocardial infarction in primary care
ZALZALA, Sajad, MD (201602527) Dearborn, MI	7/15/2025	In May 2023, MD agreed to not reapply for registration to practice medicine in Ontario. The Consent Agreement with the College of Physicians and Surgeons of Ontario (CPSO) resolved an inquiry conducted by the	Reprimand

		CPSO. This Board had MD's care of five patients in NC reviewed by an independent medical expert. The expert was concerned with MD's consistent lack of documentation regarding patient history and examination. The expert commented that the treatments appeared to rely heavily on the patients' responses to vague and incomplete questions, and there was insufficient clinical evaluation or corroboration. MD completed a continuing medical education seminar on medical record keeping and is participating in a 6-month educational preceptorship with a family medicine physician.	
DENIALS OF LICENSE/APPROVAL			
HUSSAIN, Basharat, MD (200701692) Multan	8/8/2025	MD's NC medical license expired and became inactive in 2008. In 2018 MD pled guilty to two felony counts of battery in Florida and agreed to forfeit his license to practice medicine and to not seek re-licensing as a doctor. In 2024 MD applied for reinstatement of his NC medical license.	Denial of NC medical license
SURRENDERS			
FERREE, Charles Elliot, MD (000027175) Charlotte, NC	8/13/2025		Voluntary surrender of medical license
MARKO, Bruce Howard, MD (009601783) Charlotte, NC	7/3/2025		Voluntary surrender of medical license
PUBLIC LETTERS OF CONCERN			
ABU-SALHA, Yousef Mohammad, MD (202401262) Chapel Hill, NC	7/16/2025	During MD's license renewal, he disclosed that he had been the subject of an investigation with the UNC Health Privacy Office	Public Letter of Concern

		regarding the unauthorized viewing of patient charts. This investigation was the result of an audit which found that in March 2021, while a resident, MD used his UNC privileges to access medical records for multiple individuals with whom he had no physician-patient relationship and without medical justification.	
AZZATO, John Anthony, MD (000020698) Southport, NC	7/30/2025	MD prescribed controlled substances to family members and to those with whom he had a significant emotional relationship. The Board ordered MD to produce medical records for four patients. In several instances the medical records of these four patients have dates of service that do not match the dates of note creation in the records, leading the Board to infer that no records were created at the time of the patients' visits.	Consent Order; Prohibited from prescribing controlled substances except buprenorphine for treating opioid use disorder
BERGLUND, Laura Harman, MD (000039357) Mebane, NC	7/24/2025	The Board is concerned about MD's inappropriate prescribing. MD self-reported that she was investigated by her employer and received a written corrective action for failing to follow procedure when she directed a certified medical assistant (CMA), in March 2024, to submit a prescription for a family member under another physician's name. The patient was under	Public Letter of Concern

		another Physician's care and had previously received a prescription for gabapentin. The physician specifically noted NO REFILLS in the chart, because he was assessing if the pain was attributed to an earlier knee surgery or a more recent cause. The physician received a notification that the prescription was sent for the patient under his name and instructed his CMA to immediately call the pharmacy and cancel it. The investigation also identified that MD ordered gabapentin for the patient in February 2024.	
CHURUKIAN, Allan Christopher, MD (202103143) San Diego, CA	8/11/2025	The Board is concerned about MD's care of a 77-year-old-male with a history of hypertension, diabetes, and coronary artery disease treated with antiplatelet medications, who presented to the emergency department following a low-speed motor vehicle accident. Patient developed right side neck pain, headache, weakness, inability to ambulate and an episode of bowel incontinence. MD documented that he performed a physical examination and general neurological assessment "by observation" but did not record a detailed neurologic exam. Lab work was largely unremarkable, except for mildly low glucose. MD diagnosed Patient with cervical strain, generalized	Public Letter of Concern

		weakness, hypoglycemia, and muscle tension headache. Patient was given IV fluids and Tylenol and discharged. Patient returned to the emergency department two days later. A CT scan revealed subdural hematomas and subarachnoid hemorrhage. Patient was discharged to a rehabilitation facility a week later, with extensive brain bleeds. The Board's reviewing expert opined that MD's failure to order a head CT scan in an elderly patient on antiplatelet medications with symptoms suggestive of neurological compromise following a motor vehicle accident was not consistent with the widely accepted clinical guidelines. MD's limited documentation failed to meet the minimum standard.	
DAMIANI, Brad Steven, MD (000031972) Vero Beach, FL	7/18/2025	The Board is concerned about MD's care of a 41-year-old female who presented to the ER by ambulance with complaints of upper abdominal pain, midback pain, and nausea. Patient had a medical history of cardiac pacer, congestive heart failure, cardiomyopathy, obesity, atrial fibrillation, and hypertension. Ultrasound, non-contrast CT scan of the abdomen and pelvis, chest X-ray, and multiple labs were ordered. Ultimately, MD discharged Patient with a prescription of Norco, Pepcid, and Zofran and with	Public Letter of Concern; MD shall complete six hours Category I continuing medical education

		no definitive diagnosis. Patient returned to the ER the following day with complaints of abdominal pain and vomiting. While preparing to be discharged, Patient suffered cardiac arrest. Despite extensive codes, Patient was pronounced dead. An autopsy later revealed that Patient was suffering from a thoracic aortic dissection. A malpractice suit was settled against MD for failure to properly diagnose and treat, resulting in Patient's death. The Board's reviewing expert found MD's diagnosis and documentation to be below the minimum standard of care. Patient presented with high-risk factors for dissection, including hypertension. The reviewing expert noted that MD also failed to document a complete medical decision-making process as well as a wide differential.	
EDWARDS, Christopher Andrew, MD (200700930) Arden, NC	7/28/2025	The Board is concerned about MD's care of a 29-year-old male who presented to MD for a consultation regarding weight loss surgery and consented to undergo laparoscopic Roux-en-Y gastric bypass. Patient was scheduled for the laparoscopic Roux-en-Y gastric bypass procedure to be performed by MD. However, due to a scheduling and documentation error, a laparoscopic sleeve gastrectomy was performed	Public Letter of Concern

		instead. The Board's independent medical expert found that MD's documentation and communication failed to meet the minimum standard in NC. The reviewing expert noted that a scheduling error – spiraled into a miscommunication of the intended surgical procedure, resulting in incorrect surgical consent and confirmation of the wrong procedure during surgical time-outs.	
FRASCA, Anthony Adolph, MD (009901177) Morganton, NC	6/14/2025	The Board is concerned that MD's care of a patient may have failed to conform to the standards of care. Patient worked as a licensed mental health worker, with specific training and extensive experience in the therapeutic use of ketamine. Patient recruited MD to participate in a ketamine-assisted psychotherapy (KAP) program as a complement to MD's existing clinic-based ketamine practice. When they began collaborating he was not yet MD's patient. Patient later requested ketamine treatment at MD's clinic due to anxiety and received ketamine injections due to life stressors. Patient then requested to receive ketamine at home. MD prescribed lozenges and tablets of ketamine. Patient refilled the prescriptions in quick succession. Shortly thereafter Patient died by suicide. The Board's independent medical expert	Public Letter of Concern

		criticized MD's failure to maintain appropriate boundaries, also his reliance on Patient's experience and knowledge to guide his ketamine treatment. There was no documentation of a detailed history, psychosocial assessment, or assessment of possible comorbidities or alternative diagnoses, and there was no documentation of the rationale for prescribing ketamine for Patient nor for his decision to prescribe home-based ketamine treatment.	
GARRIS, Jeffrey Bruce, MD (200300344) Arden, NC	7/30/2025	The Board is concerned about MD's care of a 43-year-old female with a history of endometriosis and sacral pain on whom MD performed vaginal wall prolapse repair and cystoscopy. When Patient's Foley catheter was removed days later, she was unable to void and experienced pain and distention in her lower abdomen. After two visits to the ER and her post-operative follow-up with MD, Patient continued to suffer from the same pain and was admitted to the hospital with fever and chills, headache, and abdominal pain. MD performed exploratory surgery and removed a retained sponge from the operation.	Public Letter of Concern
MATHEUS, Virgilio, MD (201300919) Orlando, FL	8/25/2025	The Board is concerned that in 2025, the Florida Board issued a Letter of Concern, a	Public Letter of Concern

		fine, ordered MD to complete CME and deliver a one-hour lecture on wrong-site surgeries at an approved medical facility. The action was taken because a 60-year-old male patient presented for a scheduled minimally invasive transforaminal lumbar interbody fusion at L4-L5 level. MD operated at the L3-L4 level constituting a wrong-site surgery.	
PETERS, Brandon Moseley, MD (000039372) Hertford, NC	7/21/2025	The Board is concerned that MD prescribed controlled and non-controlled substances over a period of four years to a Patient without seeing her in person or by telehealth. MD saw Patient in his office in 2020 for treatment and management of anxiety, depression, and insomnia. For the next four years, MD refilled Patient's prescriptions without any personal evaluation of her medical conditions. MD's office staff abruptly declined to refill Patient's alprazolam prescription in 2024, which can cause withdrawal issues including seizures. The Board's reviewing expert opined that the standard of care requires routine evaluation of physical and mental health conditions, particularly when medications, including controlled substances, are prescribed. Abruptly denying prescription refill requests also does not meet the standard of care.	Public Letter of Concern
POTTHOFF, Troy Lane, MD	7/2/2025	The Board is concerned that	Public Letter of

(201901435) Kent, WA		in January 2025 MD was reprimanded by the Maine Board, which found that MD did not timely report all adverse actions taken against his medical licenses by the licensing authorities of other jurisdictions. The Maine Board reviewed the medical records of sixteen patients treated by MD via telehealth. The Board's outside expert opined that MD's treatment of two patients lacked appropriate medical decision-making. Specifically, MD prescribed an antibiotic to which a patient had a documented allergy and prescribed a three-week course of antibiotics for another patient without adequate evidence to support a diagnosis of Lyme disease. The expert also noted failures in medical record documentation for most of the patient records reviewed.	Concern
SALEEBY, Yusuf Michael, MD (200601034) Mount Pleasant, SC	7/3/2025	The Board is concerned that MD aided and abetted the unlicensed practice of medicine in NC. In 2024, MD introduced Person A to two PAs who owned and operated a functional medicine practice. MD served as their primary supervising physician. Person A was a licensed PA in Arizona, California, and with the First Nation Medical Board, but was not licensed in NC. The practice advertised the services of Person A on its website as an “Integrative Physician	Public Letter of Concern

		Assistant." The practice further allowed Person A to see patients by conducting telehealth visits where she performed examinations, ordered tests, made treatment recommendations, and dispensed medical advice while identifying herself as a PA. She would have one of the two PAs write a prescription if she believed a patient needed medication.	
SHIM, Inbo, MD (201100005) Salisbury, NC	8/28/2025	The Board is concerned that MD's care of a 71-year-old male with a complex medical history may have failed to conform to the standard of care. Patient presented to the emergency department for a perianal injury after reporting a fall in the bathroom. MD evaluated Patient's wound and documented a superficial laceration of the gluteal cleft, but an intact anal canal and no muscle injury observed. No imaging was ordered due to MD's belief that the injury was superficial. Patient was discharged. During the 24 hours following discharge, Patient became unresponsive and was urgently transferred to another hospital where he was intubated for instability and CT imaging showed an extraperitoneal bladder injury and rectal wall thickening. Patient was found to be septic and underwent emergency surgical intervention for bladder rupture and rectal	Public Letter of Concern

		injury. Patient subsequently passed away approximately ten weeks later due to complications. The Board concluded that MD's evaluation and management of Patient did not reflect adequate consideration of potential occult injury in a high-risk presentation. MD failed to properly document the full extent of the mechanism of injury as reported by two separate nurses and Patient's wife. MD failed to obtain diagnostic imaging to rule out deeper tissue or rectal injury despite the high-risk mechanism and patient medical history. Lastly, MD pursued conservative management without sufficient exclusion of occult rectal or bladder injury.	
MISCELLANEOUS ACTIONS			
MADANICK, Ryan David, MD (200601696) Morrisville, NC	7/31/2025	In March 2019, a Board Consent Order limited MD's license to the practice of administrative medicine. MD was ordered not to practice clinical medicine unless permitted to do so by the Board. In addition, MD was ordered to maintain a contract with NCPHP. MD requested relief from the condition that requires maintenance of a contract with NCPHP. The Board recognizes that MD has complied in all respects with this condition of the 2019 Consent Order.	Partial Relief of Consent Order Obligations

CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			