NORTH CAROLINA MEDICAL BOARD

Adverse Actions Report November 2023 – December 2023

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			
SALEH, Omar Mohammed, MD (202002501) Fort Myers, FL	11/09/2023	MD was convicted of felony Conspiracy to commit Health Care Fraud.	Revocation of NC medical license
SUSPENSIONS			
BREITBART, Eric Adam, MD (201500422) Fayetteville, NC	11/ 02/2023	From January 2019 to October 2022, MD prescribed controlled substances to persons who included friends, someone with whom he was romantically involved, and an employee. In all cases MD did not perform an examination prior to prescribing these medications and did not maintain proper medical record documentation. MD self-reported inappropriate prescribing to the Board and placed his license on inactive status.	Indefinite Suspension
MEHTA, Hemal Vinod, MD (200301497) Brentwood, TN	12/15/2023	MD voluntarily surrendered his DEA registration and has not practiced pain management or prescribed controlled substances since 2020. In July 2023, MD and the Tennessee Board of	Indefinite suspension stayed with conditions; MD is required to obtain Board permission before applying to reinstate DEA registration

		Medical Examiners entered into a consent agreement whereby his Tennessee medical license was placed on probation, he was assessed a civil penalty, and required additional Continuing Medical Education, among other conditions.	
LIMITATIONS/CONDITIONS			
STACKHOUSE, Danielle Andrea, MD (200801632)	11/06 /2023	In July 2022, MD was summarily suspended from all clinical privileges pending an investigation due to concerns related to alcohol impairment while on duty. MD immediately enrolled in an impaired provider program, the Substance Use Disorder Clinical Care (SUDCC), and began weekly sessions for sobriety. She submitted to a treatment center in Texas for group and individual therapy. MD successfully completed the program and continues in the SUDCC program. Her privileges were reinstated in November 2022. MD signed a five-year monitoring contract with the North Carolina Professionals Health Program in April 2023.	Suspension; Stayed with conditions
REPRIMANDS			
BEAMER, Mark Edward, MD (009400718) Belhaven, NC	12/07/2023	In December 2022, the Board received information that MD engaged in a romantic	Reprimand; MD shall complete the Professional /Problem-Based Ethics course

		relationship with one of his patients. A review of the patient's medical records revealed the existence of a physician-patient relationship beginning in 2013 and ending in 2021. Throughout the romantic relationship, MD prescribed both controlled and non-controlled substances to the patient. He only prepared documentation for one of the controlled substances prescribed.	and CME
FULLER, Lance Robert, MD (200701083) Raleigh, NC	11/29/2023	In February 2023, MD unknowingly became involved in a financial scheme with a woman he met on an internet dating app. She asked MD to act as her power of attorney to help her recover an inheritance. The woman requested that MD open multiple bank accounts and send her the access information. The woman then conspired with another person, purporting to be a "banker," and this "banker" then used MD to deposit fraudulent checks in the bank accounts he opened. MD has fully cooperated with the investigation of these fraudulent transactions.	Reprimand
MACKAY, Daniel Alexander, MD (202202084) Dallas, TX	11/09/2023	MD was reprimanded by the Texas Medical Board for improper supervision of two advanced practice providers, substandard	Reprimand

		care, non-therapeutic prescribing, and improper withholding of medical records. MD has complied with the terms and conditions of his Texas Board Order, which was terminated in September 2023.	
MERKLE, Peter Frank, MD (009300236) Pompano Beach, FL	12/6/2023	While Patient A, a 19-year-old female, was anesthetized during operation for a broken arm and clavicle, MD engaged with a surgical technician in inappropriate banter as to whether Patient A's breasts were natural or implants. MD adjusted the blanket that covered the bottom quarter of Patient A's right breast, exposing the juncture of the chest wall and her right breast before commenting that he saw no surgical scars, so her breasts were natural. In addition, MD operated on Patient B's legs following a motor vehicle collision. MD used "Talon Distal Fix" nails for the fixation of Patient B's comminuted fractures. A Board expert reviewer opined that this hardware was contraindicated for the type of fractures sustained by Patient B. MD denies that his care fell below acceptable standards of care. However, MD admits	Reprimand; Public Letter of Concern; MD shall complete the Professional/Problem Based Ethics Course (ProBE) and continuing medical education in surgical hardware selection

		that the Board's expert opinion, if proven, would provide grounds for the Board to conclude that the care departed from acceptable standards.	
DENIALS OF LICENSE/APPROVAL			
NONE			
SURRENDERS			
NONE			
PUBLIC LETTERS OF CONCERN			
BARBER, Matthew Don, MD (009800461) Durham, NC	12/14/2023	The Board is concerned that MD's care of a patient may have failed to conform to accepted medical standards. MD was the attending surgeon when a patient underwent a sacrospinous ligament suspension and other procedures. Three sutures were placed on the right sacrospinous ligament. Postoperatively, the Patient complained of right buttock pain with radiation down the back of her legs, tingling and numbness on the plantar aspect of the right foot, and foot drop. Approximately one hour after surgery, MD removed one sacrospinous ligament suture because palpation of that suture reproduced the pain. Patient experienced	Public Letter of Concern

		relief of radiating pain down her right leg; however, she continued to have numbness and tingling in her right foot and foot drop. The remaining two sutures were removed two days after the initial surgery. The standard of practice would have been to remove all three sutures immediately in the post-operative setting when right foot drop was identified.	
BECKENSTEIN, Charles Robert, MD (201700342) Tampa, FL	12/11/2023	The Board is concerned that MD's postoperative care of a patient may have failed to conform accepted standards. MD was the attending anesthesiologist during back surgery on a 55-year-old male with a history of obesity and obstructive sleep apnea (OSA) requiring a continuous positive airway pressure (CPAP) machine. Upon arriving at the post-anesthesia care unit (PACU), the patient remained very sleepy. Over the course of almost an hour, the patient became less responsive. The PACU nurse alerted MD of the	Public Letter of Concern

		patient's state and requested an assessment. An oral airway was in place as well as a non-rebreathing mask. MD ordered a beta blocker to treat the patient's blood pressure and heart rate, as well as noninvasive ventilation. The results of an arterial blood gas (ABG) test took close to an hour to come back, during which time the patient's condition continued to deteriorate. Once the ABG test results came back, the patient was emergently intubated. However, he went into cardiac arrest during which he suffered an anoxic brain injury. Pursuant to the family's wishes, the patient was placed on comfort care and subsequently died. The Board's independent reviewing expert criticized MD's failure to follow-up on the patient in either the operating room or the PACU during the time he was emerging from anesthesia. MD should have followed-up on the delayed ABG test results, as the patient was in obvious acute respiratory	

		failure. While MD's support staff caused numerous delays in the care of the patient, the responsibility is ultimately on the anesthesiologist.	
BELAYEV, Andrey, MD (201601370) Raleigh, NC	12/11/2023	The Board is concerned about MD's care of a patient, who presented with what turned out to be a previously-ruptured arteriovenous malformation (AVM). The care was reviewed by an independent medical expert. While treating the patient, MD performed a procedure using an infusion microcatheter and a separate embolization agent. During the embolization procedure, the microcatheter tube ruptured and inadvertently delivered copolymer into the normal vasculature and proximal to the target AVM. The independent reviewer felt that MD should have considered using a different microcatheter and embolic material combination that were more compatible. The Board also notes that MD's own independent medical expert who practices and teaches in this area of medicine opined that the	Public Letter of Concern

		complication was in no way related to the choice of microcatheter and embolic material.	
CADET, Edwin Richard (201300934) Raleigh, NC	12/14/2023	In February 2022, a patient presented to MD with a mass near her elbow, and complaints of tingling and numbness in her left ring and pinky fingers. MD ordered an MRI with and without contrast to gather data. The interpreting musculoskeletal radiologist did not include a potential malignancy in his differential diagnosis, and MD similarly saw no indication that the mass was malignant. Based on the radiologist's conclusions and MD's evaluation of the patient's history, physical examination, and imaging, MD agreed with the radiologist that the patient likely had a fluid-filled lump under the skin (ganglion cyst). In June, MD performed surgery to remove the mass and performed a cubital release to treat the symptoms of cubital tunnel syndrome. The pathology report of the mass revealed it was cancerous. The patient was referred to an oncologist, and in July 2022, underwent a second surgery for additional resection of	Public Letter of Concern

		the tumor to establish normal tissue borders followed by radiation therapy. The Board's reviewing expert believes that MD's care of the patient may have fallen below the standard of care in NC. Specifically, the reviewing expert noted that a ganglion cyst at the elbow is extremely rare, and that the surgical treatment MD performed would have been typical for treatment of a wrist ganglion. Further, the reviewing expert criticized MD's failure to follow the principles of tumor surgery.	
DUAN-PORTER, Wei, MD (201301203) Minneapolis, MN	12/28/2023	The Board is concerned that MD failed to recognize potential indicators of a gastrointestinal (GI) bleed in a patient, including laboratory findings on admission indicating an abnormally low hemoglobin along with a low platelet count. The patient's lab work also indicated an abnormally high blood urea nitrogen level. These lab results were strongly indicative of a GI bleed. Although there is no documentation of consideration of a GI consult, MD states that she discussed a GI consult with the patient, but he declined. MD's	Public Letter of Concern

		plan was to treat the patient's ulcer. MD did not obtain further workup or serial hemoglobin, or platelet counts during the hospitalization until the patient experienced a syncopal episode five days after admission. The patient became unresponsive, requiring intubation, resuscitation for hypotension, and transfer to the intensive care unit for further management. The patient then coded, was placed on comfort care, and died shortly after. The presumptive diagnosis as cause of death was a massive GI bleed.	
ELFEKY, Hamed Abdelfatah, MD (202203208) Orlando, FL	11/08/2023	The Board is concerned that MD entered a Consent Order with the Virginia Board and was reprimanded in July 2023. The reprimand was based on concerns related to two patients that MD treated as a pathologist in 2019. In one case MD's report indicated a finding that no cancer was present in Patient A's breast tissue. A re-evaluation ordered by the treating physician confirmed the presence of cancer. Similarly, while in surgery, Patient B's treating physician sent a sample for analysis by MD requesting the	Public Letter of Concern

		results before the surgery was concluded. MD spoke with Patient B's treating physician on this date and told her that the lymph node was negative for cancer. MD did not mention at that time that he had not completely examined all of the sections. Once he finished his review of all the sections, he found carcinoma in Patient B's lymph node section and contacted Patient B's treating physician, who had to reopen a closed incision site and begin an axillary node dissection procedure.	
GOODWIN, Anika Saron (201400564) Boca Raton, FL	12/05/2023	The Board is concerned that MD failed to properly identify and excise the correct lesion resulting in a patient having to undergo an additional surgery. In November 2016, a 93-year-old male, was referred to MD by a dermatologist for surgical management of a lesion on the right lower ear due to concerns of basal cell carcinoma. In January 2017, MD excised a lesion on Patient's right upper ear instead. In February 2017, Patient underwent another surgery by another provider in which the correct lesion was removed. The pathology of the lesion confirmed	Public Letter of Concern

		basal cell carcinoma. The Board notes that the Department of Veterans Affairs Review Panel acknowledged that systemic deficiencies related to communication between the Dermatology and Plastic Surgery Services in the referral of this patient contributed to this error.	
KILLMER, Scott Matthew, MD (201700889) Daniels, WV	12/28/2023	MD performed an unremarkable laparoscopic appendectomy on a patient who came to the emergency department with right lower abdominal pain and 102.8-degree fever. A kidney, ureter, and bladder x-ray showed no evidence of acute intra-abdominal infection or free air. The pathology report of the appendix demonstrated no active or acute inflammation. The patient went into cardiac arrest, was resuscitated and taken back to surgery. The exploratory surgery revealed restricted blood flow to the patient's right colon (ischemic colitis), abscess, and fecal contamination. The right portion of the patient's colon was removed and drains were placed. However, the patient's condition continued to deteriorate, and he died.	Public Letter of Concern

		The Board's reviewing expert noted that the patient's presenting history and physical exam were likely more consistent with ischemic colitis. Further, if MD had performed a CT scan earlier postoperatively, it would likely have revealed the ischemic colitis and fecal contamination with abscess formation, thereby allowing for earlier intervention. The Board is concerned that MD’s care may have failed to conform to accepted standards.	
NETH, Zaroh Lu, MD (202303438) Sunnyvale, CA	12/13/2023	The Board is concerned that MD was reprimanded by the Virginia Board in September 2020 because of poor prescribing of controlled substances to a patient who was undergoing buprenorphine treatment for opioid use disorder. Despite being advised by the patient’s addiction treatment provider to taper clonazepam, MD failed to do so. Rather, MD, increased the dosage in direct contradiction to the advice of the addiction treatment provider. In addition, MD prescribed opioid pain medication despite her awareness of the patient’s recent	License issued with Public Letter of Concern

		hospitalizations for opioid use disorder, overdose, anxiety, benzodiazepine use disorder, alcohol use disorder, and detoxification from benzodiazepines. Finally, MD prescribed buprenorphine for the patient even though MD did not hold a waiver from the Drug Enforcement Agency, as required at the time of treatment. As a result of the substandard prescribing practices described above, MD entered into a Consent Order with the Virginia Board. This required her to complete fifteen hours of continuing medical education in proper prescribing. The Board acknowledges that MD has satisfied the terms of the Virigina Board's Consent Order.	
PANDYA, Avni Bansi, MD (201501598) Addison, TX	12/14/2023	The Board is concerned about MD's care of a 43-year-old, morbidly obese male who called MD at a telehealth service with complaints of stabbing pain in his upper body. During the call, MD took a brief history of the pain, including onset, location, pain quality, aggravating factors, and alleviating factors. MD inquired as to whether the patient was having symptoms of trouble	Public Letter of Concern

		breathing, cough, cold, congestion, or coughing up blood. MD did not verify any past medical history, family history, or tobacco or drug use and did not ask any specific cardiac-related questions. The patient reported that the stabbing pain was from the sternum to the top of his shoulders and was worse when he lay on his side and/or took a deep breath, coughed, or sneezed. MD diagnosed the patient with costochondritis and prescribed a steroid dose pack and ibuprofen. MD advised the patient that if his symptoms got acutely worse, to go to an emergency room or urgent care and encouraged him to follow-up with an urgent care the next day to rule out other causes. The patient did not seek follow up care and subsequently died two days later of a heart attack due to a blood clot inside a blood vessel of the heart. The Board's independent reviewing expert believed MD should have recognized several red flags related to the patient's chest pain and directed him to have an in-person evaluation. Although MD directed the patient to	

		seek medical attention if he “acutely” worsened, MD failed to explain what that meant or to expressly mention that his symptoms could be those of a heart attack.	
SICA, Roger Sebastian, DO (201001567) Supply, NC	11/29/2023	Patient was seen by a PA at DO's practice in May 2021 for evaluation of a scaling lesion on her right lateral cheek. Following a biopsy, the patient was diagnosed with an invasive well-differentiated squamous cell carcinoma. The patient did not schedule the Moh’s procedure until October of 2021. DO performed the procedure after having the patient confirm the treatment site. Postoperative photographs revealed the area where DO operated was several centimeters away from the location of the patient’s biopsy from almost five months prior. MD proceeded with surgery at that site, based upon his observations of the patient’s cheek that day, his review of two prior photographs taken in his office, and the patient’s confirmation of the site. After the procedure was performed and the abnormality that MD believed to be the squamous cell carcinoma was removed, a	Public Letter of Concern

		hypopigmented scar developed at the site of the prior biopsy. This should have been identifiable before surgery. When the patient returned to see DO six days after the Moh's procedure, she expressed concerns that the site of the surgery was wrong. The Board notes that DO has amended his protocols to better prevent wrong site surgeries.	
SCHMITZ, David Brian, DO (201902628) Bolivia, NC	11/14/2023	In December 2021, DO referred a 42-year-old-male to an arthritis clinic for evaluation of joint pain. The laboratory workup revealed a low hemoglobin of 8.7. Results were provided to DO's office with recommendation to start oral iron therapy. DO was on vacation when the laboratory results arrived at his office. A medical assistant mistakenly placed results in an incorrect place. As a result, DO did not review them until January 2022. DO recommended continuing with oral iron therapy and follow up in 3 to 4 weeks. The patient did not follow up as requested and thereafter switched to a different primary care physician who recommended an urgent endoscopy due to the	Public Letter of Concern; DO shall complete eight hours continuing medical education

		low hemoglobin level. A subsequent colonoscopy identified colon cancer that had metastasized to the liver and peritoneum. The Board believes that the lack of an in-person evaluation limited DO's ability to discuss symptoms and allow for a proficient physical exam. The Board's independent medical expert thought that DO should have considered working the patient up in January 2021 and ordered a colonoscopy, repeat laboratory work and possible liver ultrasound.	
MISCELLANEOUS ACTIONS			
EMERY, Henry Ronald, Jr., MD (200300594) Waxhaw, NC	12/28/2023	In September 2023, a federal grand jury for the United States District Court for the Western District of NC indicted MD for one count of Conspiracy to Distribute Controlled Substances Outside the Bounds of Professional Medical Practice. The grand jury also indicted MD for ten counts of Distributing Controlled Substances Outside the Bounds of Professional Medical Practice	Interim Non-Practice Agreement; MD will not practice medicine until given permission by the Board President
CONSENT ORDERS AMENDED			
MACKIE, Crystal Monique, MD **(**202001935) Charlotte, NC	12/12 /2023	In January 2022, MD entered into a Consent Order with the Board in which her NC medical license was indefinitely	Amended Consent Order; MD is relieved of Paragraphs 1a and 1b of her August 2022 Consent Order. All

		suspended. In August 2022, MD's NC license was reinstated with terms and conditions. In September 2023, MD requested relief from the terms and conditions of the August 2022 Consent Order, specifically Paragraphs 1a and 1b, which required practice site approval and prohibited the prescribing of Schedule II/IIN (2/2N) and III/IIIN (3/3N) controlled substances.	other terms and conditions of the August 2022 Consent Order remain in effect.
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			