Adverse Actions Report – August 2020

The digital edition of the *Forum* typically presents a two-month report of recent adverse actions. As this issue of the newsletter has been distributed earlier than usual, this report presents only the month of August 2020. 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			
NONE			
SUSPENSIONS			
DIMKPA, Okechukwu, MD (200501338)	08/11/2020	In November 2019, the Board received information from the Drug Enforcement Administration that MD had been charged in the U.S. Middle District of North Carolina with the Unlawful Distribution of Prescription Opioids. On August 22, 2019, after plea negotiations between MD and the U.S. Attorney's Office, MD entered a guilty plea to the charges. In December 2019, MD was sentenced to forty-six months imprisonment, to be followed by three years of supervised probation and was fined $50,000. MD surrendered his North Carolina medical license on January 21, 2020.	Indefinite Suspension
LU, Kang, MD (201200203) Crestview, FL	08/24/2020	Action based on the action of another state medical board. The Massachusetts Board of Registration in Medicine issued a February 2019 order related to	Indefinite Suspension

		allegations that MD was convicted of a crime, that he did not accurately report information on some of his MA Board medical license renewal applications and that he violated the laws of Massachusetts regarding the practice of medicine. After a series of additional procedural activities related to the February 2019 order, the MA Board revoked MD's Massachusetts medical license on March 5, 2020.	
ONUSCHECK, Douglas Samuel, MD (201902561) Holly Springs, NC	08/11/2020	In February 2020, MD appeared at the hospital where he worked in an intoxicated state. He was not scheduled to work that day. While on site, MD encountered a female hospital employee and inappropriately touched her as she was getting out of an elevator in which they both had ridden. The hospital investigated this incident, which resulted in MD resigning from his position at the hospital. On March 18, 2020, MD voluntarily inactivated his license to practice medicine. MD has a history of anxiety and depression, has been diagnosed with alcohol use disorder and has undergone	Indefinite Suspension

		residential treatment for this disorder. Currently, MD is a participant in the NCPHP.	
RIFENBARK, Jr., Neil Petree, MD (201702180) Chapel Hill, NC	08/07/2020	MD has suffered from substance use disorder. On several occasions in early 2020, he obtained fentanyl for his personal use from medication intended to be administered to patients. Hospital personnel saw this and confronted him, leading to his resignation. MD inactivated his medical license on March 2, 2020. He joined NCPHP and has completed residential treatment.	Indefinite Suspension
LIMITATIONS/CONDITIONS			
HAMBIDGE, Bertha Bowen, MD (000031994) Greenville, NC	08/03/2020	MD suffers from alcohol use disorder and has not actively practiced medicine since 2002 when she surrendered her license, which was later revoked in 2005. In 2015, MD actively reengaged with NCPHP with the intent to apply for reinstatement of her North Carolina medical license. She is currently under a monitoring agreement with NCPHP, which advocates for her safety to practice medicine.	License reinstated via consent order; MD to comply with all terms and conditions of her NCPHP agreement.
REPRIMANDS			
ARIS, Robert Michael, MD (009300412) Chapel Hill, NC	08/13/2020	On November 2019, the Board received a Notice of Change in Staff Privileges for MD effective October 16, 2019, in which MD's	Reprimand

		privileges were summarily suspended. The summary suspension of privileges was based on observations by staff that MD had reported to work while possibly impaired. The Division Chief ordered a blood alcohol examination and it was determined that MD had a blood alcohol content of .093. MD has successfully completed a residential treatment program and signed a 5-year monitoring agreement with NCPHP. He is compliant with his monitoring agreement and NCPHP advocates for his safety to the practice of medicine.	
MISHRA, Shashank, MD (200301021) Charlotte, NC	08/25/2020	Quality of care. The Board is concerned about the treatment that MD provided to a patient who presented to the emergency department with what the MD felt was diabetic ketoacidosis ("DKA") and that he treated as such. MD determined that the patient should be transferred to a higher-level care facility and, while in the process of making these arrangements, the patient began to have a seizure, coded and required resuscitation and intubation prior to transfer. It was later determined at the	Reprimand

		receiving hospital that the patient had hyperglycemic hyperosmolar syndrome ("HHS") and not DKA. The Board sent the patient medical records to an independent medical expert to evaluate MD's care. The medical expert acknowledged that the initial diagnoses in the patient could have been DKA or HHS. However, the Board expert felt that MD should have considered a diagnosis of and treatment for HHS as laboratory testing results became available that indicated the possibility of HHS.	
SULS, Howard Lee, MD (000040003) Mooresville, NC	08/21/2020	Action based on the action of another state medical board. In April 2019, MD entered into a Settlement Agreement with the New Hampshire Board of Medicine which included a reprimand and required at least six hours of continuing medical education in the areas of ethics and boundaries and/or working effectively and professionally on a medical team. MD was assessed a fine of $1,000.00. The NH Board based this action on information received that MD's employment had been terminated after an	License reinstated with a reprimand

		investigation revealed misconduct in the form of inappropriate and disruptive comments and actions towards co-workers. In November 2019, MD applied for reinstatement of his NC medical license.	
DENIALS OF LICENSE/APPROVAL			
TRAN, Trung Trieu, DO Greensboro, NC	08/27/2020	DO applied for a North Carolina medical license in August of 2019. In his license application, DO failed to respond truthfully to whether he was aware of any complaint or investigation by any professional licensing board or agency; military service, medical or professional organization/association; local, state, federal, or other governmental agency. A background check revealed charges of Failure to Act to Prevent Bodily Harm to a Child and Child Neglect Resulting in Death, filed on September 20, 2017, and the plea of no contest and conviction of Resisting or Obstructing an Officer that DO entered on July 12, 2019. Additionally, the North Carolina Board received information in April 2020 from the Wisconsin Department of Safety	Denial of licensure

		and Professional Services Division of Legal Services and Compliance that DO is being investigated regarding providing controlled substances to a family member and requested medical records.	
SURRENDERS			
NONE			.
PUBLIC LETTERS OF CONCERN			
BELLE, Beverly Ann Vanessa, MD (009800468) Huntersville, NC	08/04/2020	The Board is concerned about care that MD administered to a patient and her child. In March 2016, a patient presented to a hospital and was diagnosed with preterm labor at 31 weeks, 6 days gestational age. MD provided care to slow contractions, but labor progressed. MD decided to perform an operative delivery using a Kiwi vacuum device and the baby was delivered shortly thereafter with Apgar scores of 7 and 9. Approximately a week later, the baby was diagnosed with having bilateral intraventricular hemorrhage and intraparenchymal hemorrhage. An OB/GYN expert who reviewed the care provided felt that a more prudent approach would have been to consider having the laboring mother continue to push in the usual fashion, the use of forceps, an	Public Letter of Concern

		episiotomy or possibly a cesarean section.	
DICKERSON, (IV), Edward Ernest, MD (009400044) Fayetteville, NC	08/21/2020	The Board is concerned with the treatment that MD provided for laser tattoo removal in which MD utilized Lumenis Lightsheer Duet ("LLD") laser. MD's patients experienced some level of hypertrophic scarring on the old tattoo site after LLD treatment. The Board feels that the benefits of LLD technology (less expensive and with fewer treatments than Q-switch laser technology), do not outweigh the increased risk of possible scarring when used to remove permanent tattoo ink. The Board is also concerned MD's informed consent forms used back in 2013-2014 may not have adequately described the risk of scarring.	Public Letter of Concern
HENNINGSGAARD, Bradley Lynn, PA-C (001006919) Durham, NC	08/31/2020	Quality of care. The Board is concerned about the treatment that PA administered to a patient who presented to the emergency department with complaints of lower abdominal pain and cramping and a stated suspicion that she was pregnant. PA evaluated the patient and diagnosed her with abdominal and round ligament pain and discharged her with a	Public Letter of Concern

		pain prescription and instructions to follow-up with her obstetrician. Two days later, the patient presented to a different emergency department with the same symptoms, and vaginal bleeding and an ultrasound revealed a ruptured right tubal ectopic pregnancy. The patient required emergency surgery in which her right fallopian tube was removed. The Board had PA's treatment of the patient reviewed by an independent medical expert who opined that based upon the medical records, an ultrasound would have been appropriate but was not ordered and that there was not a documented recheck of the patient's vital signs prior to discharge. Correspondingly, the reviewing expert expressed concern about PA's documentation, noting that PA incorrectly documented the patient's obstetric history.	
MIAH, Rohima Davi, MD (009701494) Durham, NC	08/11/2020	The Board is concerned about the treatment that MD provided to a patient with depression and a family history of depression and bipolar disorder. After prescribing several different medications to treat patient's	Public Letter of Concern

		symptoms, MD prescribed Tegretol® and reviewed the common risks and side effects of Tegretol® with the patient. However, contrary to a "black box" warning, MD did not perform the recommended genetic testing prior to prescribing Tegretol®. In March 2016, the patient presented to a burn clinic with severe exfoliative rash and was diagnosed with a rare and serious disorder of the skin and mucous membranes (Stevens-Johnson syndrome) as a result of an adverse reaction to Tegretol®.	
O'CONNOR, Brian Joseph, PA-C (000102119) Gastonia, NC	08/28/2020	The Board received a complaint that PA had called in prescriptions to a pharmacy for Plaquenil® for himself and members of his immediate family. It was noted during the investigation that no one in the PA's family had been diagnosed with COVID-19 and his action was purely to stockpile Plaquenil®. PA admitted that he did not prepare any documentation or medical charting for the prescriptions in violation of 21 NCAC 32S .0212(6), which requires a physician assistant to document prescriptions in writing on the patient's record, including the medication	Public Letter of Concern

		name and dosage, amount prescribed, directions for use, and number of refills. Additionally, PA's action was in derogation of the Board's Position Statements entitled, "Writing of Prescriptions" and "Self-Treatment and Treatment of Family Members."	
SCHUETT, Andrew Marvin, MD (009501406) Whiteville, NC	08/25/2020	The Board is concerned that MD performed a wrong site surgery. In March 2016, MD intended to perform left sided arthroscopic knee surgery on a patient and, prior to the surgery, MD identified and marked the patient's left knee for the surgical procedure. Despite this, the patient's right knee was prepped and draped by hospital nursing staff. MD proceeded with the surgical procedure and realized that the incorrect knee had been prepped and promptly informed the patient. The Board notes that the misidentification and prepping of the wrong knee was not an error by MD but by another member of the operative team. As the surgeon, MD takes responsibility for his role in the procedure.	Public Letter of Concern
MISCELLANEOUS ACTIONS			
NONE			
CONSENT ORDERS AMENDED			

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