

Adverse Actions Report January-February 2025

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	Cause of action	Board action
	action		
ANNULMENTS			
NONE			
SUMMARY SUSPENSIONS			
NONE			
REVOCATIONS			
CIRELLI, Stephen Rocco, MD (200201566) Johnson City, TN	2/3/2025	MD's felony conviction for Conspiracy to Distribute Controlled Substances; Conspiracy to Falsify Medical Records; Conspiracy to Commit Money Laundering	Revocation of NC medical license
DALBY, Richard Hunter, LP (100000471) Durham, NC	2/10/2025	The hospital where LP practiced received a report that he was falling asleep during a case and went into the locker room to drink liquid from a container in his locker, followed by rinsing with mouthwash. LP was given a drug and alcohol screen, the results of which were positive for alcohol. LP was terminated from his position at the hospital. In March 2015, LP also received a Public Letter of Concern from the Committee and the Board after he was found to have consumed alcohol while on call for the hospital where he worked. The Board ordered LP to NCPHP for a comprehensive examination. To date, he has not complied with the Board's order. LP has not practiced perfusion since September 2024.	Revocation of perfusionist license



SUSPENSIONS			
GROSSMAN, Peter Daniel, MD (201302114) Atlanta, GA	1/16/2025	MD worked at a women's health clinic where he primarily performed abortions. In 2023MD made inappropriate and sexually charged comments toward two female coworkers. MD claims that his intentions were misinterpreted. As a result of this behavior, MD completed CME courses on professional boundaries and professional sexual misconduct. Colleagues also observed MD having aunusually high surgical complication rate, with some patients having to be transferred to the hospital for emergency care. The Board reviewed medical records of six patients who developed complications following surgeries performed by MD. In October 2023the Board ordered MD to a comprehensive examination to ascertain MD's fitness to practice medicine. During the examination in January 2024, MD demonstrated cognitive impairment ranging from mild to severe in multiple areas.	Indefinite Suspension
UWENSUYI-EDOSOMWAN, Fidelis Iguodala, MD (009600362) Waxhaw, NC	2/21/2025	In 2015, MD was charged with nineteen counts of misdemeanor sexual battery offenses and eighteen counts of felony sexual offenses resulting from patient allegations. MD entered into an Interim Non-Practice Agreement with the Board. In 2023 MD entered an Alford Plea to four counts of misdemeanor	Indefinite suspension of medical license



		assault on a female, and the	
		remaining sexual offense	
		charges were dismissed. MD	
		was ordered to pay a fine	
		and sentenced to eighteen	
		months of supervised	
		probation. MD submitted to	
		examination by NCPHP The	
		Board ordered MD to	
		undergo a professional	
		competency evaluation in	
		2024. The evaluation found	
		that MD demonstrated	
		significant knowledge gaps	
		in many topic areas and	
		inadequate overall clinical	
		judgement and reasoning. In	
		some cases, MD's	
		recommended care could	
		have placed patients in	
		danger. An evaluation at a	
		PROBE: Ethics & Boundaries	
		Course concluded that MD	
		has not demonstrated an	
		ability to think ethically	
		about the concern that	
		prompted his referral to	
		PROBE.	
LIMITATIONS/CONDITIONS			
DEMARCHI, William Michael, MD	1/31/2025	As Medical Director of a	Consent Order with
(202201446) Raleigh, NC		skilled nursing facility, MD	terms and conditions
		pre-signed blank	
		prescriptions for controlled	
		substances and other	
		medications for the facility's	
		Director of Nursing to use in	
		his absence. MD issued	
		hand-written prescriptions	
		in violation of the STOP Act.	
		The Board found that MD	
		prescribed a Schedule IV controlled substance to an	
		CONTROLLO CLINETANCO TO AN	
		immediate family member.	
		immediate family member. The Board also found that	
		immediate family member. The Board also found that Some of the APPs	
		immediate family member. The Board also found that Some of the APPs supervised by MD did not	
		immediate family member. The Board also found that Some of the APPs	



DEDDIMANOS		Additionally, MD serves as the medical doctor on staff at an aesthetic medical spa owned and operated by his family member who is not a licensee of the Board. As a rule, a business where medicine is practiced must be owned by a licensee of the Board. Furthermore, the Board received two complaints alleging MD failed to sign death certificates for two patients in a timely manner, despite repeated requests.	
REPRIMANDS			
BOBB, Michael Dean, Jr. DO (201200926) Zanesville, OH	1/13/2025	In May 2024, the Ohio Medical Board indefinitely suspended DO's license, issued a fine and required him to complete continuing medical education on Professionalism and Boundaries. From 2020 through 2022, DO engaged in a sexual relationship with a Patient who was also employed as a nurse at the primary care practice where he worked. DO relocated to NC to practice as a hospitalist in a locum tenens position in November 2022. When the NC hospital where he worked learned about the Ohio Board's Consent Order, it did not renew DO's employment contract.	Reprimand
DURBIN, Courtney Lynne, PA-C (001006588) Charlotte, NC	2/27/2025	The Board is concerned that PA's diagnosis, documentation and treatment of two patients she treated via telemedicine failed to comply with the standard of care. PA ordered only one laboratory	Reprimand; PA shall complete CME on testosterone replacement therapy and telemedicine documentation



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		test for both Patients A and B, failed to perform follow-up laboratory testing after initiating their testosterone treatments and increased both patients' testosterone dosage without any additional testing or monitoring. Patient A experienced a medication induced overdose due to high levels of testosterone. Patient B's testosterone levels were later found to be	
		over twice the targeted	
		range for testosterone	
		treatment.	
EPSTEIN, Micheline Lataliza, MD (201901497) Charlotte, NC	2/13/2025	In 2024, MD was censured, reprimanded and required by the New York Medical Board to complete CME based on MD committing professional misconduct. MD revealed personally identifiable facts, data, or information obtained in a professional capacity without the prior consent of the individual and for no medically justifiable reason.	Reprimand
FRERICHS, R. Everett, MD (000033241) Wilmington, NC	2/26/2025	MD documented that he examined Baby A within hospital policy at twenty-four hours of birth. However, a contradictory note by MD indicates that MD had only spoken to the parents by phone and planned to round on Baby A the following Monday. MD documented that he had examined Baby B at approximately twenty-nine hours after Baby B's birth, which is outside of the hospital's policy.	Reprimand; Conditions for reinstatement established
GINSBURG, Justin Davis, PA-C	1/2/2025	During renewal of his	Reprimand; PA shall



(001003343) Winston Calana NG		aharidan sadakant lisansa	consulate CNAF commen
(001003343) Winston-Salem, NC		physician assistant license,	complete CME courses
		PA disclosed that his	on professional ethics
		employment was	and medical record
		terminated for making false	documentation
		representations in	
		psychiatric patient records.	
		Three patients told their	
		physician that they were	
		never seen by PA although	
		their charts showed PA had	
		seen and treated each of	
		them. In one case, PA	
		decreased some of a	
		patient's medications and	
		discontinued other	
		medications. PA	
		acknowledged his actions	
		and cooperated with	
		identifying the relevant	
		patients to correct the	
		medical record. PA has	
		entered a two-year	
		monitoring contract with	
		NCPHP, and NCPHP supports	
		PA's safety to practice as a	
		physician assistant.	_
HOQUE, Mohammed Merajul, MD	2/12/2025	MD practiced vascular and	Reprimand
(201801169) Las Vegas, NV		interventional radiology in	
		Nevada. In 2020, a female	
		patient presented to MD for	
		a radiology guided biopsy of	
		a right renal mass. MD	
		performed a time out to	
		ensure the surgical team	
		was aware of the correct	
		surgery and the correct	
		location on her body. The	
		right renal biopsy was	
		cancelled, and MD	
		performed a biopsy on the	
		left renal mass. At a follow-	
		up with her urologist,	
		Patient was informed that	
		MD biopsied her left kidney	
		instead of the right kidney.	
		In September 2024, MD self-	
		In September 2024, MD self-	
		In September 2024, MD self- reported to the Board that he entered into a	



		Settlement Agreement with	
		the Nevada Board. The basis	
		being MD's malpractice and	
		failure to maintain adequate	
		records. MD was	
		reprimanded and ordered to	
		fulfill certain requirements.	
		The Nevada Board has	
		confirmed MD's completion	
		of all requirements of the	
		Agreement and that his	
		compliance file would be	
		closed.	
KENT, Collin Lyle, MD (202201555)	1/22/2025	MD reported on his NC	Reprimand; Two years
Durham, NC	1/22/2023	license renewal that he was	probation
Durnam, NC		arrested and charged with	ρισυατίστι
		Misdemeanor Sexual Abuse	
		while attending a concert.	
		The complainant alleged	
		that MD, while intoxicated,	
		touched her clothed	
		buttocks without her	
		permission. After the	
		incident, MD self-reported for evaluation and	
		treatment. He was	
		diagnosed with Alcohol Use	
		Disorder, Mild, and began treatment. The Board issued	
		an Order for Examination	
		requiring MD to submit to a	
		comprehensive examination	
		at NCPHP. MD later signed	
		and agreed to comply with a	
		two-year monitoring	
		contract with the Virginia	
		Health Practitioners'	
		Monitoring Program,	
		Virginia being his state of	
		residence. In July 2024, MD	
		plead guilty to	
		Misdemeanor Sexual Abuse	
		and was sentenced to 12	
10000	2/42/222	months probation.	Dec. Sec. 1
LOPEZ, Kendra Lynne, PA-C	2/13/2025	A former employee of the	Reprimand
(001009762) Charlotte, NC		aesthetics clinic owned by	
		PA complained to the Board	
		that a prescription of	



compounded lidocaine cream was written with her name and personal information as the patient for whom it was prescribed. Complainant stated that she was not a patient and had not been aware that the prescription had been written. The Board's investigation found there	
name and personal information as the patient for whom it was prescribed. Complainant stated that she was not a patient and had not been aware that the prescription had been written. The Board's	
information as the patient for whom it was prescribed. Complainant stated that she was not a patient and had not been aware that the prescription had been written. The Board's	
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Complainant stated that she was not a patient and had not been aware that the prescription had been written. The Board's	
was not a patient and had not been aware that the prescription had been written. The Board's	
not been aware that the prescription had been written. The Board's	
prescription had been written. The Board's	
written. The Board's	
investigation found there	
were 26 prescription orders	
from PA for 100 grams each	
of the compounded	
lidocaine and benzocaine	
creams. A significant	
number of these	
prescriptions were written	
in the names of clinic	
employees or their friends	
and family, who were not	
patients. The compounding	
pharmacy also produced	
evidence of conversation	
and communication with PA	
or clinic staff verifying that	
the	
compounded creams were	
for specific patients and that	
the compounding pharmacy	
warned of their danger	
when not used properly.	
During her interview, PA	
admitted to writing	
prescriptions for employees	
to have the compounded	
cream on hand for patient	
procedures. The writing of	
procedures. The writing of prescriptions for	
compounded medications in	
the names of employees	
and others who are not	
patients potentially violates	
State and Federal	
regulations.	· (·
RIYAZ, Farhaad Rahman, MD 2/5/2025 MD practiced dermatology Reprimand; \$1,000	fine
(202003897) Northville, MI via telemedicine in multiple	
states. His medical licenses	



		1 4 4 4 4 4 4 4	
		were subject to discipline in	
		multiple states where MD	
		held licenses as a result of a	
		2021 felony conviction for	
		purchasing Amazon items	
		online and returning lesser	
		priced items in their place.	
		In 2023, MD's NC license	
		was suspended for six	
		months. In August 2024 he	
		was reprimanded by the	
		Arizona Medical Board for	
		failure to disclose that he	
		was under investigation	
		when he signed his	
		Interstate Medical Licensure	
		Compact application.	
		Although the Board acted	
		against MD's NC license	
		based on his felony	
		conviction, the finding of	
		the Arizona Board warrants	
		additional discipline from	
		this Board as well.	
RUSSO, Anthony Paul, Jr. DO	1/9/2025	During the Board's	Danasina anali DO alasil
Transfer and the state of the s	-, -, - o - o	During the board's	Reprimand; DO shaii
•	2,3,2023	_	Reprimand; DO shall complete CME in
(201901110) Davidson, NC	1,3,2023	investigation of a complaint,	complete CME in
•	1,3,2323	investigation of a complaint, a patient's medical records	· ·
•	1/3/2323	investigation of a complaint, a patient's medical records were reviewed by an	complete CME in workplace boundaries; anesthetic
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert	complete CME in workplace boundaries; anesthetic documentation; and
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the	complete CME in workplace boundaries; anesthetic documentation; and
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the placement of a dental	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the placement of a dental implant and failed to	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the placement of a dental implant and failed to properly document an	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the placement of a dental implant and failed to properly document an anesthetic record.	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the placement of a dental implant and failed to properly document an anesthetic record. Additionally, the Board	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the placement of a dental implant and failed to properly document an anesthetic record. Additionally, the Board received a complaint that	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the placement of a dental implant and failed to properly document an anesthetic record. Additionally, the Board received a complaint that DO spanked and groped a	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the placement of a dental implant and failed to properly document an anesthetic record. Additionally, the Board received a complaint that DO spanked and groped a member of the oral	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the placement of a dental implant and failed to properly document an anesthetic record. Additionally, the Board received a complaint that DO spanked and groped a member of the oral surgeon's staff. During the	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the placement of a dental implant and failed to properly document an anesthetic record. Additionally, the Board received a complaint that DO spanked and groped a member of the oral surgeon's staff. During the Board's investigation of this	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
•	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the placement of a dental implant and failed to properly document an anesthetic record. Additionally, the Board received a complaint that DO spanked and groped a member of the oral surgeon's staff. During the Board's investigation of this complaint, other employees	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients
· ·	2/3/2323	investigation of a complaint, a patient's medical records were reviewed by an independent medical expert who opined that DO's care of Patient was below the standard of care. DO failed to properly administer anesthesia to keep Patient unconscious throughout the placement of a dental implant and failed to properly document an anesthetic record. Additionally, the Board received a complaint that DO spanked and groped a member of the oral surgeon's staff. During the Board's investigation of this	complete CME in workplace boundaries; anesthetic documentation; and assessment of patients



		inappropriate comments	
		towards females by DO.	
WEIL, Andrew Campbell, MD (201300837) Greenville, NC	1/24/2025	MD began using nitrous oxide in March 2024 to cope with his anxiety. In April 2024, while at home, he inhaled half of a tank of nitrous oxide. While driving to work, he took two inhalations of nitrous oxide and was involved in a single vehicle wreck. MD was charged with Driving While Impaired and Huffing Toxic Chemicals. MD self-reported the DWI charge to the Board. He was ordered to NCPHP for examination. An independent medical evaluation of MD resulted in a recommendation for further treatment. He completed inpatient treatment, and the treatment center supported MD as being safe to practice medicine beginning on August 30, 2024. NCPHP also supported MD as safe to practice medicine. MD signed a five-year monitoring contract with	Reprimand
		NCPHP in August 2024.	
DENIALS OF LICENSE/APPROVAL			
WHITE, Anne Litton, MD (000029552) Bermuda Run, NC	1/21/2025	MD's license was indefinitely suspended In March 2022. MD has a disciplinary history with the Board dating back to Consent Orders in 2005. Subsequent Orders of discipline include a reprimand in 2009, probation in 2018, and fine in 2019. In 2020 the Indiana Medical Board ordered probation and a fine for failure to disclose the	Denial of licensure



SURRENDERS		pending NC Board action. In 2021 MD was convicted of misdemeanor False Statements in Applications for Insurance and paid a fine and restitution. Following a 2022 hearing MD's NC license was indefinitely suspended, and she was not allowed to apply for reinstatement for at least two years. In August 2024, MD's application for reinstatement was denied and MD was granted a hearing in December 2024 on the Board's denial of reinstatement.	
NONE			
PUBLIC LETTERS OF CONCERN			
ADAMS, James Wellington, MD (009801132) Leland, NC	2/26/2025	The Board is concerned that MD's care of a patient fell below the standard of care and had MD's care of a Patient reviewed by an independent medical expert. The reviewing expert found issues with MD's documentation and care of Patient. In MD's care of Patient, the referral to nephrology was not done in an appropriate time frame based on the lab results. By the time Patient was referred, there was little that could be done to reverse the condition. Drug changes that were implemented per recommendations of nephrology could have been implemented much earlier and may have made a difference in reversing his condition. Adequate communication would have	Public Letter of Concern; MD shall complete six hours continuing medical education



		induded a discussion of the	
		included a discussion of the	
		possible treatment and	
		prognosis of the condition.	
ALTOM, Laura Kathleen, MD	2/25/2025	The Board is concerned that	Public Letter of
(201600654) Raleigh, NC		MD's failure to timely report	Concern
		test results to a patient	
		could delay care and may	
		have failed to conform to	
		the standard of care. When	
		investigating Patient's	
		complaint, MD failed to	
		respond to Board inquiries.	
CALHOUN, Shannon Patrick, DO	1/31/2025	The Board is concerned that	Public Letter of
(200501925) Omaha, NE		in 2024 the Wyoming Board	Concern
		reprimanded DO, assessed a	
		fine and placed conditions	
		on his medical license. DOs	
		had failed to respond in a	
		timely manner to repeated	
		requests by the Wyoming	
		Board concerning regulatory	
		actions taken against his	
		medical licenses in	
		Colorado, New Mexico,	
		Wisconsin, Virginia,	
		Kentucky, Tennessee,	
		•	
		Florida, Illinois, Hawaii, and California.	
DIDETTE Luckin Doub NAD	1/20/2025		Dulalia Lattan af
DIREZZE, Justin Paul, MD	1/30/2025	The Board is concerned that	Public Letter of
(202103278) Novi, MI		in November 2023, the	Concern
		Michigan Board placed MD's	
		medical license on	
		probation, imposed a fine	
		and ordered him to	
		complete ten hours of CME	
		in documentation and	
		supervision and in wound	
		management due to	
		documentation errors and	
		violating the Public Health	
		Code. The Board notes MD's	
		compliance with the	
		Michigan Board Order,	
		completion of the required	
		CME, and discharge from	
		probation.	
EATON, Matthew Travis, DO	2/4/2025	The Board is concerned that	Public Letter of
(202001172) Monticello, KY		DO failed to properly	Concern



	I		
		supervise a PA who operated an urgent care and a weight loss clinic. The Board investigated complaints against the PA involving allegations that the PA used unlicensed staff to perform injections for weight loss, and that the PA was not on site when the injections were being administered. DO is accountable for the care provided by his supervisee. During the course of its investigation, the Board learned that the DO and PA's collaboration agreement did not specify the type of medicine the PA would be practicing, and that DO was unaware that the PA owned and operated a weight loss clinic. DO did not have access to any	
MARCHUK, Jerome Michael, MD (000018800) Mooresville, NC	2/4/2025	medical records at the weight loss clinic. The Board is concerned that MD's care of a patient may have fallen below the standard of care. MD performed surgery on a patient who had a medical history of testicular pain. After the surgery, Patient noted left testicular pain and testicular positional abnormality. This resulted in Patient seeking multiple opinions from urologists leading to surgical correction. The Board had MD's care of Patient reviewed by an independent medical expert. The reviewing expert criticized MD's failure to perform bilateral scrotal	Public Letter of Concern



		surgery,resulting in a poor postoperative result for Patient and failing to ensure that both testicles had been replaced in their normal	
MISCH, William Kyle, PA-C (001012141) Westerville, OH	2/19/2025	The Board became aware of PA's DWI conviction in Ohio and revocation of his NC driver's license. PA admitted to knowingly driving without a valid license on multiple occasions. In November 2023 PA fled the scene of a car accident in which the occupants of the other vehicle required medical attention. This resulted in felony charges. In January 2024 PA was suspended from a hospital in Ashville when he was discovered drinking while on-duty. NCPHP assessed and diagnosed PA with severe alcohol use disorder. PA successfully completed inpatient treatment and signed a five-year monitoring contract with NCPHP. PA inactivated his NC PA license in January 2024 and must apply for	Public Letter of Concern
SMIGRODZKI, Rafal Marek, MD (201401922) Winston-Salem, NC	1/7/2025	reinstatement in the future. According to records reviewed during the course of the Board's investigation, MD prescribed multiple non-controlled substances to himself 2019 to the present. MD's self- prescribing was frequent, continuous, and covered multiple medical conditions. For some medical conditions MD acted as his own primary care physician. Selfprescribing in this manner	Public Letter of Concern



SMITH, Joshua David, MD (201802210) Hickory, NC	2/20/2025	is contrary to longstanding principles of medical ethics. MD did not document his self-care and prescribing in a medical record. This suggests that MD did not conduct proper examinations, order tests, or otherwise follow standard medical practice in establishing diagnoses that would justify the prescriptions. The Board is concerned that in 2024, MD mistakenly operated on Patient's left middle finger. MD immediately disclosed the error, apologized, and addressed Patient's options for correcting the error. Patient agreed to return to the operating room so that MD could operate on the correct finger, which was	Public Letter of Concern
AMEGEL ANEQUE ACTIONS		done without complication.	
BIRCHARD, Katherine Rachel, MD (200400190) Chapel Hill, NC	1/27/2025	A DWI charge in 2023 resulted in the Board issuing an Order for Examination by NCPHP. NCPHP recommended that MD undergo a comprehensive examination to rule out an alcohol use disorder and determine her safety to return to clinical practice. NCPHP did not support MD as safe to practice medicine at the time. The comprehensive examination found that prior to attempting to return to practice she needed to complete a residential	Consent Order; MD shall not practice medicine until given permission to do so by the Board



		treatment program and after treatment enter into a NCPHP monitoring contract. In May 2024, MD stated that she would be deferring the recommended residential treatment due to a health emergency in her family.	
DUNN, Lawrence Anthony, MD (000030018) Raleigh, NC	2/6/2025	The Board was notified of a Change in Staff Privileges by MD's employer regarding allegations of MD's professional boundary violations and substandard prescribing. MD hired Person A to be his scribe. He personally paid her salary and health insurance. Person A filed a complaint against MD alleging that he crossed professional boundaries. MD acknowledged that in addition to hiring Person A, he treated her as a patient for psychiatric issues and administered ketamine injections at her apartment. An investigation further revealed that MD treated another former employee and prescribed her diazepam for anxiety. MD was terminated from his employment and his privileges summarily suspended indefinitely until an investigation was completed. MD underwent a comprehensive evaluation at NCPHP, which resulted in	License inactivated



		a number of treatment recommendations. In July 2024, NCPHP notified the	
		Board that MD had chosen	
		not to follow its	
		recommendations and that	
		he would be closing his	
		practice and retiring from	
		the practice of medicine.	
SCHULTZ, Heather Kay, PA-C	1/16/2025	PA has fulfilled the	Reentry Completion
(001014131) Matthews, NC		requirements set forth in	
		her Reentry Agreement.	
CONSENT ORDERS AMENDED			
NONE			
TEMPORARY/DATED LICENSES:			
ISSUED, EXTENDED, EXPIRED, OR			
REPLACED BY FULL LICENSES NONE			
COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			