

**Adverse Actions Report March-April 2026**

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](http://www.ncmedboard.org/BoardActions).

Name/license #/location	Date of action	Cause of action	Board action
<b>ANNULMENTS</b>			
<b>NONE</b>			
<b>SUMMARY SUSPENSIONS</b>			
<b>NONE</b>			
<b>REVOCATIONS</b>			
<b>NONE</b>			
<b>SUSPENSIONS</b>			
<b>BOSWELL, James Lewis, MD</b> (201801418) New Bern, NC	4/2/2026	A staff nurse reported that MD was acting erratically and could be drunk. After talking to MD, his medical director did not believe he was impaired. MD left the hospital and drove to a restaurant where he consumed alcohol. Later that day, MD rear-ended another vehicle and law enforcement arrested him for DWI. MD was scheduled to work at an ambulatory surgical center the next day. Two employees reported that MD had difficulty initiating an IV on a pediatric patient and both smelled alcohol emitting from MD. MD surrendered his medical license in May 2025 and was diagnosed with alcohol use disorder, moderate. He completed outpatient and inpatient treatment programs. NCPHP supports MD beginning the re-licensure process. He is currently being monitored by the NCPHP under the terms of a five-year monitoring contract.	Indefinite Suspension

<p><b>CASSELBERRY, Jeane Marie, MD</b> (201902540) Dallas, TX</p>	<p>3/26/2026</p>	<p>In October 2023, the North Dakota Board ordered MD to undergo a fitness-to-practice evaluation and a physical examination. MD entered into a Non-Practice Agreement with the North Dakota Board, agreeing not to practice pending further investigation. An evaluation found MD was not safe to practice unless she had further neurological evaluations to rule out a neurodegenerative condition affecting cognition. MD failed to schedule a neurological evaluation and has not complied with the North Dakota Board Order, which suspended MD's license in January 2025.</p>	<p>Indefinite Suspension</p>
<p><b>COOPER, James Bryan, MD</b> (200400320) Greenville, NC</p>	<p>4/17/2026</p>	<p>In February 2023, the Board ordered MD to the NCPHP for examination after multiple complaints that he appeared impaired or intoxicated while at work. NCPHP was also concerned about MD's overall physical and cognitive functioning and deemed him unfit to practice medicine at that time. MD was diagnosed with Alcohol Use Disorder, Severe and residential treatment was recommended. MD signed a five-year monitoring contract with NCPHP in August 2023. MD closed his medical practice and inactivated his medical license. In March 2024, MD disclosed to NCPHP that he had returned to active alcohol use. In August 2024,</p>	<p>Indefinite Suspension; Reprimand</p>

		<p>NCPHP closed MD's case due to his noncompliance with his monitoring contract. The Board received complaints from MD's former patients due to their inability to obtain copies of their medical and billing records. The Board discovered that MD stored his medical records in a rented storage unit. MD failed to notify his former patients of how they could obtain their medical records or have them transferred to other providers. MD also failed to respond to the Board's inquiries regarding access to his patient records.</p>	
<p><b>FACTOR, Avi Yosef, MD</b> (201801082) Los Angeles, CA</p>	<p>3/31/2026</p>	<p>In April 2025 the Colorado Medical Board denied MD's application for a medical license due to unprofessional conduct. In June 2024, the Centers for Medicare and Medicaid Services terminated MD's participation in Medicare and other federal healthcare programs due to an affiliation that poses an undue risk. The Board made repeated attempts between July and August 2025 to contact MD for an interview and to obtain an updated address and telephone number. MD did not cooperate with the Board's investigation, update his contact information as directed, or participate in the required interview within the specified timeframe.</p>	<p>Indefinite Suspension</p>

<p><b>MARKO</b>, Bruce Howard, MD (009601783) Charlotte, NC</p>	<p>4/9/2026</p>	<p>In September 2023, MD pled guilty to one count of Conspiracy to Commit Wire Fraud and Bank Fraud. MD was seeking capital to invest in a real estate development project in Las Vegas, NV. In securing loans, MD falsely claimed that the loans would be used for medical equipment purchases. The financial institutions wired the loan proceeds to fake medical equipment company accounts controlled by Person A who then wired funds to an account controlled by Person B who in turn wired funds to an account controlled by MD. MD then wired the funds to entities associated with his Las Vegas project. In April 2025, MD was sentenced to 12 months and one day in prison. MD voluntarily surrendered his NC medical license in July 2025.</p>	<p>Indefinite Suspension</p>
<p><b>LIMITATIONS/CONDITIONS</b></p>			
<p><b>CHRISTOPHER</b>, Frank Leonard, MD (0009700034) Carthage, NC</p>	<p>4/17/2026</p>	<p>In July 2025 MD was arrested and charged with driving while impaired and driving left of center. MD underwent a comprehensive assessment and was diagnosed with Alcohol Use Disorder, Moderate, and the assessor did not support his safety to practice medicine at that time. MD successfully completed six weeks of treatment. NCPHP supports his return to practice with a five-year monitoring contract.</p>	<p>Consent Order with terms and conditions</p>
<p><b>REPRIMANDS</b></p>			

<p><b>ALUKO</b>, Gbenga, MD (200501333) Charlotte, NC</p>	<p>3/6/2026</p>	<p>In 2024, MD entered into a Settlement Agreement with the Government to settle allegations of improper remuneration during his relationship with a laboratory used by MD's medical center. MD agreed to cooperate against the laboratory if called upon to do so. The Government alleged that the laboratory improperly compensated MD for his exclusive use of its services. MD and his medical center denied liability. MD self-reported the Settlement Agreement on his annual renewal with the Board and cooperated with the Board's investigation.</p>	<p>Reprimand</p>
<p><b>FERGUSON</b>, Steven Wallace, MD (000036700) Powellsville, NC</p>	<p>4/17/2026</p>	<p>Patient A died due to an accidental overdose involving multiple illicit drugs. MD treated Patient A for chronic pain and other medical conditions. MD prescribed oxycodone and gabapentin, while her psychiatrist prescribed two controlled substances. Patient A's medical record did not support MD's claims that he routinely performed urine drug screens or other forms of drug testing and checks of the NCCSRs. MD treated Patient B for chronic pain and partial quadriplegia following an accident. He prescribed oxycodone and intermittently prescribed gabapentin though it was unclear from Patient B's medical record why gabapentin was started. MD treated Patient C for chronic</p>	<p>Reprimand; MD shall complete a minimum of 20 hours live Category I CME</p>

		<p>pain including right ankle and right shoulder pain with oxycodone and an anti-inflammatory medication. MD treated Patient D for chronic back, hip, and knee pain with morphine, pregabalin, and an anti-inflammatory medication. There was no documented discussion about overdose risk and naloxone was not prescribed. MD failed to document urine drug screening or review of the NCCSRS. The standard of care required MD to take a thorough history, perform an appropriate examination, and utilize relevant tests and request consultations, if needed, before diagnosing and prescribing opioid therapy; however, this was not done in all four cases.</p>	
<p><b>GLEASON</b>, Thomas Gillette, MD (202201004) Asheville, NC</p>	<p>3/30/2026</p>	<p>The Board received an anonymous complaint alleging that MD attempted a thoracentesis during a single encounter without obtaining consent from the family. Patient was an immunosuppressed male with a history of a prior kidney transplant who had contracted COVID-19 which resulted in hypoxic and hypercarbic respiratory failure, acute respiratory distress syndrome, and pneumonia. MD recognized that the patient's lung compliance and pulmonary function had further deteriorated and concluded that an attempt at pleural fluid aspiration/drain</p>	<p>Reprimand</p>

		placement could directly benefit Patient. The Board's reviewing expert found that there was no documented discussion with, or informed consent obtained from, the patient's family before the procedure.	
<b>HEADEN, Kenneth Jay, MD</b> (009400266) Greensboro, NC	3/24/2026	MD has a disciplinary history with the Board related to substandard care in prescribing controlled substances and other medications to patients. In 2020, MD voluntarily surrendered his DEA privileges. In 2021, MD's medical license was indefinitely suspended. The Board's action was based on MD's failure to conform to the standard of care. The Board reinstated MD's medical license via a Consent Order in September 2024 imposing several conditions. In April 2025, MD began working for a Critical Access Behavioral Health Agency in Greensboro. However, he had not obtained site approval in advance from NCMB as required by his 2024 Consent Order. MD was instructed by the Board to cease performing patient evaluations or otherwise practicing medicine.	Reprimand and fine
<b>KISHBAUGH, David, DO</b> (009500379) Southern Pines, NC	4/16/2026	DO is the supervising physician for multiple Advanced Practice Providers (APPs). The Board received a complaint of concerns regarding substandard care, prescribing issues, and disruptive behavior toward	Reprimand; MD shall successfully complete Professional/Problem-Based Ethics course

	<p>staff regarding DO and his wife, a nurse practitioner in the office. DO personally administered Botox injections to his wife on at least two occasions and was aware that his wife performed Botox injections on other staff providers for medical and cosmetic purposes. DO admitted that leftover Botox medication billed to other patients was used for personal and staff treatment, but the staff was not billed for these Botox injections, and a medical record was generated, but often incomplete. In 2023, when DO and his wife were traveling out of the country, an NP under DO's supervision who had recently begun working at the clinic, submitted controlled substances prescriptions before her DEA registration had been approved. These prescriptions were not co-signed by a physician and occurred in the absence of appropriate supervision. Although another physician (Physician A) was listed as a backup supervising physician for the APPs, multiple staff members, including PAs, indicated that they had no working knowledge of Physician A's involvement with the practice, nor were they given Physician A's contact information. Additionally, there was no active or documented coverage plan for a supervising physician</p>	
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		during DO's absence. Physician A denied supervising any APPs at DO's practice, did not have any knowledge of his role as the backup supervisor, and never signed anything agreeing to a backup supervisory position.	
<b>KURUP</b> , Sunil Radhakrishna, MD (202400838) Plano, TX	3/3/2026	In March 2025, the Texas Medical Board required MD to complete CME on the topics of ethics and maintaining appropriate boundaries with staff. This was related to an incident in which MD engaged in unprofessional conduct and was alleged to have assaulted a female colleague. In June 2025, the Agreed Order was terminated when MD completed all requirements. Further investigation revealed that in 2023 the Texas Board required MD to complete CME on the topics of risk management and ethics. MD failed to disclose this investigation to the Board on his initial November 2023 NC license application. Also, MD failed to comply with a Colorado Board Order to submit to a mental or physical examination by the Colorado Physician Health Program.	Reprimand
<b>LUCAS</b> , Daniel Nathan, MD (202300148) Scottsdale, AZ	3/13/2026	A female patient presented to the ER with abdominal pain, nausea, vomiting, and diarrhea. MD interpreted the results of a CT scan of the abdomen and pelvis as normal. Patient was treated with painkillers, antibiotics	Reprimand

		and Zofran and discharged. Patient made two more visits to the ER with persistent symptoms and was provided similar treatment and discharged with antibiotics for possible bacterial gastroenteritis. Patient once again returned to the ER where a repeat CT scan revealed perforated appendicitis with abscesses. MD's diagnosis fell below the minimum standard of care. The first CT scan clearly showed an abnormal appendix that likely represented acute appendicitis without abscess and should have been recognized by MD.	
<b>PACCA</b> , Richard Joseph, MD (201000526) Oxford, NC	3/27/2026	MD received a formal disciplinary warning from the hospital where he worked as Hospitalist Medical Director for violating professional boundaries with another provider. MD made inappropriate comments to a female coworker over whom he had supervisory responsibilities.	Reprimand
<b>RAPALJE</b> , James John, PA (000100077) Benson, NC	4/20/2026	The Board is concerned that PA did not employ pill counts, utilize urine drug screens, or routinely check the NCCSRS when prescribing controlled substances to Patient A despite indications of possible diversion. PA failed to document both an initial formal diagnostic assessment for Patient A as well as ongoing reassessment of diagnosis, symptoms severity, and	Reprimand

		<p>functional status, yet he continued to prescribe benzodiazepine and stimulant medications. Patient A overdosed and died. Patients B through E were treated by PA for chronic and acute conditions. In each case, PA's documentation failed to meet the minimum standards and in three of the four cases, treatment also fell below the minimum standards. In two cases, PA prescribed narcotic medications concurrently with a benzodiazepine and did not document risk assessment or alternatives. PA's written agreement with his supervising physician and documentation regarding quality improvement meetings did not meet the requirements of NC general statutes.</p>	
<p><b>SUDD, Deep, MD (201301702)</b> Butner, NC</p>	<p>3/5/2026</p>	<p>A 70-year-old woman with a history of hypertension, diabetes, hyperlipidemia, chronic pain, and end-stage renal disease arrived in the ER with pain following a motor vehicle collision. All images MD ordered were unremarkable. MD prescribed Patient acetaminophen for pain relief, and baclofen for muscle spasms in the emergency room. Patient was discharged home with a prescription for baclofen three times a day. Prior to prescribing baclofen to Patient, MD reviewed information pertaining to baclofen and found no</p>	<p>Reprimand; MD shall complete six hours of Category I CME</p>

		specific warning about the use of baclofen in patients receiving hemodialysis. The next morning, Patient was transferred to the hospital where she was diagnosed as suffering from baclofen toxicity. The Board's reviewing expert opined that prescribing baclofen resulted in toxicity and Patient's ultimate cardiac arrest.	
<b>DENIALS OF LICENSE/APPROVAL</b>			
<b>HUSSAIN</b> , Basharat, MD (200701692) Multan	4/1/2026	MD inactivated his NC license in 2008. The Board denied MD's reinstatement application in 2025. MD requested a hearing on the Board's decision to deny his application. In June 2018, the Florida Board executed a Final Order accepting written relinquishment of MD's Florida medical license and his agreement to never reapply for licensure as a medical doctor in the state of Florida as a final action to avoid further disciplinary action based on allegations of sexual misconduct with a patient. MD's 2018 felony conviction constitutes unprofessional conduct.	Denial of licensure
<b>SURRENDERS</b>			
<b>SHIELDS</b> , Wright Davis, MD (000033892) New Bern, NC	3/24/2026		Voluntary surrender of medical license
<b>PUBLIC LETTERS OF CONCERN</b>			
<b>CAVIN</b> , Lillian Whitley, MD (09700892) City, ST	00/00/2026	The Board is concerned about MD's care of a Patient who was found unresponsive at home from an overdose of both stimulant and sedative prescription medications. MD interpreted a CT scan as	Public Letter of Concern

		<p>negative for acute intracranial abnormalities. Patient was admitted with a preliminary diagnosis of acute encephalopathy of metabolic or neurological origin. A repeat CT scan two days later showed signs of possible evolving strokes in the brainstem and a small area that could indicate bleeding or an imaging artifact. Magnetic resonance imaging later that day revealed narrowing or possible blockage of the basilar artery. MD missed a clear, classic sign of stroke on the first CT scan.</p>	
<p><b>COUNTRYMAN</b>, David Mark, MD (000033352) Charleston, SC</p>	<p>4/21/2026</p>	<p>The Board is concerned about MD's care of a 75-year-old with several chronic medical conditions. Patient saw MD for treatment of a right groin hernia. A CT scan showed that Patient had a hernia on the left side as well. MD performed the open surgical repair of both the right and left inguinal hernias. During surgery, MD found that Patient had hernia defects in two areas on both sides. MD repaired the hernias using a patch technique with mesh and removed a small segment of the ilioinguinal nerve on each side. A permanent Ethibond suture was used to secure the mesh to nearby tissue, including a bony area in the pelvis called the pubic tubercle. In the weeks after surgery, Patient complained several times of pain and tenderness in the groin and</p>	<p>Public Letter of Concern</p>

		scrotum. During a visit with his urologist, an ultrasound showed that there was no blood flow to the right testicle. Patient underwent surgery to remove the right testicle. During that procedure, the surgeon found a permanent suture passing through the spermatic cord. Accidentally tying off or stitching through the blood vessels to the testicle during hernia repair is below the minimum standard of care.	
<b>DAVIS, Barry Duval, MD</b> (201401846) Clewiston, FL	4/17/2026	The Board is concerned that in December 2025, the Florida Board issued a Letter of Concern, imposed a fine and required MD to complete five hours of CME in risk management, and requiring MD to present a one-hour lecture on Wrong Site Surgeries to medical staff at an approved medical facility. This Order was based on MD performing a wrong site surgery in September 2025, when a patient presented for excision of a lipoma from the left lower back, but MD performed an excision of a lipoma from the left upper back.	Public Letter of Concern
<b>DEPRENGER, Anna Marie, DO</b> (202400517) Chapel Hill, NC	3/25/2026	The Board is concerned that DO inappropriately accessed the protected health information of a high-profile patient, by entering into Patient's electronic medical record without a medically justifiable reason During the course of the hospital's	Public Letter of Concern

		investigation, it was also discovered that DO accessed her own medical record in violation of hospital policy.	
<b>FLYNN</b> , Michael Joseph, III, PA-C (001007639) Greenville, NC	3/24/2026	The Board is concerned that PA's privileges were suspended by his employer after a patient complaint. Patient alleged PA sexually propositioned him during a medical appointment. An investigation revealed that after the appointment concluded, PA walked Patient to the parking lot and proceeded to talk for an additional ninety minutes about multiple topics that included ones that were sexual in nature and were unrelated to medical care. PA conceded that he exercised poor judgment in having these discussions outside a clinical setting and in engaging in excessive self-disclosure. PA completed a plan to develop and implement skills to protect and maintain boundaries.	Public Letter of Concern
<b>GARRETT</b> , Jeffrey Paul, MD (201100980) Greenville, NC	3/3/2026	The Board is concerned about MD's care of a 64-year-old male who suffered from primary left hip osteoarthritis. During a left total hip arthroplasty, MD implanted a 36-millimeter femoral head component into a 40-millimeter liner and did not readily appreciate the size difference. Several weeks later, post-operative x-rays showed the femoral head component was the wrong size. MD informed Patient	Public Letter of Concern

		about the mistake, and revision surgery was recommended.	
<b>GASKELL</b> , Abby Alysse, PA-C (001009391) Charlotte, NC	4/16/2026	In November 2023, PA treated a co-worker at the medical spa where PA works, for cystic acne on her forehead. After the second injection, Patient developed significant lipoatrophy at the injection site that resulted in a depression in the tissue on her forehead. The Board notes the absence of documented potential side effects discussion and the lack of a signed informed consent. The Board’s investigation revealed that PA had failed to maintain adequate documentation of QI meetings with PA's supervising physician as required by 21 NCAC 32S.0213(e).	Public Letter of Concern: PA shall complete a minimum of eight hours Category I continuing medical education
<b>GODLY</b> , Kathryn Michelle, PA-C (001003453) Durham, NC	3/3/2026	The Board is concerned that PA contracted with an independent contractor as a PA who was not licensed to practice in NC. While this individual was licensed as a PA in other states and recognized as a PA by the First Nation Medical Board, these credentials did not allow her to treat NC patients. The unlicensed individual performed several medical tasks and treated one of PA's family members, raising an issue of the conflict of interest. PA's practice advertised the unlicensed physician assistant on its website, and she identified herself as a “physician assistant” when interacting with patients	Public Letter of Concern

		without referencing that she was unlicensed in NC.	
<b>GREEN, Sinikka Liisa, MD</b> (202201848) Boston, MA	3/23/2026	The Board is concerned that in September 2025, MD was reprimanded and fined by the Maine Medical Board for failing to timely notify the discipline imposed by the California Board. When notifying the Maine Board of the discipline imposed by the California Board, MD represented that the California Board’s investigation “did not find any deviation from the standard of care,” and that the matter pertained solely to medical record documentation. However, documentation obtained by the Maine Board indicated that the California Board’s disciplinary action concluded that between August 2017 and April 2019, MD committed repeated negligent acts in the care of a patient and failed to maintain adequate and accurate medical records.	Public Letter of Concern
<b>ICHIRIU, Wanda Gwen, PA-C</b> (001015046) Mount Pleasant, SC	3/3/2026	The Board is concerned that in May 2024, PA entered into an independent contractor employment agreement with a Durham-based practice to provide PA services. She saw patients and identified herself as a PA when interacting with North Carolina patients. PA did not obtain a North Carolina PA license. Although she was licensed as a PA in other states and recognized as a PA by the First Nation Medical Board, these credentials did not	Public Letter Concern

		allow her to treat NC patients. These actions constituted unlicensed practice in NC. Prior to the Board's investigation PA obtained her NC license.	
<b>JACOBSON, Mary Therese, MD</b> (202003473) Palo Alto, CA	3/26/2026	The Board is concerned that in November 2025, the Mississippi Board prohibited MD from practicing telemedicine for 90 days and required her to complete the PROBE: Ethics & Boundaries Program. The Mississippi Board determined that MD prescribed medications via an online telehealth platform without establishing a physician-patient relationship, used store-and forward transfer technology to replace real-time physician-patient interaction, utilized a questionnaire in lieu of a physical examination, and displayed unprofessional conduct.	Public Letter of Concern
<b>JUBERG, Breton Chester, MD</b> (000034367) Hobbs, NM	3/24/2026	The Board is concerned about MD's care of a patient with a history of seven miscarriages who presented with a confirmed pregnancy. MD closely monitored her pregnancy. At 36 weeks gestation, Patient reported decreased fetal movement, intermittent swelling, and headache. Fetal heart tones were obtained; however, no additional evaluation was performed. Patient returned nine days later at which time an intrauterine fetal demise was diagnosed. Abnormal labs and vitamin deficiencies were not	Public Letter of Concern

		managed, reported headaches with high-normal blood pressures late in pregnancy were not evaluated for possible pre-eclampsia, and decreased fetal movement was not assessed. Appropriate antepartum surveillance was not performed.	
<b>KARIKARI, Isaac Obiri, MD</b> (201400912) Edmond, OK	3/25/2026	MD attempted to repair a CSF venous fistula by means of spinal decompression surgery. After surgery, Patient experienced ongoing symptoms, due to MD having operated at the wrong spinal level. Patient had an anatomic variant at the junction of the mid and lower regions of the spine that was present on preoperative imaging and also identified on the post-operative CT myelogram. This variant is a significant risk factor for wrong-site surgery. Patient agreed to a second surgery during which MD appropriately took care of the problem. The Board's reviewing expert found that MD failed to appreciate Patient's anatomic variant on preoperative imaging and failed to confirm the correct level by counting in at least two different manners prior to skin incision as well as after surgical exposure.	Public Letter of Concern
<b>KIM, William Youngkwan, MD</b> (200600263) Chapel Hill, NC	3/17/2026	The Board is concerned about MD's care of a Patient. MD appropriately evaluated, staged, and planned chemotherapy for a 58-year-old male with newly diagnosed metastatic clear	Public Letter of Concern

		<p>cell renal carcinoma. Prior to initiating treatment, two routine urinalysis tests showed clear evidence of a urinary tract infection. MD did not prescribe antibiotic treatment or order a urine culture. Approximately two weeks after the second urinalysis, Patient was admitted to the ICU with urosepsis. Despite broad-spectrum antibiotics, vasopressor support, and aggressive intensive care, Patient's condition deteriorated and he was transitioned to comfort care approximately ten days later. The absence of recognition and treatment of the urinary tract infection on two separate occasions was a missed opportunity to prevent progression to urosepsis.</p>	
<p><b>KURPAD, Rajesh, MD (201500555)</b> Wilmington, DE</p>	<p>4/3/2026</p>	<p>The Board is concerned about MD's care of a patient in the ER with complaints of left testicular pain, nausea and vomiting. A scrotal ultrasound showed normal testicles with normal blood flow to both testicles but indicated reduced blood flow to the left sperm storage duct with suspected twisting of the left epididymis. As the consulted urologist, MD felt preliminary diagnosis of intermittent epididymal torsion was correct and recommended conservative management with nonsteroidal anti-inflammatory drugs and prophylactic antibiotics. A</p>	<p>Public Letter of Concern; MD will complete a minimum of four hours Category I CME</p>

		<p>repeat scrotal ultrasound the following day showed significant swelling and bleeding in the testicle and epididymis with early signs of tissue damage which fits with a history of testicular torsion. Patient underwent an urgent removal of the left testicle, however MD did not perform surgical fixation of the right testicle during surgery. Patient should have gone directly to the operating room based on his symptoms alone and should not have had conservative management.</p>	
<p><b>LEE, Gene Hyung, MD (201802806)</b> New Canaan, CT</p>	<p>3/2/2026</p>	<p>The Board is concerned that when MD renewed his Wyoming medical license in 2023, he reported that he had obtained the required CME. MD was selected for a random audit of CME credit hours and the Wyoming Board staff sent multiple letters requesting MD provide supporting documentation for the CME he reported from 2020-2023. MD failed to respond. MD also did not respond to a request to submit to an interview. In May 2025, the Wyoming Board issued a reprimand, suspended MD's Wyoming medical license for 90 days, and imposed a fine based on the above conduct. MD also failed to notify the Wyoming Board that he changed his address. In July 2025, the Kansas Board suspended MD's Kansas medical license based on the action taken</p>	<p>Public Letter of Concern</p>

		by the Wyoming Board.	
<b>MARTIN, Eric William, MD</b> (201500759) Rock Hill, SC	3/31/2026	The Board is concerned about MD's care of a patient with a history of coronary artery bypass surgery and aortic valve replacement who presented to the ER with complaints of generalized malaise, including headache, nausea, dizziness, and lower extremity muscle cramping. Lab tests suggested an acute bacterial infection or systemic inflammatory response, mildly elevated CO2, creatinine, and bilirubin levels, and slightly low sodium and chloride levels. Despite these findings, MD documented that no emergent pathology was identified at that time and Patient was stable for discharge. Patient was subsequently diagnosed with infective endocarditis and suffered severe complications, including sepsis, multiple septic emboli with intracranial hematomas, multi-organ involvement, and irreversible damage to his artificial heart valve requiring surgical replacement. MD's documentation may have fallen below standard because significant laboratory abnormalities, including the marked leukocytosis, were neither acknowledged nor addressed despite their presence in the laboratory results.	Public Letter of Concern; MD shall complete CME in emergency department management of infective endocarditis
<b>PATEL, Rupesh Parag, MD</b>	4/9/2026	The Board is concerned that	Public Letter of

(202601935) Lake Forest, IL		MD failed to disclose on his license application that in 2021 the Wisconsin Medical Board issued a Reprimand and fine. The action resulted from a 2017 incident involving a 71-year-old male in the ER with complaints of neck pain following a fall. CT head and C-spine scans were read by a senior radiology resident who the head and c-spine scans in the computer application. MD viewed and affirmed that he reviewed the images and agreed with the resident's impressions but MD did not scroll beyond the report of the CT head study and missed the CT C-spine study because the scans were combined.	Concern
<b>SLOAN</b> , Aleta Lynn, PA-C (000101395) Wilmington, NC	3/24/2026	The Board is concerned that PA performed a portion of a periocular aesthetic laser treatment using an Nd:YAG 1064 nm laser device while neither Patient or PA was wearing the required protective eye shields. The Board's independent reviewing expert expressed an opinion that documentation did not support the diagnosed condition, the expert could not determine whether the blood vessels and veins described under Patient's inferior eyelid were visible on the video, and the lack of protective eye wear for both PA and Patient was contrary to safety protocols.	Public Letter of Concern
<b>SLOAN</b> , Timothy Council, MD (009801499) New Bern, NC	3/24/2026	The Board is concerned about MD's supervisory relationship with his PA. In	Public Letter of Concern

		<p>2024, a PA supervised by MD posted on social media a periocular aesthetic laser treatment procedure in which she touched-up a vein within the periocular area on a patient without required protective eyewear for either the patient or herself. The Board is concerned that the posted video may have unintentionally portrayed and normalized an unsafe clinical practice, thereby potentially misleading other practitioners, or patients. The Board also notes its concern regarding MD supervising this PA, who is both his wife and a physician assistant practicing aesthetic laser procedures. MD is trained as a radiologist. Although he has experience with lasers, the Board expects supervising physicians to possess appropriate specialty-specific education, training, and experience relevant to the procedures they authorize and oversee.</p>	
<p><b>SURLYN</b>, Colleen Stephanie, MD (202200211) New York, NY</p>	<p>4/16/2026</p>	<p>The Board is concerned that in September 2025, MD was reprimanded by the Maine Board and assessed a civil penalty based on practicing with a lapsed license and practicing outside the scope of her medical practice. During the Board’s investigation of this matter, MD explained this misunderstanding happened due to relying on a third-party credentialing service. However, until this time,</p>	<p>Public Letter of Concern</p>

		<p>this Board was unaware that MD possessed a Maine medical license. The Board reminds MD that, even when using third-party services, it is one's duty to ensure compliance and take an active role in maintaining medical licenses in multiple states.</p>	
<p><b>THOMPSON, Robert Leon, III, MD</b> (202601999) Houston, TX</p>	<p>4/13/2026</p>	<p>The Board is concerned that in March 2020 the Texas Board suspended MD's medical license due to nonpayment of child support. The suspension was lifted in April 2020. Subsequently in July 2021 MD entered into a non-disciplinary Remedial Plan with the Texas Board and was required to complete CME in ethics and pay an administrative fee due to MD's failure to inform his employer of the 2020 license suspension and continuing to practice medicine, treat patients and participate in the ER call schedule. The Texas Board terminated the remedial plan in March 2022 based on MD's completion of all requirements.</p>	<p>Public Letter of Concern</p>
<p><b>VEREB, Margaret Jeanne, MD</b> (200101620) Sylva, NC</p>	<p>3/18/2026</p>	<p>MD evaluated a patient and observed a large scrotal abscess located on the lower portion of the scrotum, with dead tissue in the center, which raised concern for possible Fournier's gangrene. MD recommended an urgent incision and drainage (I&amp;D) procedure, discussed the risks and benefits of the procedure, the need for</p>	<p>Reprimand; MD shall complete Category I CME on documentation and informed consent</p>

		wound care post-procedure, and options for pain management. MD proceeded with the I&D procedure, in-office, without using an anesthetic. It is inappropriate to perform an in-office incision in a patient's skin and scrotal wall without anesthesia. Additionally, there was no documentation of a differential considering possible Fournier's gangrene, a physical exam, procedure note, or documented informed consent to perform an in-office I&D procedure.	
<b>MISCELLANEOUS ACTIONS</b>			
<b>KIMPTON</b> , Mark Troy, MD (201801739) Nashville, NC	4/9/2026	MD entered into a Reentry Agreement with the Board in April 2025 requiring that MD begin a Reentry Plan within 12 months. MD has not begun the Reentry Plan within the time allowed or requested an extension. MD's license will not be reinstated and this matter is concluded.	Failure to start reentry
<b>RIKARD</b> , Kimberly Ann, PA-C (000103252) City, ST	3/16/2026	PA and NCMB entered into a Reentry Agreement in March 2025 requiring that PA begin a Reentry Plan within twelve months. Since PA has not begun the Reentry Plan within the time allowed or requested an extension, her license will not be reinstated.	Failure to start reentry
<b>CONSENT ORDERS AMENDED</b>			
<b>NONE</b>			
<b>TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR</b>			

<b>REPLACED BY FULL LICENSES</b>			
<b>NONE</b>			
<b>COURT APPEALS/STAYS</b>			
<b>NONE</b>			
<b>DISMISSALS</b>			
<b>NONE</b>			