Adverse Actions Report March 2022 – April 2022

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			
SWAYNGIM, Dowzell Medford, Jr., MD (000019408) Sandusky, OH	03/09/2022	Action based on another state board action. MD practiced medicine in Ohio. In March 2021, he agreed to a Permanent Surrender of Certificate to Practice Medicine and Surgery in Ohio with consent to permanent revocation with the State Medical Board of Ohio (Ohio Board). In April 2021, the Ohio Board entered an Order permanently revoking MD's license to practice medicine and surgery in Ohio. The Ohio Board's Order was based on MD's April 2021 conviction of five counts of first-degree misdemeanor Attempt to Traffic in Hydrocodone in Erie County, Ohio. In December 2021, MD's North Carolina medical license became inactive when he failed to register with the Board.	Revocation of NC Medical license

SUSPENSIONS			
HOUSTON, Robert Edgar, MD (200200740) Chesapeake, VA	03/22/2022	At the time MD received his North Carlina medical license, he had a diagnosis of opioid use disorder, was in compliance with his North Carolina Physicians Health Program (NCPHP) monitoring agreement and his Virginia Health Practitioners Monitoring Program (VHPMP) monitoring agreement and was in good recovery. At all times relevant hereto, MD practiced anesthesiology in Lumberton, North Carolina. In May 2021, he relapsed by inappropriately obtaining and using the opioid called fentanyl. In June 2021, MD self-reported his relapse to NCPHP, who later notified the Board. MD has not practiced medicine since June 9, 2021. After his relapse, he obtained inpatient treatment from June 2021 to October 2021, which he successfully completed. MD currently has monitoring agreements with NCPHP and VHPMP and is in compliance with both agreements. In February 2022, MD became certified as a specialist in Addiction Medicine by the American Board of Preventative Medicine.	Indefinite suspension, retroactive to June 15, 2021

JOHNSON, John Anthony, MD (200000474) Mooresville, NC	03/30/2022	MD practiced maxillofacial surgery in Mooresville, NC. In July 2015, a patient was referred to MD by her dentist for treatment of ailing and missing teeth. Between July 2015 and May 2018, MD performed numerous procedures on the patient including extractions, bone grafting, and implant placement. In November 2019, the Board received a complaint from the patient alleging that MD performed extensive and costly oral surgery without her signature and failed to advise or include the patient in all aspects of her care. The patient was displeased with the results of the dental implants and suffered nerve damage as a result of her treatment. Based on the complaint and concerns regarding MD's care of the Patient, the Board ordered him to produce the patient's medical records. The medical records were reviewed by an independent medical expert to determine if the care rendered by MD was within the acceptable and prevailing standard of care in North Carolina. The independent medical expert opined that MD's overall care of the patient fell below the	Indefinite Suspension; immediately stayed with terms and conditions

		standard of care in North Carolina. Specifically, MD failed to provide a clear diagnosis or treatment plan for the patient. Further, the reviewing expert stated that the office visits, informed consent, sedation records, and post-operative notes were not properly documented in the medical record. The reviewing expert also criticized MD's failure to follow-up and manage the patient's nerve damage.	
MCGEE, Thomas Page, Jr., MD (200200740)	03/22/2022	MD has a disciplinary history with the Board, including prior allegations of performing inappropriate examinations. Those allegations are more specifically described in the September 2015 Consent Order he entered into with this Board. In October 2021, the Board received a complaint that MD inappropriately reached under a female patient's shirt and bra to rub her shoulders and abdomen during an appointment to address the patient's hair loss. A chaperone was not present during the examination. At the time of the patient's allegations, MD was under investigation by the Board regarding a similar incident in which a patient alleged that he	Indefinite Suspension

		had inappropriately touched her breasts. As part of that investigation, MD was assessed by the North Carolina Professionals Health Program (NCPHP). NCPHP recommended that MD obtain a comprehensive inpatient assessment for sexual boundary issues. In October 2021, at the request of the Board, and in lieu of submitting himself for a comprehensive inpatient assessment, MD inactivated his North Carolina medical license. He has not practiced medicine since that time.	
PARKER, Jennifer Jeanne, PA-C (001000425) Fletcher, NC	04/20/2022	PA practiced as a physician assistant in Asheville and Arden, North Carolina. She has a history of alcohol use disorder. In July 2021, the Board was informed by the North Carolina Professionals Health Program (NCPHP) that PA had been terminated by her employer as a result of her reporting to work while impaired by alcohol. PA has not practiced as a physician assistant since the time of her termination. She maintains that she did not consume alcohol at work, but that her high blood alcohol level was a result of her consuming an excessive amount of alcohol in the early hours of the day, prior to her	Indefinite Suspension

		work shift. In August 2021, PA presented to NCPHP for an assessment. She was given a provisional diagnosis of severe alcohol use disorder and referred to inpatient treatment. NCPHP opined that PA was not safe to practice at that time. PA attended residential inpatient treatment. In November 2021, after completing residential treatment, she signed a five-year monitoring agreement with NCPHP.	
SMITH, Gregory Eugene, PA-C (000103971) Hope Mills, NC	03/21/2022	PA practiced as a physician assistant in Whiteville, North Carolina. He has an extensive history with the Board, including prior allegations of professional sexual misconduct, which are more specifically described in the February 2011 Consent Order. In March and April of 2021, the Board received two separate complaints that PA had engaged in and/or attempted to engage in sexual contact or sexual activity with two patients. While the Board was investigating the allegations regarding the patients, the Board received information that PA allegedly inappropriately touched and attempted to engage in a sexual	Indefinite Suspension

		activity with an employee while providing medical treatment to the employee.	
WHITE, Anne Litton, MD	03/17/2022	Following a hearing in August 2018, MD was disciplined and subject to certain conditions. One condition of the 2018 Final Order was that MD be monitored by Affiliated Monitors for three years at MD's expense. In March and April 2020, MD emailed Affiliated Monitors that her office was closed to patients. In April 2020, MD emailed the Board's Investigator that her office was closed. The Board heard testimony from the Board's Investigator who investigated information that MD was, in fact, still seeing patients after reporting to Affiliated Monitors and to him, that she was closed and not seeing patients. The Board heard testimony from four former employees that MD's office remained open and the MD continued to see patients during the time she reported that she was closed and not seeing patients. The Board received and reviewed the medical records of three patients, treated during the time MD reported that she was closed and not seeing patients. The	Indefinite suspension; MD may not apply for reinstatement for at least two years

		Board heard testimony from a former employee of MD that she received a report from MD's office that contained all the patients seen and the amounts billed during the time MD reported to Affiliated Monitors and the Board's Investigator that she was closed and not seeing patients. The Board heard testimony from a former employee who worked as the graphic designer and marketing director for MD who testified that when MD received written requests from the Board in April 2021 to produce certain documents, she was instructed by MD to review all prior social media postings made during the time MD reported that she was closed and not seeing patients and to either delete the postings or alter the verbiage to make it appear that the office was closed during that period of time. The Board heard testimony from a former employee that MD asked him to author a false letter stating that she had not seen any patients during the time MD reported that she was closed and not seeing patients. Upon learning that MD was under investigation by the Board, the former	

		employee contacted the Board's Investigator and reported to him that the information contained within the letter was false and that MD was, in fact, seeing patients during that time. In January 2020 MD entered into a Final Order with the Indiana State Medical Licensing Board in which she agreed to be placed on Indefinite Probation for a period of not less than two years and pay a $500.00 fine. The Board reviewed the North Carolina Criminal Conviction Docket regarding MD's criminal misdemeanor conviction for False Statements in Applications for Insurance in which MD was ordered to pay $2,576.51 in restitution and $100.00 fine.	
LIMITATIONS/CONDITIONS			
NONE			
REPRIMANDS			
EMERSON, Scott Sherlock, DO (201200588) Asheville, NC	03/9/2022	In May 2020, DO reviewed a prescription for Adderall® (amphetamine) for a patient as recommended by a PharmD at the Asheville Veterans Administration Hospital (Asheville VA). The patient is a veteran suffering from post-traumatic stress disorder and other diagnoses. In reviewing the necessity for the prescription, and per Asheville VA policy,	Reprimand

		DO would have become aware of the patient's mental health history, and of course become aware that the patient was receiving psychiatric care from the Asheville VA. DO had no pre-existing relationship with the patient, and prior to reviewing her chart, had never met her. Despite having prior knowledge that she was a patient of the Asheville VA, despite having reviewed her mental health record and thus gaining knowledge of her medical condition, and despite having a physician–patient relationship albeit one that was primarily administrative, isolated, and limited by virtue of authorizing a prescription for a controlled substance, DO, nonetheless, knowingly entered into a romantic relationship with the patient. For months, DO failed to notify his supervisor or Asheville VA of his relationship with the patient. Furthermore, DO only disclosed the relationship after the patient continued to struggle with life stressors and after he was approached by Asheville VA staff to authorize more prescriptions to the patient. DO had time	

		after he knew the patient to be a patient of the Asheville VA, and having reviewed her medical chart, to prevent the relationship from developing.	
GIBBONS, Mark Calverley, DO (200801266) Goldsboro, NC	03/9/2022	Action based on another state board action. DO practiced general medicine in Georgia. In March 2021, DO. pleaded guilty to one count of conspiracy and was sentenced to five years of probation and ordered to pay $24,480.00 in restitution to the Centers for Medicare and Medicaid Services. The basis for the conviction arose from DO's participation in an unlawful telemedicine scheme for which he received compensation for authorizing orders of durable medical equipment by signing false medical records and describing consultations and examinations of Medicare patients that never occurred. In August 2021, DO and the Georgia Composite Medical Board (Georgia Board) entered into a Consent Order in which DO was reprimanded, ordered to successfully complete ten hours of continuing medical education in ethics, and fined $8,000.00 dollars, including a $5,000.00	Reprimand

		fine for unprofessional conduct and a $3,000.00 fine for failing to disclose a felony conviction. In February 2021, DO's North Carolina medical license went inactive for failure to renew.	
WILLIAMSON, Bridget Alaire David, PA-C (001011566) Southport, NC	03/07/2022	Action based on another state medical board. PA practiced as a physician assistant in Indiana. In September 2021, she entered into a settlement with the State of Indiana's Physician Assistant Committee (Committee) in which her license to practice as a physician assistant was summarily suspended until December, 2021. The Committee's Order, stated that PA owned and worked at Pele Bonita Medical Aesthetics (Pele Bonita) as a physician assistant. While she had a controlled substance registration (CSR) with Johnson Memorial & Community Health Network, she had no CSR for Pele Bonita. Additionally, she failed to have a practice agreement on file with Indiana Professional Licensing Agency (IPLA) for a collaborating physician that oversaw her practice at Pele Bonita. As part of the weight loss program offered by Pele Bonita, PA often prescribed	Reprimand; Prior to resuming practice in North Carolina, PA must first obtain practice site approval from the Board's Office of the Medical Director

		phentermine, a Schedule IV controlled substance, to facilitate weight loss without first performing a proper physical examination or justifying the prescription with a detailed medical record. In October 2021, PA surrendered her Drug Enforcement Agency (DEA) registration based on the Committee's Order. In January 2022, PA provided the Board with a settlement agreement reinstating her license to practice as a physician assistant. In the agreement reinstating her Indiana license, the Committee recited numerous violations of its rules and regulations, and PA consented to an indefinite probation of her license with a minimum period of at least three years based on those violations.	
DENIALS OF LICENSE/APPROVAL			
YANK, Glenn Russell, MD (000000000) Chapel Hill, NC	03/04/2022	Action based on another state Board Action. In November 2016, MD entered into a Consent Order with the Tennessee Board of Medical Examiners (Tennessee Board) in which he was Reprimanded and restricted from prescribing opioids and other medications. MD was also required to be	Denial of licensure

		monitored for a period of three years. In July 2020, MD entered into a Consent Order of Modification of Prior Order with the Tennessee Board. The 2020 Consent Order indicated that MD failed to satisfy the monitoring requirement imposed by the 2016 Consent Order. The 2020 Consent Order indicates MD retired from the practice of medicine in April 2020 and states certain restrictions and conditions that would be placed on his Tennessee medical license should he apply to reactivate that license.	
SURRENDERS			
NONE			
PUBLIC LETTERS OF CONCERN			
HALL, Gregory James, MD (200901902) Houston, TX	03/4/2022	In June 2015, a fifty-three-year-old male presented to a North Carolina emergency department with a primary complaint of right foot and ankle pain two days after rolling his ankle. MD interpreted the radiograph as "soft tissue swelling without acute osseous abnormality." The patient was discharged	Public Letter of Concern

		with a diagnosis of a sprain and instructions to follow-up with an orthopedist. Approximately one month later, the patient was seen by an orthopedic surgeon who ordered another radiograph study. The radiologist who reviewed this radiograph noted findings that were concerning for a Lisfranc injury, which is a type of injury to the bones and/or ligaments in the middle part of a foot. The patient then underwent surgery to address this issue. The Board had MD's care of the patient reviewed by an independent medical expert, who had a concern about the care. Specifically, the reviewing expert opined that MD should have considered a Lisfranc injury on the radiograph study that he interpreted in June 2015.	
LOBAO, Celso Benedito**,** MD (000035411) Raleigh, NC	04/27/2022	The Board is concerned that MD's care of a patient may have failed to conform to the standards of acceptable and prevailing medical practice in NC. In March 2019, MD assumed	Public Letter of Concern; MD to complete six hours Category I continuing medical education in the subject of polypharmacy

		psychiatric care of a forty-eight-year-old male (Patient) during his admission to a partial hospitalization program (PHP). Patient had a history of chronic and severe mood disorder with a diagnosis of Bipolar Disorder II. Patient had previously been treated with a variety of psychiatric medications, including lithium, and had received numerous electroconvulsive therapy (ECT) treatments. Following Patient's discharge from the PHP, MD continued outpatient psychiatric care. Over the course of 18 months, MD saw Patient approximately every two weeks and prescribed on average eight or more psychiatric medications at any one time. Patient continued ECT treatments by other providers concurrent with psychopharmacological management. MD documented periods of partial mood stabilization and symptom reduction, but Patient continued to manifest signs and	

		symptoms of a chronic and severe mood disorder. MD also noted concerns over the impact of the ECT treatments on Patient's memory and made efforts to reduce the frequency of the ECT treatments. In June 2020, Patient was admitted to the hospital and diagnosed with lithium toxicity. Unbeknownst to MD a blood pressure medication (lisinopril) had been prescribed to Patient by another provider approximately three months before his hospital admission, and it was determined to be a critical factor in the lithium toxicity. Patient recovered, was discharged five days later. The Board had MD's care of Patient reviewed by an independent medical expert. The reviewing expert highlighted MD's failure to adequately monitor Patient's lithium level, renal function, and thyroid function, potentially leading to Patient's hospitalization for lithium toxicity. The expert reviewer	

		criticized MD's failure to routinely reconcile Patient's medications; specifically noting MD's failure to recognize the prescribing of lisinopril by another provider. Further, the expert reviewer opined that the psychiatric medications MD prescribed represented "overlap and redundancy of medication types and certain of the medications used would be viewed as atypical even for a treatment resistant bipolar disorder. The potential for adverse drug events and drug-drug interactions was high…" Regarding the documentation of MD's care of Patient, the reviewing expert noted that in several instances, MD's documentation "did not adequately describe the patient's condition, clinical course, and services rendered." MD agreed to complete six hours of a Category I continuing medical education concerning the subject of polypharmacy within six months.	

Mercer, Cynthia Cecil, MD (201902012) Hayesville, NC	04/22/2022	The Board is concerned that MD's care of a patient may have failed to conform to the standards of acceptable and prevailing medical practice in NC. In September 2017, a sixteen-year-old pregnant female (38 weeks, 1 day) presented with early spontaneous labor to a hospital where MD was the attending physician. Patient had a history of obesity and gestational hypertension (GHTN), and it was suspected that the fetus was larger than average (fetal macrosomia). her labor progressed in a timely fashion and fetal heart tracing (FHR) was considered indeterminate (Category II). MD performed an artificial rupture of the membranes (AROM), and an intrauterine pressure catheter (IUPC) was placed. Patient's vital signs were never in range of severe preeclampsia, and she was not febrile. However, throughout the afternoon and early evening, the FHR recorded several decelerations. Patient	Public Letter of Concern

		continued to labor until 11:17 p.m. at which time she delivered a viable male infant via vacuum-assisted vaginal delivery. Due to low apgar scores the infant was transferred to a tertiary care facility with a Level IV Neonatal Intensive Care Unit, where he died approximately two weeks later from cardiopulmonary failure, persistent pulmonary hypertension, and meconium aspiration syndrome. The pathology of the placenta showed a true knot of the umbilical cord and infection of the placenta and the amniotic fluid (chorioamnionitis). The Board had MD's care of the patient reviewed by an independent medical expert. The reviewing expert specifically criticized MD's failure to recognize fetal distress a 9:00 p.m. and noted that the use of Pitocin at the time of Category III FHR is contraindicated. The reviewing expert opined that the plan to deliver an infant vaginally in the presence of fetal distress would only work if such	

		delivery was imminent, which in this instance, it was not. Further, the reviewing expert noted that the young age of the patient with a BMI of 31 and suspicion of fetal macrosomia are disadvantages to vaginal or vacuum-assisted vaginal delivery at the second stage of labor in the presence of fetal distress.	
MILES, Benjamin Carl, MD (201000654) Mooresville, NC	03/21/2022	A patient presented in February 2017, with complaints of post-menopausal bleeding. An ultrasound revealed a dense acoustical shadowing in the left ovary. MD performed a pelvic exam, pap smear, urinalysis, and endometrial biopsy; and then recommended a follow-up appointment in one week to discuss the results. In the meantime, MD sent a message to the patient through the patient portal with results and treatment plan for her urinary tract infection. The Patient misunderstood these messages and test results to mean a follow-up appointment was not needed and continued to take unopposed estrogen, a known risk factor for endometrial	Public Letter of Concern

		cancer, as prescribed to her by her primary care health care providers. On May 19, 2017, the patient presented to another gynecologist with complaints of daily post-menopausal vaginal bleeding since January. A repeat biopsy showed endometrial carcinoma which initially responded to treatment but later developed into metastatic disease. The Board has some concerns regarding MD's care of the Patient. Specifically, the Board believes that MD should have informed the patient of her endometrial biopsy results and arranged for an urgent referral to Gynecologic Oncology. The Board also believes that MD should have communicated his clinical findings to the Patient's primary care and referring providers as well as the need for them to discontinue unopposed estrogen therapy.	
ZEMAN, Peter Anton, MD (2005-00346) Wilmington, NC	04/28/2022	In September 2021, MD performed a bilateral vasectomy on a patient. The Board is concerned that MD failed to keep adequate records regarding his care of the patient. Specifically, he failed to obtain written consent to perform the bilateral vasectomy and	Public Letter of Concern

		to administer nitroxide. Further, MD's operative notes describing his encounter with the patient were severely lacking and did not adequately describe the procedure (no scalpel vasectomy) and did not include a documented pre-operative physical examination or document the administration of the nitrous oxide. In addition, MD failed to provide written discharge instructions.	
MISCELLANEOUS ACTIONS			
THORN, Lindsay Megan, PA (001012238) Fuquay Varina, NC	04/28/2022	PA last practiced as a physician assistant in June 2016, in Florida and recognizes the need for a reentry plan to assist her back into practice as a physician assistant. The Board has approved PA's reentry plan with certain added modifications.	License issued with reentry agreement; PA to undertake a two-phase reentry plan
CONSENT ORDERS AMENDED			
AGBAFE-MOSLEY, Dorothy Ejinkonye, MD **(**200901999) Wilmington, NC	03/04/2022	MD practiced family medicine in Wilmington, NC. The Board's 2020 Consent Order involved quality of care concerns and the Consent Order concluded that MD had committed unprofessional conduct, reprimanded her, restricted and prohibited her from prescribing or dispensing any medication or substance classified as Schedules I and II/IIN (2/2N) controlled substances and also required MD to	Amended Consent Order; Restriction from prescribing or dispensing Schedules 1 and 2/2N controlled substances lifted; MD to begin Phase II of Compliance Plan

		obtain a competency assessment and comply with all practice improvements made as a result of the assessment. MD obtained a competency assessment in October 2020 from the Center for Personalized Education for Professionals (CPEP) that resulted in practice improvement recommendations that included an education preceptor and continuing medical education. MD thereafter submitted a two-phase Compliance Plan which was based on the CPEP assessment and approved by the Board's Office of Medical Director (OMD). Phase I consisted of working with an educational preceptor and taking CME courses. Phase I has been approved as complete by the Board's OMD. Phase II contemplated removing the prescribing restriction contained in the 2020 Consent Order, taking further CME, and continuing to work with an educational preceptor. The Board reviewed MD's successful Compliance Plan progress in January 2022 and determined that the prescribing restriction contained in the 2020 Consent Order should be removed and	

		that MD should proceed to Phase II of her Compliance Plan.	
EVANS, Michael Allen, MD (200001370) Wilson, NC	03/28/2022	MD's license to practice medicine was reinstated by Consent Order in September 2021. He has a history of substance use disorder more specifically described in Consent Orders issued in June 2012, January 2013, and September 2021. The 2021 Consent Order limits MD to working a maximum of fifteen shifts per month. In February 2022, MD informed the Board's Compliance Coordinator that his employment had changed and requested that the Board lift the restriction limiting his work to a maximum of fifteen shifts per month. MD appeared before the Board for an investigative interview in March 2022, and discussed, among other matters, his request to lift the work shift restriction and potential new employment. MD is in compliance with his North Carolina Professionals Health Program (NCPHP) agreement and NCPHP supports the lifting of the work shift restriction and new employment opportunity.	Amended Consent Order; MD no longer restricted to working a maximum of fifteen shifts per month
TEMPORARY/DATED LICENSES: ISSUED, EXTENDED, EXPIRED, OR REPLACED BY FULL LICENSES			
NONE			

COURT APPEALS/STAYS			
NONE			
DISMISSALS			
NONE			