Negligence Issues;

Plantation FL
Licensee
1/31/12 Public Letter of Concern Re; FL Settlement agreement/Probable malpractice for issue occurring in FL
Wrong-site surgery of spine

Wilkesboro NC
Licensee
7/21/07 received a Reprimand for inadequate practice of medicine
2010 Consent Order Amended requested correction of order
1/25/2012 Consent Order Amended to allow physician to leave OB-GYN and work in Primary Care only

Wilmington NC
Licensee
6/2007; Public Letter of Concern due to discussing private life, which made patient uncomfortable
6/2008; Consent Order after errors due to 2 second trimester abortions, one of which required total hysterectomy, mandated to education on 2nd trimester abortions and had to be monitored doing them for a period of time afterwards
1/2012; Public Letter of Concern due to inadequate supervision of PA-C who covered his practice when he left for vacation

Jacksonville NC
Licensee
3/2008; Public Letter of Concern for giving IV Rocephin, High-dose steroids, over-testing by both the physician and his PA
8/2010; Reprimand, 6 month suspension/stayed for all but 30 days & Consent Order due to above and inadequate record keeping, mandated Continuing Medical Education (CME), within 1 yr needed to do CME on Mgmt of common community-acquired respiratory infections and steroid use and IV Therapy, all medical records completed within 72 hours of patient visit and physician to co-sign every mid-level entry within 72 hours
1/13/2012; Public Letter of Concern for not obtaining CME above and $1000 fine

Beulaville NC
Licensee
3/2008 Pt. "A with Chronic Obstructive Pulmonary Disease (COPD) or emphysema presented to ED with exacerbation, admitted to hospital for treatment for COPD, Congestive heart failure (CHF), Atrial Fibrillation (AFib), Pneumonia, pt placed on oral potassium supplements. Hospital day 5 Nausea/vomiting/Abdominal Pain (N/V/abd pain), Lab→elevated potassium/creatinine, physician aware, didn't alter supplements, no investigation of renal insufficiency or change of therapy, patient died that day of cardiac arrest probably due to hyperkalemia Advised to take more CME's
1/10/2012 Public Letter of Concern; Med-Mal Pmt.

*****PLOC seems light; reprimand and CME's would have been more appropriate**

Southern Pines NC
Licensee
1/3/12 Public Letter of Concern due to no signed supervisory agreement in office
1/3/2013 Public Letter of Concern due to signed prescriptions that he allowed the nurse to complete, ignored evidence that patients he was prescribing controlled substances to were actually addicts.
***** 1/3/13 Reprimand may have been more appropriate**

Morehead City NC
Licensee
9/2009 Consent Order/Reprimand/one-year probation Unprofessional Conduct due to removing skin tags and other minor procedures without wearing gloves, no steam-sterilizer in office/using bleach and detergent instead of sterilization, outdated drugs and test-kits in his practice, was forbidden to ever own, manage or operate a medical practice
2/28/2012 Consent Order Amendment; now allowed to own his practice but must first notify the board and prove that he maintains sanitary conditions

Charlotte NC
Licensee
2/27/12; Consent Order/Reprimand; Needs to take CME courses due to being Overly indulgent with pain meds
3/2012; Consent order amended
4/2013; Relief of all consent order obligations

Linville NC
Licensee
2/17/2012; Consent Order/Reprimand/12 months probation/may not give>5d course of class II-III medications due to over-prescribing of controlled substances

Davidson NC
Licensee
2/26/12; Consent Order/Reprimand/$10,000 fine for importing non-FDA approved drugs from Canada

Atlanta GA
Licensee
2/16/12 Reprimand and license inactivated; Had 3 bad outcomes on laparoscopies in Sylva NC, had reduction in hospital privileges, failed to notify NCMB of reduction, will need to appear before NCMB for hearing if he wishes to return to NC

Dallas TX
Licensee
2/15/12; Non-disciplinary Consent Order; Internet-based practice/telemedicine, was not examining patients prior to writing Rx's

*****Lenient**

Charlotte NC
Licensee
1/2008; Consent Order, 90-day suspension followed by indefinite probation, must take a course on compliance issues with NCMB, must examine patient prior to prescribing worked for Internet company/telemedicine, failed to physically examine patient, had prescribed controlled substances to self
7/2010; Public Letter of Concern; owns a tattoo parlor which she's not allowed to do
3/2011; Voluntarily surrenders license
2/2012; Consent Order; Indefinite suspension. Was prescribing to herself and spouse via Internet; Ultram, Prednisone, Lisinopril, Testosterone, Schedule III substances via telemedicine to two patients, Testosterone, had inactive DEA license since 2007

Fayetteville NC
Licensee
2/1/2012 Public Letter of Concern; Lack of signed supervisory agreement at place of employment.

Morehead City NC
Licensee
7/2004; Patient "A" admitted for Gastric Bypass Surgery, following day tachycardic/Shortness of Breath (SOB), Chest X-Ray (CXR) of 7/22/04 revealed Left Lower Lobe (LLL) infiltrate; antibiotics started, symptoms persisted, 7/25/04 revealed anastomotic leak, repaired in Operating Room (OR), Pt developed sepsis/complications. Board concerned that leak wasn't suspected sooner.
2/14/2012; Public Letter of Concern due to 7/2004 complication of surgery, MedMal Pmt

China Grove NC
Licensee
3/29/12; Public Letter of Concern. Prescribing Methotrexate for Psoriasis, patent developed cirrhosis. Practitioner neglected to do Liver Function Tests (LFT's). MedMal Pmt.

Charlotte NC
Licensee
3/22/12; Public Letter of Concern; Runs an IVF clinic, patient tested for Cystic Fibrosis (CF), nurse mis-charted entry as negative for CF, baby had CF when delivered/physician had missed abnormal lab due to nurse charting error.

Jefferson NC
Licensee
6/14/07 Patient "A" a new patient in the urgent care clinic with Shortness of Breath (SOB)/fatigue/swelling/loss of appetite/lower extremity swelling, CXR showed CHF with history (Hx) obesity/Diabetes Mellitus (DM)/Hypertension (Htn), random sugar 315, UrinAlysis (UA) showed glucose and ketones, was prescribed additional

medications and restarted medications that patient had stopped 6 weeks earlier, did not do EKG, scheduled follow-up (F/U) visit in a week but failed to refer patient to any specialist for any additional care, patient died 2d later.
3/21/12 Consent Order; Public Letter of Concern Re; 6/1/07;
*****Light discipline Unclear of this was MedMal**

Windsor NC
Licensee
3/20/12 Public Letter of Concern; Missed diagnosis of retained Foreign Body in thumb, later found by surgeon and removed.

St. John FL
Licensee
12/2006 Patient "A" discharged from hospital with Diagnosis of Anemia 2' to Dysfunctional Uterine Bleeding. The following day patient evaluated in ED for continued complaints with Hemoglobin 5.7 and Platelets 80K, 4 days later patient taken to ED in cardiac arrest then died of myocardial ischemia 2' to anemia
3/2012 Public Letter of Concern due to above after notice from malpractice carrier

Pinehurst NC
Licensee
3/15/12 Public Letter of Concern from 3/2012 wrong-site/side spinal surgery

Fayetteville NC
Licensee
3/2010 Consent Order/Suspension-immediately stayed; in the future before 2nd trimester abortions are permitted he must observe 10 procedures then be observed doing 10 procedures, then notify NCMB upon completion
10/2005 Outpatient dilation and evacuation (D&E) /abortion, uncontrolled bleeding uncontrolled with uterotonic agents, clamp applied to control cervical bleeding, patient taken to ED, Surgeon left clinic unattended to go to ED where significant laceration at cervical-vaginal junction was repaired in the OR
OB-GYN had done 2nd trimester D&E as an outpatient 6/18/09; 7/10/09 still bleeding with significant cervical laceration and retained suture needle in cervix requiring emergency hysterectomy
3/13/2012 Consent Order; 12-month suspension all but 90 days stayed. Medical Director @ HRC NC, a professional corporation based in TN, while doing bio-identical HRT, patients were not given information Re; side-effects of Hormone Replacement Therapy (HRT), Off-label use of Femara for feminization effects/not FDA approved.
*****Harsh**

Albemarle NC
Licensee
2011 Consent Order; 6-month suspension immediately stayed, must take CME course of 10 hours. Narcotic prescribing is without clear indication or safeguards in place
3/1/2012; Order of relief of obligation.

Charlotte NC
Licensee
4/12/10 Pt. "A" Presents to ED with diarrhea, mid-epigastric pressure, Left upper extremity pain, physical, labs all within normal limits (wnl), 2 EKG's an hour apart while having chest pain, EKG evidence of ischemia present but interpreted as non-specific, given IV Zofran and GI cocktail, responded to treatment for presumed gastroenteritis, given Rx for Pepcid, advised that CardioVascular (CV) event could not be ruled out, to see primary care physician (PCP) within 2 days, Pt. (discharged) DC'ed from Emergency Dept. (ED)
4/14/10 pt. returned with cardiac arrest from Left anterior descending artery coronary thrombosis/occlusion
4/30/2012 Public Letter of Concern due to Malpractice Issue; "failure to conform to standards of current medical practice".

Oxford NC
Licensee
3/2011 Pt. "A" referred to evaluate persistent tongue pain/bleeding since 9/2010, initial exam shows ulceration of L side of tongue Compatible With (C/W) Squamous Cell Carcinoma (SCC), no airway compromise, Biopsied (Bx'ed) several days later. Unable to be intubated after anesthesia, Bx done without secure airway, complicated by loss of airway, pt. expired
4/30/2012 Public Letter of Concern; failure to maintain standard of care. It's unclear if this was due to a MedMal pmt;
*****if not a MedMal pmt, a letter of concern is to lenient**

Asheville NC
Licensee
1/2007 Pt "A" admitted for evaluation of SOB/intermittent chest pain, CT Scan showed enlargement of R superior mediastinal mass, Bx recommended, both physician and PA were aware that the scanner reversed images on the monitor but did the Bx on the wrong side, puncturing pulmonary artery causing pericardial tamponade and death.
4/24/12 Public Letter of Concern Re; failure to adhere to standard of care.
*****If this was due to a MedMal Pmt, it's in keeping with other providers, if it was not due to a medMal pmt, it is to light of a disciplinary measure**

High Point NC
Licensee
4/20/12 Consent Order/Reprimand, unable to prescribe Class II or III controlled substances, NCPHP Competency evaluation and training.
4 year period of prescribing medications non-emergently for family and friends without documentation.
12/2012 Amendment Consent Order; is in compliance, still unable to prescribe II/III
1/2013; Released from all restrictions.

Moncure NC
Licensee
1/2011 Investigation by NCMB by prescribing pain meds, NCMB requested that she take CME classes which she did, F/U investigation Pt's A-E for pain and other conditions were found to be treated below accepted standards of care, given 30d to transfer her pain pt's to another provider if they require Schedule II-III medications
1/2011 Consent Order agreeing to above after investigation
4/20/2012 Order of relief of obligations but will undergo further inspections

Paduca KY
Licensee
12/2006 Pt "A" Discharged (DC'ed) from hospital with Diagnosis (Dx) Anemia 2' to Dysfunctional Uterine Bleeding (DUB), returned the following day to the ED with chest pain/Shortness of breath (SOB)/continued vaginal bleeding, PA on duty assessed pt., reviewed labs from recent hospitalization with Platelet count 8K, Hemoglobin 5.7, Pt DC'ed from ED, physician did not examine but did sign off on the chart. 2d later to ED via Rescue, died due to ischemic cardiac arrest
4/20/12; Public Letter of Concern/failure to meet standard of care. MedMal Pmt

Red Springs NC
Licensee
2/2007 Consent Order found poor record keeping of all controlled substances on pt's A-E, given 2 year suspension, all but 30 days stayed, probation for the remainder, physician must be on-site at all times.
7/30/09; requested relief of consent order probation
2/26/10; Partial relief
4/19/12; relieved of all probationary obligations

New Bern
Licensee
3/2008 Voluntarily surrendered license
7/24/08 Requested reinstatement, told to have evaluation @ Acumen in 2009 which indicated areas in which he needed improvement
10/13-14/2009 given education program followed by another assessment which required further education
9/2010 Consent Order related to above
3/2011 Full license reinstated
4/19/12 order for partial relief of obligations
No evidence on website as to what obligations were or what necessitated same.

Licensee
3/2004 Consent Order/Reprimanded, given 6 months to have evaluation
4/2010 Diagnosed Pt "A" with DM, started Metformin 1000 mg bid, went to ED, no evidence of Diabetes (DM) but had uncontrolled hypertension (Htn), labs never supported Dx of DM, Htn was not addressed
5/2012 Consent Order took assessment from Medical Director of the NCMB

*Reason for evaluation unknown/cannot open on NCMB website

Bolivia
Licensee
10/2007 Pt "A" presented to ED after Motor Vehicle Accident (MVA) with Right upper extremity (RUE) pain and R ear laceration, hematoma RUE, surgical dressing to ear and XR's of arm, Pt discharged DC'ed with pain meds R ear avulsion instructed to Follow Up (F/U) with Private MD (PMD) in 2d, the following day found unresponsive at home, brought to ED revealing large R subdural hematoma, referred to a tertiary center where he died of injuries.
4/17/2012 Public Letter of Concern due to Malpractice Payoff

Decatur AL
Licensee
4/12/12 Public Letter of Concern
No NC License, analyzes sleep lab results in AL

Charlotte NC
Licensee
11/2010 Scheduled partial gastrectomy based on EsophagoGastroDuodenoscopy (EGD) for probable gastric malignancy, no pre-surgical consultation with thoracic surgeon or oncologist was scheduled, no staging imaging was done. Pt was found to have esophageal cancer
Patient had significant post-surgical complications necessitating 26 day hospital stay
4/12/12 Public Letter of Concern Re; Above
*****Seems like light discipline**

Los Angeles CA
Licensee
1/2009 Pt "A" seen to schedule Radiation Therapy (Radtx) for lung cancer Right Middle Lobe (RML), seen with supervising resident who mistakenly entered that tumor was in L lung, patient had 32 radiation treatments to L lung, transcriptionist noted the error. RML treatment was then undertaken. Patient died after completion of treatment
4/4/12 Public Letter of Concern due to malpractice claim

Fayetteville N
Licensee
4/3/2012 Given Consent Order/Reprimand for allowing one of his PA's of his pain clinic to sign Rx's for another PA in his clinic who was not allowed to write for controlled substances instead of the physician signing off on those Rx's
9/2013 Given NPA until NCMB relieves him of it.
3/3/14 Consent Order Indefinite Suspension
*****Why an indefinite suspension on an NPA? What needs to be done to relieve the suspension?**

Oxford NC
Licensee
3/2011 Patient "A" presents for outpatient biopsy (Bx) of lesion on tongue. Anesthesiologist CNRA attempted to establish airway but failed, patient died of respiratory distress due to lack of endotracheal intubation
5/29/2012 Public Letter of Concern after malpractice award

Poplar Bluff MO
Licensee
3/17/11 NCMB learns of Malpractice award from actions of 2/13/09 after laparoscopic hernia repair with mesh and cholecystectomy which lead to complications requiring a second surgery 11 days later, became septic, required prolonged mechanical ventilation, tracheotomy, complicated post-operative course.
3/2011 No response to multiple letters sent to him.
6/2011, 7/201 no response to messages left at his office
5/10/12 Reprimand for failing to respond

Asheville NC
Licensee
7/2011 Investigation of prescribing practices after complaints from local pharmacies
On 4 occasions from 8/4-9/13 2011 on each occasion without physical exam or medical justification gave Rx for 10-15 mg Oxycodone tabs to Patient "A" who was an undercover policeman and falsified reason and other notes for the visit.
6/22/12 Consent Order Indefinite suspension

Moorseville NC
Licensee
7/28/09 Patient "A" presented to ED with Nausea/Vomitting/Fever/Abdominal Pain (N/V/F/Abd) pain X 3d, CT Scan→acute appendicitis, laparoscopic appendectomy, did well, was sent home the following day, then…
8/3/09 N/V/bloating/constipation, re-admitted with dehydration with elevations of BUN/Creatinine signifying kidney problems and/or dehydration.
8/4/09 Small Bowel Obstruction (SBO) noted on CT,
8/5/09 sent home after clinically improved
8/8/09 Expired, post-mortem showed necrotic appendical stump and abdominal abscess
6/11/12 Public Letter of Concern 2' to prior malpractice event.

Gastonia NC
Licensee
4/28/10 Patient "B" was to have surgery L eye, spouse insisted it was the R eye, discrepancy with incorrect paperwork was reconciled but not noticed until patient was already in the OR, unacceptable
5/12/10 Patient "C" arrived in the OR for lens implant to the R eye, that eye had already had the lens replaced, the L eye was due to be operated, wrong-site surgery was prevented by the OR staff.

7/28/10 Patient “A” presents for lens implant to correct cataract, was prepped for surgery brought to the OR, is 66 yo with cardiac history, anesthetist anesthetized the patient without the surgeon knowing which lens to insert into the patient. Surgeon left the OR to go to his office to look up the correct power lens, 45 minutes later the patient had been moved from the OR
8/4/10 Placed on precautionary suspension after Dr. left OR while preparing to perform cataract surgery on patient “A” and had been inattentive in the OR, had paperwork indicating the wrong eye for surgery. Staff caught errors prior to surgery.
11/2/10 repeat suspension of hospital privileges when the incorrect powered lens was inserted in patient “D”.
12/2010 NC Physicians Health Plan (NCPHP for impaired physicians) initial assessment was done, appeared unkempt/disheveled and had no insight into his situation, referred to Acumen for further assessment which he never reported to, requesting his license be placed on inactive status
6/11/2012 Hearing scheduled, given non-disciplinary consent order to inactivate license

Charleston WV
Licensee
1/2006 Consent Order Reprimand/NCMB concerning 6/2005 WV consent order for unprofessional conduct for allowing a minor to witness a procedure that the patient had not given consent for the observation.
11/14/11 WV Consent Order due to repeated infections in his WV pain clinic and delegating responsibility to a person not trained to do procedures that were assigned to that person in WV in 2009
6/7/2012 NC Public Letter of Concern

Wilmington NC
Licensee
4/2010 Law enforcement notified NCMB that Dr. Dyer was under investigation by law enforcement, he had not renewed his medical license 5/3/10
5/11/10 License suspended by NCMB due to law enforcement investigation for diversion of controlled substances by physician License revoked
3/14/12 Entered Alford Plea for 3 counts of prescribing controlled substances without justifications and 2 counts of attempting to traffic in opiates, all of which are felonies
6/7/12 License Revoked/Physician requested hearing

Hamlet NC
Licensee
9/27/12 Amendment to Consent order of 10/28/11
Pt. “A” fetal distress on monitor ignored/child dies
Pt. “B” induced labor, fetal distress unaddressed
10/2011 Suspension x 1 yr. immediately stayed, required 9 month OB-GYN mentor and pmt. of $5K fine
9/2012 Relief of Consent Order, required further education on fetal heart monitors

Greenville NC
Licensee
8/2010 dispensing Soma to pt. “A” to help wean pt. off of Xanax, he had given the Pt. “A” a bottle of outdated Soma with label of another patient on it, and it was outdated. NCMB investigator found numerous old bottles from former patients who didn’t use their medications, some outdated in the office. Patient “A” had been originally prescribed Xanax by a prior psychiatrist. Patient went to the pharmacy, showed him the Soma bottle, was referred back to Dr. Acosta and stopped taking her Xanax until she had withdrawal symptoms and was hospitalized by a psychiatrist for 3d of withdrawal.
3/13/12; Reprimand after Investigator collected records and meds on patient “A”-“F” and had failed to comply with accepted medical standards, must take classes on Record keeping and prescribing
8/2012; CME requirements fulfilled, under probation, periodic monitoring by NCMB
*****an unusually light disciplinary action, Soma does not Detox from Xanax!**

7/17/12
Dearborn MI
Licensee
7/17/2012 Consent Order and non-disciplinary public letter of concern and $2000 fine due to malpractice issue,
Urologist, 2/1/11 Settlement on malpractice issue. Repeated refusals to respond to NCMB
8/2011 NCMB started attempting telephone contact to his office, NCMB was advised that Dr. Nutting would not renew his NC license
8/2011 Email from NCMB ignored

Dunn NC
Licensee
3/2006 event when pt presented to ED with burning epigastric pain radiating to back, received labs/EKG/Chest XR (CXR). Labs showed minimally elevated myoglobin and new 2-3 mm ST elevation and T-wave changes Compatible With (C/W) Myocardial Infarction (MI or “heart attack”) reflected on chart, sent pt home with
Dx’ GastroEsophageal Reflux Disease(GERD). Pt died. Public Letter of Concern included Continuing Medical Education (CME) on EKG interpretation
7/16/12 Public Letter of Concern due to malpractice issue

Charleston SC
Licensee
8/29/12 Public Letter of Concern after malpractice event that lead to pt’s demise

Harahan LA
Licensee
2011 Louisiana Medical Board (LA MB) investigated controlled substance prescribing and Complementary and Alternative Medicine (CAM) practice, fined $3000, told to comply with LA rules Re; Integrative Medicine, needs an approved practice monitor, cannot prescribe Schedule II or III, CME on Family Practice and Medical Ethics

8/27/12

Hendesonville NC
Licensee
1/2005 Consent Order/Reprimand because she allowed an RN who was assumed to be a RNP to see patients.
8/21/2012 Reprimand for a doctor-shopping patient that she didn't catch, she was not allowed to prescribe controlled substances or Suboxone except for inpatients, must complete 10 hours of Category 1 CME on record keeping

Raleigh NC
Licensee
2007 Owner of orthopedic practice did surgery on Lumbar spine level L2,L3,L4 decompression 9/2007 patient transferred to Post-anesthesia care unit/recovery room (PACU) 0900 stable, 1545 patient had weakness and decreased sensation of both lower extremities (BLE), 1900 the only on-call provider for the group called reporting same with additional bladder incontinence. He contacted primary supervising physician, not Dr. Nelson who had done the surgery, 0419 patient had nausea, lower abdominal pain, weak/numb legs, ordered Phenergan for nausea, did not contact supervisors, 0900 after surgery, Dr. Nelson reviewed chart, complaints etc., 0902 ordered MRI, 1400 had epidural hematoma, 1600 hematoma removed, a rare but recognized complication.
8/20/2012 Consent Order Reprimand for unprofessional conduct.
***** incredibly light discipline; supervising physician should also have been disciplined**

Charlotte NC
Licensee
8/15/12 Consent Order/Reprimand after his RNP Dispensed 48 controlled Rx's for a patient within 3 months, one of his midlevel Registered Nurse Practitioners (RNP) Adams was using the pills with the patient, he provided inadequate supervision to his midlevels. Between 11/25/11 and 2/16/12 30 Rx's for Oxycodone, 14 Rx's for Hydrocodone written by RNP Adams who was getting medications from this patient as well. Dr. Edwards was not meeting with RNP Adams per regulations to review Adams' care.

Durham NC
Licensee
8/14/12 Consent Order; suspension for 12 months immediately stayed for all but 30 days, full license after thirty days
Physician practiced medication at times in Wake County working for a professional corporation headquartered in TN. This company was founded to provide bio-identical hormone replacement therapy. He supervised a mid-level practitioner, licensed by the VA Medical Board (VAMB) as a nurse practitioner and RN but not licensed in NC. Patients "A" through "C" received substandard care without documentation of a history and physical in their charts, vital signs were not documented, mammogram results and/or breast exams were not checked prior to starting therapy, therapy was given despite

normal lab parameters such as Estradiol, Progesterone and Testosterone. Progesterone can increase coronary artery diseases, the nurse provided the surgical procedures with an excessive dose of lidocaine. Patients were injected with Vitamin B12 despite normal serum B12 levels. The CEO of the Company, Dr. Hale is licensed in TN but not in NC, yet directed the therapy with Dr. Syed's role as being a "figurehead" as the nurse treated patients per Dr. Hale's protocols. Dr. Syed did not directly direct care nor supervise the staff, which constitutes unprofessional behavior

***** As an employee, how was he to know what her credentials were/that she was licensed in VA not NC, the employer was responsible for ensuring she had correct credentials. It could be argued that as supervisor he should have gone the extra step, but that's taken as a "given" that she'd be legal. He was simply following his boss's orders.**

Charlotte
Licensee
9/2008 Consent Order; Charged with over-testing, illegible records, ordered to take CME classes in proper record keeping.
2010; no improvement, records illegible
8/1/2012; Non-Disciplinary Consent Order; over-testing, wrong diagnosis, wrong therapy for patient "A", investigator for NCMB also randomly chose patients "B, C, D, E" but investigating committee of NCMB could not determine whether standards of care had been violated. Ordered to have a professional assessment of skills then an interview with the NCMB.

*****This is excessively light/ineffective discipline. What was accomplished in 2008 with an incompetent provider? He should have probably been suspended until he had proven competence at an outside testing/consulting agency**

Greensboro
Licensee
9/24/12 Public Letter of Concern due to malpractice 2008, 2009 radiologist for SE Over-read services.
9/2007 read screening mammogram, report noted normal findings with benign calcifications among moderately dense breast tissue. Outside experts noted assymetric density in superior lateral breast quadrant, recommending further views.
On 9/2008 there was a suspicious mass in the same breast, superior lateral quadrant; there was delay of diagnosis and treatment.
4/2009 Interpreted B breast US on patient "B" in FL, on F/U US 9/2009, multiple solid nodules R breast and axilla were present, Dx'ed with breast cancer, currently being treated after delay of diagnosis.
NCMB recommends CME then notify the NCMB.

Cleveland NC
Licensee
2006 Consent Order/Reprimand for failure to supervise midlevels who were doing false testing and billing

9/11/2012 inappropriate controlled substance prescribing, inadequate charting patients "A-F" failed to conform to standards of medical care, insufficient diagnostic approach and medical history obtained, no corroborating physical signs of illness, failed to address abnormal findings or document adequately communication with patient
6/4/12 Indefinite suspension but may re-apply at any time if he maintains a NCPHP contract and has their advocacy. Will not prescribe controlled substances for 1 year except as otherwise permitted by NCMB (immediately stayed)
*****How did the NCMB let this guy go for 6 years without periodic chart audits? Indefinite suspension seems quite harsh from what is available. Needs NCPHP evaluation for competence/CME orders**

Durham NC
Licensee
10/2010 Consent Order/Reprimand, probation for 6 months, has 4 months to have another physician to review records of patients being treated for psychiatric and pain issues, must meet with monitoring physicians twice monthly to review psychiatric and pain management issues. Shall comply with NCMB Medical Record Documentation position paper and policy for use of controlled substances for the treatment of pain and pain mgmt./end of life care. No time off of work.
Giving Diazepam, Oxycodone, Hydrocodone, Oxycodone-ER, Temazepam, Alprazolam and Tussionex; failed to perform to the standard of care, failed to monitor drug testing for compliance issues, escalating opiate treatment without documenting reason for escalation, failed to document liver function to R/O acetaminophen induced hepatotoxicity, escalating opiate treatment without documenting reason for escalation, prescribing overlapping refills of opiates with documenting reason for early renewal of Rx's. Records for four additional patients reviewed, failed to provide legible adequate documentation to support diagnosis and treatment of patients "B-E", violating acceptable standards of medical practice
7/2011 NCMB received complaint from ED physician of UNC who had seen patient "A" with acute psychosis/delusional parasitosis, the patient had been prescribed large numbers of opiates; "outrageously inappropriate doses of opiates which may have caused or worsened the psychosis". ED Physician attempted to contact prescriber who was out of town,.
9/2011 NCMB received a complaint from a high school social worker concerned about patient "B" prescribed 6 mg of Xanax and 60 mg Vyvanase bid with student unable to function at school. Patient "B" had expressed to prescriber that he "was having trouble selling his pills". Prescriber wrote a letter to the school that there was no risk in giving these medications to patient "B"
9/2011 NCMB received complaint from a pharmacist in ME, indicating that patient "C" had received Rx for Xanax, Oxycodone, Hydrocodone, Vyvanse, Valium, Adderall that had been filled at 11 different pharmacies in the Augusta ME area
12/2011 and 6/2012 NCMB received complaints from two local pharmacies about quantities of controlled substances by said Dr to his patients, also frequently authorized early RF's of the controlled substances for his patients, especially Oxycodone. One of the local pharmacists described particular concern Re; patient "D" Oxycodone 15 mg #360 11/17/11 then Rx'ed #720 Oxycodone 30 mg 11/19/11.

NCMB obtained records from patients "A-D" which were reviewed by a forensic psychiatrist who opined failure to comply to standards
6/2012 Partial Summary Suspension of License; may not prescribe controlled substances as described by the DEA
6/2012 Hearing for partial stay of suspension. So that he can continue to take care of his at-risk patient, motion to stay denied
9/5/2012 Actual Facts Findings, granted an appeal by Wake County Superior Court
10/1/12 Indefinite suspension, may not reply until after 1 year has elapsed
1/2013 Appeal to Wake County Superior Court in process

Greenville NC
Licensee
9/2011 Complaints to NCMB about practice lead to assessment of medical skills, report 3/14/12; demonstrated medical knowledge to an acceptable level in most areas
9/4/12 Consent Order/Public Letter of Concern to fulfill and complete all educational requirements advised by his evaluators within 1 month of this order.

Roanoke Rapids
Licensee
11/30/06 Patient "A" presented to ED with severe Headache/dizziness/heavy bleeding, initial exam by ED physician who ordered lab work and blood transfusion, consult done due to heavy uterine bleeding. Lab also revealed low platelets and elevated serum bilirubin that was not reported to you. Patient diagnosed with severe anemia 2' to Dysfunctional uterine bleeding, morbid obesity, was transfused, placed on oral contraceptive taper and serial hemoglobin/hematocrit blood counts. Discharged 12/2/06 with F/U appt in office in 2 weeks
12/3/06 Returned to ED, assessed and discharged by ED staff
12/4/06 cardiac arrest, died of myocardial ischemia, died due to microangiopathic hemolytic anemia; at the time of the above treatment patient suffered thrombotic thrombocytopenia purpura. Failed to diagnose condition.
Late October to December 13th 2011 allowed an unlicensed PA to work as a PA-C in his office for the direct purpose of continuing her education
8/1/2012 Letter of Concern Re; NCMB investigation from patient "A" of 11/30/06 MedMal Pmt
10/11/12 Consent Order/Reprimand Regarding unlicensed PA working in office, within 6 months must pay $3000 fine, reimburse patients and their insurers that were seen by the unlicensed PA and within 4 months can ask for relief of this.
4/2013; Relief of obligations

Asheville NC
Licensee
10/9/12 Public Letter of Concern Re; Malpractice 2011 concerning patient of 2/2006, 42 wk Estimated Gestational Age, thin meconium stain upon Rupture of Membranes, external heart monitor placed which showed that the final 4 hours of labor showed fetal distress; fetal heart decelerations were noted with poor tracings during the last hour. Patient was taken for emergency C-Section, baby born with neurologic injuries

Wilson NC
Licensee
6/2011 Consent Order/Reprimand
Provider had 6 chart reviews done due to poor record keeping, mandated to CME's, and a mentor who must review 75% of chart
10/2/12 Relief of restrictions

Flushing NY
Licensee
5/2003 NYMB Consent Order for Probation/3 year suspension immediately stayed, probation for the remainder and must take ACLS class and anesthesia practice restricted to hospital setting for 5 years
Patient "A" for termination of pregnancy in an outpatient center
12/31/12 NCMB Issues Public Letter of Concern when he applied for NC license assuming that 5/2003 was MedMal pmt

Charlotte NC
Licensee
12/20/12 Consent Order 12 month suspension/immediately stayed other than 30 days which were divided into 2 15 day increments
Locum tenen in Rutherford NC, saw patients over a 5 day period of time, on arrival at the job she was told the other physicians had retired, in actuality they had both been suspended due to prescribing controlled substances inappropriately. The wife of one of the suspended physicians was a therapist and was running the practice in her spouses absence. Dr. Alexander had been seeing >100 patients/d, had to surrender his DEA license etc.
12/13/11 NCMB obtained report from controlled substances database that Dr. Black was prescribing Friday 7/15/13, Friday 8/26/11, Friday 10/7/11, Friday 12/9/11 and Friday 12/10/12. According to patient records obtained, Dr. Black did see each patient but saw as many as 60 patients/d, many of whom had complex psychiatric conditions. Dr. Black's care fell well below standard of care. All of those patients were scheduled for 20-30 minute patients
*****Seems to be excessive discipline; she was a temporary employed physician who had been lied to, who was worked like a dog and had no say in patient volume. She was victimized by her employer and suspended by the NCMB. What action was taken against the clinic?**

Winston-Salem NC
Licensee
6/30/11 Change in staff privileges for this gastroenterologist. Stamey Regional Medical Center privileges for Endoscopic Retrograde CholangioPancreatography ERCP were suspended effective 6/7/11 as a result of a perforation event on patient "A" of 6/6/11. Hospital notified NCMB, provider did not notify NCMB as is required for licensure; apparently he failed to disclose, as such a Reprimand is appropriate, had he disclosed, a public letter of concern would be appropriately.

NCMB found unacceptable patient care
12/20/12 Consent Order/Reprimand

Zebulon NC
Licensee
10/2007 Consent Order for Remedial Education Training, shall not treat chronic pain
After review of numerous records, was sent to center for personalized education for physicians (CPEP) revealing that there is the need for improved knowledge in several clinical topics, needs to obtain a mentor and take specific CME
1/2008 Approval for Mentor/Practice site
12/2012 Release from Consent Order

Burlington
Licensee
12/13/12 Public Letter of Concern Re; Failure to meet standard of care/MedMal issue
Patient "A" discharged from hospital after care for cardiomyopathy, sent to SNF on Coumadin, notes written on Lab report, not SNF order sheet to Discontinue Coumadin. Complications occurred, re-admitted to hospital, died

Richmond VA
Licensee
6/14/06 licensed in VA
6/24/11 While in VA, Patient "A" had ambulatory surgery, Dr. Stone was the anesthesiologist, after surgery he administered phenylephrine instead of a steroid, informed patient of his error, patient was admitted to the ICU due to hypertensive episode followed by post-operative hypoxia/low oxygen levels and spent 4 days in the hospital instead of having an outpatient/same day surgery
1/17/13 Consent Order/Reprimand in NC despite the fact that the episode happened in VA and probably warranted a Letter of Concern if it had been a MedMal Pmt, but no evidence of such was on the NCMB website.

Bayboro NC
Licensee
Complaint of excessive prescribing to patient "A" with numerous phone requests for replacement of medications and early refills, poor record keeping.
2/26/13 Public Letter of Concern mandated CME.
*****very lenient, should have at least been reprimanded**

Charlotte NC
Licensee
2/2/13 Reprimand; Mandated to stop inappropriate prescribing, start continued improvement regarding urine drug screen results, ancillary studies, medical record documentation and communication with consultants
*****Similar to Dr. Dunn, why was one reprimanded and the other given a public letter?**

Lenoir NC
Licensee
Licensed in 2008 Gastroenterologist
2008 Public Letter of Concern resulting from Michigan Medical Board who had given him a consent order in 2/1997 and mandated to take CME on medical documentation
4/2009 Patient "A" Colonoscopy and laser therapy of Arterio-Venous Malformation (AVM) resulting in bowel perforation
5/2009 Patient "B" Screening Colonoscopy and biopsies, patient discharged home, developed abdominal pain due to perforation requiring prolonged hospitalization
5/2010-12/2010 Patient "A" files Complaint from patient that he didn't conform to normal practices, NCMB reviewed patient chart, independent expert concluded that standards of acceptable practice was not followed by not decreasing the dose of her medication when she became increasingly anemic, he also failed to document medication lists and lab results, care was generally substandard.
NCMB concludes that care was substandard
5/2011 Public Letter of Concern and requirement to attend CME Re Colon perforations
2/21/13 Consent Order for 1year suspension immediately stayed with mandated professional assessment by an assessment center approved by the NCMB within 6 months.
***** Very Light Sentence and NCMB negligence due to delay**

Fayetteville NC
Licensee
3/25/13 Public Letter of Concern
Patient "A" a minor involuntarily admitted to Holly Hill treatment Center. He had a long history foster homes with diagnosis of Post-Traumatic Stress Disorder/Schizoaffective disorder, had been treated with Clozaril. During the 13 day hospitalization the Clozaril was discontinued. The primary psychiatrist made attempts to contact you, but was unable to do so. Patient was discharged 7/25/11 without medications, sending her back to her foster family.
7/26/11 was seen by her outpatient therapist who resumed Clozaril, standard of care was below par due to lack of communication with her outpatient psychiatrist.

Fayetteville NC
Licensee
11/16/07 difficult cholecystectomy on patient "A", during surgery the gallbladder was necrotic/gangrenous. Patient was treated with antibiotics, became septic, and died. Malpractice settlement was paid despite lack of proof of improper care.
4/29/13 Public Letter of Concern Re; prior malpractice settlement

Charlotte NC
Licensee
2008-2009 prescribed Methadone for pain control for patients "A-D", inadequate standard of care.

10/2010 Consent order/Reprimand; limited to not do pain mgmt. and must take CME on record keeping within 6 months and must, by until 11/12/10 to transfer patients to another physician for his pain patients.
3/14/12 Amended Consent Order, must have a proper DEA license and may prescribe all controlled substances but Methadone and Buprenorphine
4/12/13 Order for entire relief of consent order obligations

Clinton NC
Licensee
2002 NCMB addressed issues form 1995-2000 that occurred at the hospital in which he was argumentative, used profanity, abused nursing staff
2000 Diagnosed with a mood disorder, treated for same, no further incidents occurred.
3/2007 Complaint to NCMB Re; pt. "A" NCMB order for assessment at Center for Personalized Education detailing areas where he needed further improvement; medical knowledge, clinical reasoning, documentation, communication skills and NeuroPsychological evaluation was recommended
2/28/08 Consent Order for Indefinite Suspension Re; treatment of patient "A", advised to have an evaluation done
CPEP assessment questioned his ability to practice medicine, is probably not safe to work. Has been cooperative, supplied letters from colleagues attesting to his skill and professionalism
3/1/08 suspended by both hospitals that he had privileges at
3/4/08 applied for reinstatement
9/23/08 NCMB denied application for reinstatement, requested Board Hearing
2008 a complaint from patient "B" was received by the NCMB Re; care given 2000 and 2001.
9/2/08 had second neuropsych eval which showed significant improvement, functioning in a normal manner, had been working with another physician as his preceptor.
12/2/08 Assessment questioned his neurological health and areas of demonstrated need for improvement.
4/2009 Consent Order; Limited to 40 hours/wk, no overnight or weekend call, maintain relationship with preceptor with Dr. Wright and must provide a written plan to carry out the CPEP recommendations, Dr. Wright shall provide monthly then quarterly then biannual reports to the NCMB. Preceptorship will be concluded when all educational needs are met.
4/9/13 Order for relief of consent order obligations.
*****Why was the NCPHP not involved in his care this would have been a perfect provider for them to be involved with and could have saved time and administrative maneuvers?**

Columbus NC
Licensee
7/21/11 Rutherford Regional Medical Center privileges suspended due to his inability to perform complex surgical procedures
8/17/11 NCPHP evaluated and recommended further evaluation/neuropsych . Results were generally favorable, provider had appropriate knowledge and judgment

1/2013 Neuro-Psych testing done evaluating his ability to function in multiple environments including office-based
3/21/13 Investigative interview with NCMB with practice of medicine discussed
4/1/13 Non-Disciplinary Consent Order; May work as a first assistant with a licensed surgeon at all times, may not perform surgery by himself unless he's being supervised by a NC licensed surgeon at all times.

Hendersonville NC
Licensee
6/2007 Assessment of professional skills
11/2007 Further evaluation of clinical skills, unorthodox diagnosis and treatments on a mock H&P, on computer evaluation of 8 patients, 4 were appropriate, 4 involved wrong diagnostic tests and preliminary assessments
Extensively uses Oxytocin to treat his patients
5/2008 Signs Consent Order; Suspended for 1 yr, immediately stayed including at least 10 hours CME within 6 months, will make all patient charts available, will not deviate from evidence-based practice, will meet with the NCMB, and not prescribe Oxytocin; will refer patients in need of it to another provider.
5/22/2013 Public Letter of Concern due to violation of 5/2008 Consent Order, fined $1K, prohibited from using Oxytocin since he had prescribed it 3/12/12 for a patient with a low level despite agreement to refer such patients to another provider.
*****Where was the NCPHP? Why was he punished for treating a laboratory abnormality appropriately involving a low level of oxytocin? This sounds like punitive action from NCMB, not rehabilitative as a Board should be acting. When an assessment is required the NCPHP is also required!**

Charlotte NC
Licensee
5/13/13 Consent Order/Reprimand
1/4/2012 in AZ, Patient "A" presents to ED with 10/10 chest pain radiating to neck, discharged with chest pain, returned to ED 3 days later, had elevated WBC count with left shift, elevated glucose, low Na & K and elevated SGOT, EKG was not done. Patient was admitted with diagnosis of gastroenteritis and dehydraton, later developed Shortness of breath, hypoxemia, cardiac arrest, death. Failed to meet standard of care.
*****Why did NC reprimand him for an issue in another state? Public Letter would have been adequate**

Rocky Mount NC
Licensee
6/8/09 Patient "A" presented for R foot surgery and left retained drill bit in the calcaneous (heel bone) which lead to severe post-surgical infections and pain, months later removed a piece of metal from the surgery site, failed to inform the patient, document the situation or locate the drill bit.
5/13/13 Public Letter of Concern due to malpractice pmt 2/13/12

Mooresville NC
Licensee
6/27/13 Consent Public Letter of Concern for Malpractice
11/22/10 Pt. presented to ED with shortness of breath/cough X 2 weeks, Dx'ed with COPD exacerbation and pneumonia, admitted under providers care. The following day patient diaphoretic/rigors/random blood sugar 305. Without examining patient provider ordered Ativan 2 mg IV and Sliding Scale Insulin, 1 hour later patient unresponsive/asystole, code blue called, resuscitation began, patient had suffered anoxic brain injury from respiratory arrest, family opted for comfort care, patient died 12/1/10.

Licensee
6/24/13 Consent Order for Reprimand reciprocal to VAMB will need periodic NCMB meetings
Has NC license but has been practicing in VA
12/2012 VAMB entered a reprimand order,
6/15/09 Patient presented to ED with Chest pain/LUE radiation intermittently for 1 year but recently worse, mouth had been numb the past few mornings with hemoptysis the last several mornings, BP was 154/105, EKG NST and T wave abnormalities compatible with anterolateral ischemia. He remained hypertensive while in ED, 3 hours later was discharged with Dx chest pain & Htn with 199/144 BP.
3 weeks later patient died at home of MI, Htn, rheumatic mitral valve disease
11/7/12 VAMB conference with restriction of VA license & reprimand
*****Why would NCMB reprimand him for an incident that happened in VA, this should have been a Public Letter of Concern but he didn't even have a license in NC; he had inactivated it 8/2009 before the 6/2009 case would have been filed for legal action in VA, the NCMB issued a Reprimand on somebody without an active.**

Gastonia NC
Licensee
Psychiatrist
10/10/13 directed by NCMB to attend seminar by CPEP Re; Medical Records, and further training on Documentation
1st Claim inadequate documentation/assessment, treating patients "A-F" below the acceptable standards of medical care. Patient "A" Suboxone high dose without monitoring for many months
2nd Claim Medical incompetence, evaluated by NCPHP, violation of statutes, failure to respond to NCMB in a timely manner, noncompliance with NCPHP
3rd Claim Patient "G" allegations of failure to maintain acceptable standards of practice due to failure to respond to patient's numerous phone calls for medication refills and failure to respond to NCMB's inquiries
6/20/13 Consent Order/Reprimand, license on indefinite probation, needs practice mentor approved by NCMB with quarterly assessments of patient care, medical knowledge and professionalism with monitoring until monitor and NCMB are satisfied with standard of practice. $1K fine, NCPHP through 5/2017
***** Multiple patients in 3 claims, refuses to respond to the NCMB's attempts, and he only receives a reprimand? This was extremely light discipline.**

Forest City NC
Licensee
12/2010 SC reciprocates with NC
6/2010 Consent Order for stipulations below
NC between 2004-2009 provided psychiatric treatment to patients "A-F" and treated their pain issues. Prescribing practices initiated an investigation by the NCMB.
Records of patients "A-F" were provided to consulting psychiatrist and pain mgmt. specialist and fell below the standards of care. Provider neither admits nor denies, ordered to stop pain medicine and prescribing Schedule II or III for treatment of pain, shall obtain a physician assessment within 30 days and follow all recommendations.
6/10/13 Relief of Consent Order Obligations

Raleigh NC
Licensee
6/6/13 Consent for Public Letter of Concern Re; Malpractice issue
9/2007 L2-4 decompression on patient "A" and 84 yo female without apparent complications, patient went to post-anesthesia care unit (PACU) in stable condition, then developed lower extremity weakness/numbness/continence issues, the PA on call ordered the nurse to monitor patient, later developed nausea, lower abdominal pain and worsening of the prior complaints, ultimately patient had MRI revealing hematoma within the spine, second surgery was necessary to remove

Marshall NC
Licensee
10/2005 Consent Order for Reprimand
Late 2002 Saw patient "A" whom he had treated for 7 years renewed Percocet, Valium which were appropriate. Patient "A"'s sister would pick up his prescriptions, patient "A" inadvertently had sixteen months of refills due to his incarceration in prison which fell below the standard of care. NCMB has no evidence of intent of wrongdoing, no prior disciplinary record
7/22/13 Public Letter of Concern Re; investigation for opiate therapy for Fibromyalgia with early refills, another medication was not considered, prescription of opiates was continued despite evidence of efficacy. Patient exhibited diversionary behavior, mandated to take classes, which was completed on the same day as the Letter of Concern.

Charlotte NC
Licensee
5/2013 met with NCMB committee where he admitted to self-limited, no longer providing deliveries and providing care to only 28 weeks EGA, doing only minor office-based surgeries
OB-GYN from Charlotte, NCMB became concerned Re; fitness to practice, review of 4 patient charts made by the Center for Personal Education for Physicians (CPEP) and result of Neuro-Psychology Exam. 7/22/13 Non-Disciplinary Consent Order; practice limited to no surgery other than office-based, no deliveries, may not provide care beyond 28 weeks EGA, referred to NCPHP, needs a mentor.

Durham NC
Licensee
7/15/13 Public Letter of Concern Re; Malpractice pmt
4/27/10 Patient "A" referred for mgmt. of L renal angiomyeolipoma and also had L renal hemorrhagic cyst, patient wanted to have cryoablation/destruction by freezing of the angiomyelolipoma that was not indicated, procedure was done 4/27/10 under your supervision. The L renal cyst had been inadvertently targeted the procedure was also complicated by a L ureteral injury, patient eventually required L nephrectomy.

Statesville NC
Licensee
7/10/13 Public Letter of Concern due to malpractice pmt.
2/11/12 Patient "A" a 15 yo male brought to the ED with compound Fx of radius and ulna, after appropriate emergent operative reduction/fixation you continued his follow up care as an outpatient. At subsequent visits he had deformity with increasing angulation of the fracture site. 5/2012 cast was removed, mother was concerned about angulation. You incorrectly informed mother that the deformity would fix itself over time. 6/12/12 while pushing himself up he had increased pain and swelling in the forearm. Providers partner saw patient who had re-fractured his arm. Patients mother saw another physician who performed a second operation for fixation to correct the deformity

Fort Meyers FL
Licensee
7/19/13 Consent Order for Indefinite Suspension of NC License
Licensed in 2007, had prior license to practice in FL
5/2011 FL suspended her license after she treated patients from 6/2008-12/2009, charts reviewed by an independent expert concluding inadequate standard of care with cursory exams, no adequate review of medical history or development of adequate treatment plans, failed to monitor urine samples to ensure that the patients were taking the prescribed medications. Doctor had been investigated by the Pinellas County Sheriff's Office for running a "pill mill", Rx's included as many 1,260 Oxycodone tablets at a time
10/5/2010 surrendered her DEA
1/2011 hired another physician to work with her and write Rx
4/27/11 Warrant for arrest due to money laundering, conspiracy to traffic controlled substances, affidavit that provider was using a webcam to see patients with an assistant who wrote the prescriptions over the internet, at least 50 patients/d, provider was incarcerated in the Pinellas County Jail
10/26/2011 NCMB suspended license reciprocity of FL
4/20/12 FLMB indefinitely suspended license

Elizabeth City NC
Licensee
MedMal settlement by patient "A"

2/2007 EsophagoGastroDuodenoscopy (upper GI endoscopy) with esophageal dilation performed. 4 hours post-procedure patient presented to ED with chest pain, at midnight ED physician contacted provider stating the CXR showed no evidence of perforation, the ED physician had given oral medication to relieve pain which allowed sleep. *Provider allowed soft diet*, later swallowing study revealed esophageal tear which was repaired at another hospital.
7/1/13 Reprimand
***** Most get Public Letter of Concern**

Wilmington NC
Licensee
Licensed 8/82 OB-GYN
7/26/2006 Patient "A" laparoscopic removal of pelvic mass, pelvic sling, cystoscopy and rectocoele repair done on an outpatient basis
7/27/06 went to ED with pain complaints, ED did not contact surgeon, later that day a nurse in his office was learned that patient had been to the ED
7/28/06 POD2 patient with significant pain, provider did not request office visit, recommended to increase pain medications to every 3 hours and go to ED if not improved
7/29/06 POD3 went to ED with CT showing pneumoperitoneum (gas in the abdominal cavity) with peritonitis, provider did not go to ED but consulted general surgeon who found sigmoid perforation causing peritonitis. Provider failed to document any communication with surgeon including review of the prior procedure, pt had sigmoid colectomy with diverting colostomy, was moved to the ICU with a difficult subsequent hospital courses
12/2012 Scheduling Order, numerous motions precede this date
8/23/13 Consent Order/Reprimand; Licensed OB-GYN since 1992
*****Normally this gets a public letter of concern, why was it dismissed in 2009 then 12/2012 brought back up again?**

Hickory NC
Licensee
8/21/13 Public Letter of Concern due to malpractice pmt
6/23/11 Patient "A", an elderly man presented to ED with mild back and R lateral back pain after a fall. Thoracic spine XR showed T12 compression Fx with retropulsion of bone that was of questionable age but no neurologic changes, DC'ed with pain/nausea meds.
The following day returned to the ED with increased pain and constipation, diagnosed with paralytic ileus from opiates, neurologic exam was not documented, NG tube was placed, PT was given to patient "A".
Nursing notes showed continued weakness with decreased ROM, 6/28/11 decreased ROM and inability to move toes, hospitalist ordered MRI which showed T8 compression Fx with hematoma from T5,6 to T8
6/29/13 family transferred patient to tertiary care center for neurosurgery but patient remained irreversibly paraplegic with bowel dysfunction

8/21/13
Shelby NC
Licensee
2005-2009 Treated patients "A-E" with a variety of psychiatric conditions and wrote controlled substances for pain treatment for "A, B, D, E". NCMB independent review found inadequate medical records.
12/2010 Motions to continue
10/2011 Surrendered DEA
8/15/2011 Consent Order Suspension for 6 months immediately stayed with probationary terms and conditions, shall not prescribe controlled substances for pain or pain management for the next 30 days but may continue to treat patients even those with chronic pain with buprenorphine if they have been previously prescribed it. Within 6 months he shall have a professional assessment
Provider states that if this goes to a formal hearing, he has other psychiatrists, Retired SBI and Sheriffs officers who would attest to his professionalism and competence.
10/25/11 Pennsylvania gave him probation when he surrendered his DEA
8/21/13 Relief of Consent Order Obligations

Clinton NC
Licensee
8/19/13 Voluntary surrender of NC License

Lexington NC
Licensee
8/12/13 Public Letter of Concern Re; Malpractice pmt
7/1998-3/2008 Patient "A" was treated 7 times for costochondritis
12/30/10 Patient "A" was treated for costochondritis but returned 1/7/13 with chest pain, N/V and was given Toradol 60 mg and 2 five-day prescriptions for oral
Toradol. Subsequently the patient had a duodenal ulcer diagnosed and then died of complications from the ulcer.

New Bern NC
Licensee
8/7/13 Public Letter of Concern MedMal Pmt
4/2012 Performed Laparoscopic cholecystectomy on patient "A" injuring the procedure iliac artery was injured, patient became hypotension, patient died of multi-organ failure

Raleigh NC
Licensee
9/23/13 Public Letter of Concern
Regarding prescribing of controlled substances that failed to meet the standard of care, specifically Rx not documented in the medical record as is the absence of physical exam findings, urine drug screenings. On one occasion you prescribed Adderall without a valid reason for that drug which was also not documented. NCMB is aware that you've voluntarily placed your license on inactive status and wishes to ensure this doesn't happen again.

Henderson NC
Licensee
3/9/06 Patient "A" had evaluation with EKG/spirometry/testing and was started in a smoking cessation treatment that involved 3 injections of an anticholinergic medication and was found dead in his hotel room the next morning.
7/2011 NCMB received information in a complaint that Patient "A" had called the Lifeline smoking cessation clinic, made appt for evaluation and died.
9/16/13 Findings of Fact/Conclusion of Law and Order after Hearing and Public Letter of Concern/Conditions including CME class on Documentation

Greensboro NC
Licensee
Licensed in 1973
2007-2010 reported 0 Category 1 and Category 2 CME
4/1/10 notified by NCMB and 7/7/10 Certified Mail with 30 days to respond, 7/13/10 telephoned the NCMB and notified Dr. Kirby that he intended to do so
3/3/11 further correspondence mailed from NCMB giving deadline to 3/7/11 to provide CME updates, no further updates occurred
5/18/12 NCMB gets information that he's inappropriately prescribing controlled substances Schedule II in excessive amounts, investigation is conducted with NCCSRS. Patients "A-G" independently reviewed finding failure to adhere to acceptable standards prescribing opiates without justification and documentation as well as abuse prevention, did not perform physical exams, failure to obtain required CME.
9/11/13 Consent Order for 12 months suspension immediately stayed and needs to complete 150 hours CME within 6 months, prohibited from prescribing Schedule II or III medications
*****Needs NCPHP evaluation, an elderly physician, not keeping on CME's required, not responding to the NCMB, I think an un-stayed suspension would have been in order until the NCMB is satisfied that he's a safe provider!**

****

Pre-2012

Licensee
9/20/10 NCMB investigator obtained records on patients "A-F" for independent review
2/4/11 Inactivates license
10/24/11 Consent Order; Indefinite Suspension-standards below the acceptable standard **of care**
*****No mention of why he was investigated, whether DEA was involved of what has happened to him since 10/24/11**

Licensee

OB-GYN
2/2006 Delivered baby "A" with vacuum extraction for 61 minutes which resulted in Vaginal Delivery with perineal trauma, anemia, infection and neonatal depression for baby, there had been no fetal distress but initial APGAR was 3.
4/2007 Patient baby "B", mother had prior C-Section, 1930 External fetal heart-rate monitor showed persistent/sustained late decelerations with poor baseline variability for the next 4 hours, despite evidence of compromise, no internal monitor placed. 0000 C-Section
10, 11/2007 Consultation and review of charts above by 2 independent OB-GYN's
His practice workload was to busy for a solo practitioner, he committed to reducing his days and nights by half over the next 6 months and signed a contract with NCPHP
3/2008 Comprehensive assessments at the Center for Personalized Education for Physicians (CPEP) from 5/2008 X 3 weeks and 6/2008 for 3 weeks, practice was directly observed by 3 physicians, 2 of whom were Board Certified. Their opinion was that he met the standard of care. He agreed to participate in a structured individualized education program being developed by CPEP
7/2008 Consent Order; 12 month suspension immediately stayed, probationary terms and conditions, maintain NCPHP contract.
8/31/08 Resigns from hospital, community has no more OB care.
10/3/11 Requested relief from Consent Order
12/2011; Consent Order; relief from restrictions
*****What did he do wrong? He was observed by 3 physicians, who found no evidence of problems with his clinical skills. He's had no convictions, felonies, or malpractice issues. He's just a busy practitioner. He had a couple of suboptimal outcomes during deliveries. Could this have been sabotage from the other 3-physician group in town? Most deliveries have perineal trauma, to many C-Sections are done in the US, in 2006, 2007 there were many articles in the literature about the need to reduce C-Section rates**

Licensee
Spine Surgeon in NC since 2002, previously in NY
3/5/2008 Public Letter of Concern failed to respond in a timely manner to a severe cauda equine syndrome that was not a malpractice settlement.
11/26/06 Patient "A" came to Dr with lumbar complaints, 11/26/06 L4,5 surgery, felt that pt. had a dural arterio-venous fistula, no procedure was done to address this after surgery or in a subsequent surgery that was done
9/8/2009 Patient "B" L4,5 spondylolisthesis, opting for surgical treatment. On 6/9/05 had performed a minimally invasive L4,5 micro-lumbar discectomy with continued post-op pain and foot drop that was not noted in pre-surgical history and physical, several other surgeries were performed in an attempt to stabilize the spine. Records are incomplete and fail to address factors that lead to surgical conditions.
Independent review finds that there was failure to maintain standards of care
He prescribed Xanax and Ambien to family members without documentation
He admitted to self-prescribing long-term to himself without having a physician involved
9/2009 Consent Order; Surrender of License due to…
2/10/2011 Consent Order; Reprimanded; and ordered to pay $5K

*****Out of work/out of the system since 2/10/2011, did he see the NCPHP for a boundary/substance abuse/health evaluation, CPEP for a proficiency evaluation? Why was he reprimanded after he surrendered his license? Is he just another provider "lost" that the NCMB legal dept has not done anything with? Review of other records show that he now practices in NY where he has license restrictions due to NC actions**

Licensee
Inactive license
NCMB is concerned that you treated patient with chronic pain and prescribed controlled substances to patients for pain that was not within the acceptable standards of care. Six charts were reviewed with an absence of physical exams, no urine drug screens or compliance monitoring systems in place
1/2011 Consent Order; Public Letter of Concern
*****This is light treatment, others get suspended for this type of care**

Licensee
Last worked before 12/2010
Agreed to not supervise mid-levels due to NCMB's concerns over inadequate supervision
6/2008 signed a Consent Order that has been terminated
5/2010 NCMB reviewed 5 charts noting several deficiencies; failed in adequate initial evaluations of her psychiatric patients before providing psychotrophic medications, failed to properly supervise midlevels. She continued to prescribe medications to patients despite evidence of misuse/abuse by patients and poor record keeping/documentation and at least one case of failure to maintain a chart on a patient who was prescribed medication and at least one patient who was hospitalized for an amphetamine induced psychosis
Had originally agreed to assessments and CME to address these issues
12/8/10 Consent Order Indefinite Suspension;
*****Lost to follow up; no evidence of attempts to rehab provider**

Licensee
1995; Failure to diagnose and treat a premature infant for Factor VIII deficiency resulting in the infant's death.
On or around 7/2008 GA MB entered a public consent order; He must participate in 20 hours of hematology CME class.
10/27/10 Findings of Fact, Law and Order at Hearing in NC: Reprimand for above
*****Factor VIII deficiency/hemophilia is a VERY RARE disorder, if this guy was a pediatric hematologist I could see where he might have caught the diagnosis, but if the infant was born very ill and had a CNS bleed due to birth trauma, there's no way it could have been diagnosed and treated in time to save the infant. There's no mention anywhere of a malpractice settlement. Malpractice settlements are given a Public Letter of Concern, this guy is given a Reprimand by theNCMB for an event that occurred in another state! This is totally aberrant from what other's get after malpractice, if this even WAS malpractice!**

Licensee

Medmal Settlement; worked in a penal institution, patient came in with back pain that had been relieved with opiates purchased on the street. Without examining patient, provider ordered 40 mg Methadone po. Patient died of overdose
10/11/10 Consent Order Public Letter of Concern Re; malpractice pmt.
*****PLOC is OK for killing a patient reprimand unnecessary.**

Licensee
NCMS
Gerianne Geszler MD OB-GYN
Both attempted to do a C-Section after being unable to induce labor, during the C-Section the uterus was found to be empty—the patient was not pregnant
1/2010 Public Letter of Concern issued to both physicians.
*****Unnecessary surgery and all they get is a letter of concern?**

Licensee
3/2007 While performing EGD he told his assistants he could do the procedure with his eyes closed, he then closed his eyes during part of the procedure while on of the assistants held sponges over his eyes.
7/2007 Surrendered his license
12/14/07 Consent Order; for indefinite suspension, required compliance with NCPHP
1/2009 Consent Order; Temporary license
7/2009; Consent Order; Full licensure
*****Out of work for a year and a half for a prank; the EGD would have been video-recorded so no harm was actually done to the patient.**

Licensee
NCMB Investigation showed opiates being prescribed to patients with inadequate exam, history, assessing efficacy of medications.
5/14/09 Motion for Full-Board Hearing
7/2009 Consent Order; Reviewing above Suspended for 3 years, stayed other than 8 months, shall not prescribe Schedule I, II, III, IV. At the end of the suspension may request relief from this. He must write a written apology acceptable to the Board President and Staff regarding his conduct, obey all laws, keep address current…
*****Where was the CME class on record keeping and prescribing of opiates? It sounds like he was trying to get in front of the Board and then foolishly allowed himself to be talked out of it.**

Licensee
Licensed 1991; Family Physician in Asheville with no prior NCMB issues. After his practice-partner died, he inherited all of those patients. Following the death of one of those patients who had called, stating her Rx had been stolen, he authorized a refill. She OD'ed and died the following day. Provider then met with NCMB investigator and subsequently surrendered his DEA# indefinitely as per NCMB order and was ordered to periodically appear before the NCMB. NCMB reviewed several charts expressing concern regarding prescribing patterns. No mention is made of any patient other than the

index patient "A", who lied about losing her Rx before dying of her self-inflicted overdose.
3/2009 Provider met with investigators from DEA & NCMB, following that meeting he surrendered his DEA privileges for Schedules II, III, IV.
10/8/09 Consent Order; Provider shall not re-apply for reinstatement of DEA privileges indefinitely. He shall appear before the NCMB periodically etc
*****Excessively harsh, no evidence of chart review by an independent examiner or failure to meet the standard of care. There is no evidence that this was a pattern of inadequate care of anybody. One of his patients died of an overdose after lying to him about losing her Rx to obtain more opiates. What exactly did he do wrong?**

Licensee
Greensboro Dermatologist
6/2002 forgot to renew his license for almost a year but it was renewed back to the original date without any other consequences.
9/2009 performed a thermal procedure on the skin with inadequate informed consent
9/18/09 Consent Order; License reinstated to 3/18/08 due to forgetting to renew it, license suspended 1 year effective 9/21/09 immediately stayed all but 6 months
*****Why suspend this absent-minded physician for a year with 6 months out of work? Lack of informed consent for what was probably simple hyfrecation? That's such a routine procedure, the majority of family physician's do this as a very routine procedure that no consent is signed for. Wouldn't a reprimand and small fine have been more appropriate to remind him to keep his license in order? This was very heavy-handed discipline for a "rules" violation that didn't harm anybody!**

Licensee
GYN in Alabama
2007 failed to register license in a timely manner, license was made inactive.
2009 Consent Order; NCMB allowed to have her license back-dated to 2007 with a reprimand.
*****Three years without a license, it's back-dated so that it will be continuously current, she was absent-minded at worst and gets off with only a reprimand whereas another provider is out of work for 6 months for a shorter time period of lack of licensure.**

12/12/13
Licensee
Dunn NC
Voluntary surrender of license
PA resigned abruptly on a day in which she had 20 patients scheduled. Record review by independent expert showed substandard care. She was referred to CPEP which documented inadequate knowledge, clinical judgment and documentation. CPEP recommended that she no longer practice in an "off-site" location away from her supervising physician. Initially given 12 month suspension stayed under conditions but she chose to voluntarily surrender her license instead.

12/12/13
Licensee
Elon NC
Reprimand/CME mandated
Inadequate care of patients A-C per expert, inadequate documentation as could happen with a faulty EMR improperly set up. Required to complete CME's on record taking and controlled substance prescribing and must provide 5-10 charts involving prescribing of controlled substances for the NCMB to review, the charts will be selected thru a review of the NCCSRS database. Review will be done at his expense.
*****Again with the "expert" reviews that have yet to show any physician who is mandated to "expert" review is shown to have adequate charts. Historically if a reviewer finds no deficiencies, a 2nd reviewer is called in to re-review charts.**

12/12/13
Licensee
Hendersonville NC
Order amending consent order
Prior order mandated restrictions on posterior fossa and C spine decompressive surgery for Chiari malformation patients. Physician must now have the patient reviewed by another independent neurosurgeon prior to elective surgery on surgeries in which there is <0.5 mm herniation below the foramen magnum.

12/9/13
Licensee
Gastonia NC
12/9/13
Amended consent order
1/7/13 Charges Re; medical record documentation, patient care, failing to timely respond to NCMB order
6/20/13 Consent order/Reprimand/indefinite probation
12/9/13 full compliance, termination of probation

1/16/14
Licensee
Cary NC
12 month probation/must complete CME Medical Records & Prescribing due to patients A&B who were on high dose opiates without appropriate documentation and care in prescribing

2/3/14
Licensee
Washington DC
Consent Order/Public Letter of Concern
DCMB gave consent order/required CME Re; practice mgmt., ethics, record keeping and $2K fine with monitoring for 2 years based on the allegation that he entered an incorrect diagnosis into a patients medical record.

*****This sounds like the NCMB chasing after & harrassing somebody who neither lives in nor practices in NC.**

2/21/13
Licensee
Lenoir NC
2/21/13 Consent Order 1 year suspension/immediately stayed due to not decreasing dose of medication he was using to treat a patient's hepatitis C when patient became anemic. NCMB had an expert witness who felt that he fell below standard of care. Physician hired an expert witness who felt care was appropriate.
*****Again, battle of the expert witnesses—and the NCMB always wins!**

2/21/14
Licensee
Menifee CA
2/21/14 Consent Order/Reprimand
Excessively prescribed marijuana in CA, 5 yr license suspension with mandated CME on record keeping, adequate supervising, ethics & family practice, cannot engage in patient care directly or supervise.

2/10/14
Licensee
Greenville NC
Consent Order/Reprimand
Numerous expert witnesses used by the NCMB, not in 100% agreement with each other, nurse was either going beyond her training in what she was doing or acting as a scribe, so it was assumed that she was not a scribe but going beyond her duty. He was sent to FL CARES for a comprehensive assessment that found deficits in his record keeping, pain mgmt. and general medicine practice and made recommendations to remediate these deficiencies but that he had an overall adequate medical knowledge base and cognitive skills.
*****This poor guy was the fish in the barrel that the NCMB was shooting at, there is no way he would be found adequate even if he was Albert Sweitzer MD!!**

2/15/14
Licensee
Gloucester MA
Consent Order/Reprimand
MAMB found his care of 2 patients below standard and reprimanded him and required additional CME.
*****He doesn't live in or practice in NC so that means that NCMB MUST just jump aboard and harass him too!**

3/25/14
Licensee
OB/GYN Burlington NC

3/25/14 Consent Order/Public Letter of Concern
Between 9/2011 11/2011 administered 1,680 mg Kenalog in a series of pudendal nerve blocks for dyspareunia causing Addison's syndrome, requiring endocrinology intervention for iatrogenic adrenal insufficiency.

Licensee
Charlotte NC
3/12/14 Public Letter
Provider paid $2,500,000 to US Govt and entered into a 5-year integrity agreement Re; Medicare regulations with IV Immunoglobulin therapy that was given without your presence in the office as required by Medicare.

3/12/14
Licensee
Columbus NC
7/7/07 Central line placed for patient after gallstone pancreatitis, 7/8/07 patient died with TPN in pleural space
*****No clear evidence of wrongdoing, CXR had documented slight overshoot of line which was retracted 3 cm, sequential blood draws/flushing showed normal function until patient had a known complication of a central line and died. NCMB playing "Monday AM quarterback" states that another CXR should have been done after line was retracted 3 cm—it wouldn't have made any difference in the outcome.**

3/31/14
Licensee
Salisbury NC
3/31/14 Consent Order/Reprimand
7/2011 saw patient in ED with RLE pain suddenly while walking/worse with extension, had 2+ pulses distally, discharged with a strain of the calf. 2d later returned to ED where another physician diagnosed vascular occlusion requiring amputation, patient had Hx of stent which was not documented and that Dr. Wenn did not acknowledge or act on an US report showing no visible flow in the stented R SFA, his defense was that he overlooked the arterial issue while searching for a venous issue.

3/4/14
Licensee
Consent Order/Public Letter of Concern
Chart reviews showed that 7 patients were inappropriately prescribed benzodiazepines. Independent review resulted in "concerned that you werenot as attentive as youmight ahvve been to the possibility that some of your patients might have been selling the benzo's you were prescribing to them…" Notes that you recently completed a CME class on prescribing controlled substances.
*****Seriously? A PLOC? It's great that he proactively took a CME course, but most physician's with a problem like this are out of practice for at least 1-2 years!**

4/28/14
Licensee
Wilimington NC
Consent Order/Public Letter
MedMal Pmt of 8/22/13 after patient OD 8/20/08 on MS Contin 100 bid & Naprosyn brought him to the ED obtunded/hypoxic/hypotensive/rhabdomyolysis and requiring prolonged rehab
*****PLOC is about par for the course for medical malpractice, but involving OD on opiates can also often cause loss of practice privileges for years. I guess Dr. Points got off easy… How does the NCMB decide who to make an example of?**

4/28/14
Licensee
Pembroke NC
Consent Order/Public Letter of Concern
Patients A-E, some of whom in PA, WV, VA getting excessive amounts of pain medications, needs to obtain 10 hours of CME on prescribing and has a Reprimand
*****I'm very happy to see that he got an appropriate type of punishment, but what about the folks like him who are kept out of practice for prolonged periods of time? Their careers have been marked for the rest of their professional lives IF they are practicing. There is no consistency!**

4/23/14
Licensee
Charlotte NC
Consent Order/Public Letter of Concern
30 year old patient dies of allergic reaction in ED due to inadequate care/supervision by physician, no other discipline, there was a MedMal payout
*****Allegedly, the purpose of the NCMB is to protect the public from inadequate providers. If somebody dies through gross negligence, it's really no big deal/not much of a disciplinary issue to the NCMB. God help the provider who has a patient complaint about "inappropriate touch" (Whatever that is, and what patient knows all of the various ways in which touch IS appropriate? A false accusation ruins a career forever!) or a provider who gets caught with a positive drug screen or allegation of alcohol misuse!**

4/14/14
Licensee
Graham NC
Consent Order 1 yr suspension/immediately stayed after multiple drug-abusing patient overdosed and died while getting opiates from Dr. Tate without office visits.
*****Physician is prescribing opiates WITHOUT office visits. The bipolar patient with multiple addiction issues overdoses and dies. Death due to negligence usually gets a public letter of concern. Mis-prescribing of opiates, especially without office visits can result in years of the physician being out of work. I guess he's lucky she died or he'd be out of work a lot longer!**

4/14/14
Licensee
Arden NC
Consent Order/Reprimand inadequate care of patients A-D regarding the type, frequency, quantity of controlled substances prescribes. Expert review criticized that patients were being prescribed in excess, limited assessments were done, patients were likely abusing medications and the doctor continued to prescribe. Physician is reprimanded with restrictions on prescribing and ordered to take CME classes
*****THIS is how it SHOULD be done, he's not taken out of practice indefinitely as has been done multiple times in the past to other practitioners.**

4/11/14
Licensee
Cary NC Psychiatry
Immediate suspension/stayed upon condition of CME completion after review of patients A-D, patient A was being prescribed 8X the total maximum daily dose of Xanax for sleep problem. Other patients were also getting substandard care with excessive amounts, failed to confirm diagnosis', failed to coordinate care outside of her specialty and demonstrated lack of pharmacovigilance Re; cognition of abuse. Within 6 months must complete 10 hours CME on Medical Records & Controlled substance prescribing
*****Other providers would be out of work for prolonged periods for these transgressions.**

5/29/14
Licensee
Apex NC
Public Letter of Concern
2/18/11 failed to diagnose sepsis→death, MedMal payment made 9/28/13

5/16/14
Licensee
Hickory NC
Public Letter of Concern
3/29/13 patient fell/trauma by EMS to ED where he has repair of lacerations and is admitted to trauma/Ortho consult. There was a failure to document adequate neurologic exam in the ED, even though ortho/surgery were consulted and he went to the OR for spinal decompression—what exactlhy did he do to deserve a public letter—there were no lawsuits!
*****This is a great example of a Monday morning quarterback—the patient was seen by the right consultants, I really don't see what went wrong other than lack of a documented neuro exam by the ED Dr but the patient was seen by the correct consultants etc. This suggests that enough of a neuro exam was done even if the NCMB didn't think it was documented. Should we concentrate on treating and saving patients or pay more attention to documentation?**

5/29/14
Licensee
Durham NC
Public letter of concern due to 2 cases of surgical negligence resulting in one death.
*****No Medmal payment documented, this is more like the NCMB, it's OK to kill patients and be negligent, just don't drink, do drugs, touch a patient in a manner the patient thinks is inappropriate—whether it is or not, or have sex with a patient.**

6/25/14
Licensee
Cornelius NC
Consent Order/Voluntary surrender of license 2' to fraudulent billing & substandard care.

6/3/14
Licensee
Enka NC
Consent Order/Public Letter of Concern due to an instance 1/8/13 in which a hemorrhoidectomy patient developedanal stenosis/sphincter incontinence requiring a 2nd surgery by another physician. NCMB Expert felt care was substandard, Dr. Timmerman had his own Board-Certified surgeon review all aspects of care and found it was within the standard of care.
*****No evidence of MedMal case, any possibility of negligence is questionable as it's very rare for a NCMB "expert" to that appropriate care was given; it becomes a matter of "he said, she said…"**

7/25/14
Licensee
High Point NC
Consent Order Reprimand and restricted license, cannot prescribe II, III, IV, V due to a patient diverting medications he was prescribing which triggered an investigation showing that he had inappropriately prescribed for patients "A-E" per expert review.
*****I am doubtful of any expert review by NCMB experts, they always show inadequate care, no further information about "A-E" is available. This physician cannot prescribe medications with no end-date in sight which seems harsh, no other remedy is listed on the order.**

7/ Licensee
Smithfield NC
Public Letter of Concern
Patient death due to negligence, no mention of MedMal action.

8/21/14
Licensee
Nebo/Emergency Medicine
Consent Order/Reprimand

Performing cosmetic surgery and weight control on numerous patients that fell below the standard of care
*****He got off lightly, no mandated CME, no time out of work**

8/21/14
Licensee
Non-disciplinary consent order
Shall have a mentor if she performs any inpatient surgery in the future, must have an EMR in the office.
*****Vague as to what happened, apparently she was having problems with surgical competence @ Mission Hospital system and was allowed to step down. I don't know why the NCMB didn't also give her a difficult time.**

8/13/14
Licensee
Butner NC
Public Letter of Concern
Patient death due to negligence, with MedMal settlement

8/4/14
Licensee
Public Letter of Concern
Missed Dx of pneumonia in ED.

8/4/14
Licensee
Moorehead City
Consent Order
$1,000 fine for improper documentation of notes/physical exam etc when prescribing opiates to "Patient A" another physician
*****Unbelievably light punishment, no CME's mandated, suspension/time out of practice—lucky or shrewd?**

9/30/14
Licensee
Salisbury NC
Consent Order/Reprimand for allowing staff to practice medicine without a license
Consent Order/Suspension 1 year immediately stayed for improper care including $5K fine, 10 hours CME on prescribing controlled substances and on treatment of obesity & future chart review.
*****Wow, a reprimand for allowing his staff to practice medicine without a license!! Who does he know?**

9/29/14

Licensee
Charlotte Radiologist
Public Letter of Concern
Negligence in reading CT scan that caused ultimate B BKA's to patient in New York.
*****The patient doesn't have a leg to stand on, but at least the Dr hadn't been drinking…**

9/24/14
Licensee
Greensboro
Consent Order/Reprimand
1 reviewer of the NCMB stated he failed to adhere to the standard of care in some of the patients he had prescribed opiates to. The NCMB had a 2nd expert review who found that Dr. Frazier failed to meet the standard of care. Must also complete CME's on records and prescribing.
*****Another excellent example of the NCMB using "experts" until they get the results that they want to incriminate somebody!**

9/23/14
Licensee
Fort Worth Tx
Consent/Public Letter
MedMal payment due to bowel perforation during an axillary-bifem bypass in which the patient died.

9/18/14
Licensee
Calabash NC
Public Letter of Concern
Negligence/medmal payment after patient died.
Patient had declined recommended testing.
Supervising physician felt care was adequate
"Expert" from NCMB felt otherwise
Then 5 other patient charts were reviewed, 2 were OK, but in 3 patients with URI's the reviewer felt that antibiotics were overprescribed.
*****Noncompliant patient died, supervising physician found no problems. What happens to the supervising physician? Apparently nothing. What is the "real" story?**

10/19/14
Licensee
Winston-Salem NC
Public Letter of Concern Re; MedMal Payment for arthroscopy on the wrong knee.

10/23/14

Licensee
Moorehead City NC
Consent Order/Reprimand
Physician shall have his supervising physician review every chart for which schedule II medications are prescribed due to deficiencies found in 5 charts by expert witness.

10/16/14
Licensee
Hickory NC
Consent Order/Reprimand
Had been over-prescribing opiates per an audit of the prescribers database. He was ordered to take CME and read a book on Responsible Opiate Prescribing

10/16/14
Licensee
Albemarle NC
Consent Order Suspension for 30 days with only 7 days active suspension
Physician was in SC when a patient of his presented to the hospital with fetal distress. Patient was monitored, Dr. Shen communicated for several hours with the L&D nurse before Dr. Shen allowed the patient to be admitted and covering physician called. By then there were no fetal heart tones/fetal demise.
*****A baby died, this should be a Public Letter of Concern by standard NCMB actions!**

10/15/14
Licensee
Mooresville NC
Consent Order/Public Letter of Concern
Patient A complained of care given, expert commented that there were some deficiencies, 5 additional records were reviewed, in all cases, the expert found that care may have been below the acceptable and prevailing standard and with 3 of the 5 of them it may have been below the prevailing and acceptable standard of care.
*****Who's the expert? Anybody can be a Monday Morning Quarterback, why were 5 below standard and 3 of the 5 below standard?? This sounds suspiciously like another NCMB witchhunt!**

10/14/14
Licensee
Plano Tx
Consent Order/Public Letter of Concern
8 yo child having dental office anesthesia by the physician died. A MedMal settlement 4/1/14 was paid, disciplined by TX, reciprocal action by NC.
*****Why does NC need to "pile on"? The case in TX is listed in the National Practitioners Database, he doesn't need additional discipline in every state he has a license!!**

10/6/14
Licensee
Spring Lake NC
Consent Order/Reprimand/restriction of license
Allegations of inadequate care, "expert" review of 4 charts agreed that care was inadequate and that excess controlled substances were prescribed. He can only prescribe Schedule V drugs and can no longer supervise mid-levels.
*****Where's the remedy and duration? You don't do this to a physician for the rest of his life, you give remedies such as CME, monitoring and a set time such as "to be re-evaluated upon completion of CME…" Who was the expert? 4 charts isn't a very good number to do this to a physician; statistically, a sample size of at least 30 should be needed! This guy got screwed by the NCMB!**

10/3/14
Licensee
Moorehead City NC
Denial of licensure due to lengthy history of problems related to lack of professional competence, overdose death of a patient, repeated prescribing issues and lack of supervision of midlevels between 1985 & 2009, settlement with DEA of $25K over penalties of $6.2 million, >24 months out of practice at this time.

11/17/14
Licensee
Lakewood CO
Consent Order/Public Letter of Concern
In CO missed lucencies adjacent to the knee Fx of a 23 yo woman.
*****Why does NC need to reprimand this doctor who is already on the National Practitioner Database?**

11/4/14
Licensee
Atlanta GA
Public Letter of Concern
Patient admitted to a hospital 11/30/07 in AB, treated appropriately but a nurse did not follow the written orders properly, hypertonic Na was given to excess amount and rapidity resulting in central pontine myelinolysis resulting in brain damage as a result of the nursing order. There was a MedMal settlement 4/7/13
*****The nurse screwed up and didn't follow orders. It happened in AB, it's on the Practitioners Database. Why does NC have to add to his suffering?**