BEFORE THE
NORTH CAROLINA MEDICAL BOARD

In re:	)	
	)	FINDINGS OF FACT,
Kenneth Jay Headen, M.D.,	)	CONCLUSIONS OF LAW, AND
	)	ORDER OF DISCIPLINE
Respondent.	)	

The North Carolina Medical Board ("Board") heard this matter on April 15, 2021. Board members present were Venkata Jonnalagadda, M.D., Board President and Presiding Officer; John W. Rusher, M.D.; Varnell McDonald-Fletcher, PA-C; Jerri L. Patterson, N.P.; Devdutta G. Sangvai, M.D.; W. Howard Hall, M.D.; Christine M. Khandelwal, D.O.; Shawn P. Parker, J.D. The Honorable Fred M. Morelock, Independent Counsel, assisted the Board. Marcus Jimison, Senior Board Attorney, represented the Board. Respondent, Kenneth Jay Headen, M.D. ("Dr. Headen") was represented by Mr. Matthew W. Wolfe and Mr. Brad K. Overcash.

Based upon the stipulations of the parties and the evidence presented and arguments of counsel, the Board enters the following:

FINDINGS OF FACT

1. The Board is a body duly organized under the laws of North Carolina and is the proper party to bring this proceeding under the authority granted it in Article 1 of Chapter 90 of the North Carolina General Statutes.

2. Respondent, Dr. Headen, is a physician licensed by the Board on or about March 26, 1994, license number 9400266.

3. At times relevant herein, Dr. Headen practiced psychiatry in Burlington, Greensboro, and Winston-Salem, North Carolina.

4. In 2009, Dr. Headen entered into a Consent Order with the Board ("2009 Consent Order") whereby Dr. Headen's license was suspended for two years, all but forty-five days of which were stayed. In addition, Dr. Headen was prohibited from prescribing Schedule II and III controlled substances and buprenorphine for any purpose. Dr. Headen was allowed to prescribe Schedule IIN and IIIN narcotics. The 2009 Consent Order found Dr. Headen had prescribed controlled substances in a manner which departed from standards of acceptable and prevailing medical practice.

5. In 2017, Dr. Headen and the Board entered into a second Consent Order ("2017 Consent Order") whereby Dr. Headen's license was indefinitely suspended. The indefinite suspension was stayed upon numerous conditions.

6. The 2017 Consent Order detailed significant departures from standards of acceptable and prevailing medical practice with regard to Dr. Headen's care of seven patients. These departures included poor diagnostic decision-making because of inadequate documented medical justification; poor prescribing because of failure to obtain baseline laboratory studies; unjustified medication changes; poor

pharmacovigilance; poor monitoring of vital signs; and inappropriate billing of higher level of service without supporting documentation.

7. As a condition of the 2017 Consent Order, the Board performed a follow-up chart review of Dr. Headen's patient charts.

8. Patients A through D suffered from serious mental health or psychiatric problems. Each received care from Dr. Headen which departed from standards of acceptable and prevailing medical practice.

9. Patient A was a 48-year-old with multiple previous diagnoses, including bipolar disorder, borderline personality disorder, post-traumatic stress disorder ("PTSD"), and borderline schizophrenia.

10. Patient B was a 36-year-old with a history of serious abuse and trauma, chronic pain, severe anxiety, and heavy substance abuse.

11. Patient C was a 14-year-old evaluated for "ongoing behavioral problems" and previous suicidal attempts and hospitalizations.

12. Patient D was a 55-year-old who suffered from chronic pain, opioid use disorder, anxiety, and depression.

13. Dr. Headen diagnosed Patient A with Bipolar II Disorder and PTSD. There was insufficient documentation of symptoms which would support either diagnosis. There were no references to Patient A having experienced depressive episodes or evidence of having been previously prescribed a mood stabilizer, both of which would support a diagnosis of Bipolar II. Dr. Headen prescribed aripiprazole, 400 mg IM, for

Patient A, even though this medication is indicated for schizophrenia or Bipolar I Disorder, and not Bipolar II. Additional problems with the dosing of aripiprazole includes that oral aripiprazole should have been prescribed concurrently for 14 days and the dosage of aripiprazole should have been reduced given its interaction with Cymbalta (duloxetine). Dr. Headen failed to prescribe a mood stabilizer despite a mood stabilizer being the first line treatment for Bipolar II.

14. As to other possible diagnoses, Dr. Headen failed to explore the possibility Patient A suffered from benzodiazepine use disorder because of Patient A's twenty-year history of taking alprazolam. Patient A was at an elevated risk of death from central nervous system depression by accidental overdose given on any day she may be taking Klonopin (clonazepam), 4 mg daily as prescribed by Dr. Headen, which is a very high dose, as well as unknown quantities of Ambien (zolpidem), unprescribed Xanax (alprazolam), and unprescribed Vicodin (hydrocodone acetaminophen). As for alprazolam and hydrocodone, the presence of these substances were found in Patient A's urine drug screen, the results of which were available to Dr. Headen in February 2019 and prior to him examining Patient A in March 2019. However, Dr. Headen did not address these urine drug screen results with Patient A when he saw her in March 2019.

15. Dr. Headen also departed from standards of acceptable and prevailing medical practice by failing to reconcile contradictory information in Patient A's record. In a non-physician recorded intake,

Patient A indicated she had 12 previous psychiatric hospitalizations. However, in his examination, Dr. Headen only noted one previous psychiatric hospitalization. In addition, important medication and allergy details are missing for Patient A.

16. Patient B suffered from a substance use disorder and was seen by Dr. Headen for other potential mental health problems. Relying simply on past history, Dr. Headen diagnosed Patient B with PTSD, attention deficit hyperactivity disorder ("ADHD"), Somatic Symptoms and Related Disorder, Opioid Use Disorder Sever, Cannabis Use Disorder Moderate, and dependent personality traits. There was insufficient history of current symptoms to justify a diagnosis of ADHD and only minimal symptoms related to PTSD. Of those symptoms which were documented to support a PTSD diagnosis, all were non-specific to PTSD. Dr. Headen did diagnose Patient B with an opioid use disorder severe but failed to reference Patient B's previous heroin or cocaine use. Dr. Headen also failed to record and explore any potential history of alcohol use which was critical to know for someone who had been prescribed buprenorphine (without the opioid antagonist Narcan as Patient B was allergic to Narcan) and alprazolam. Dr. Headen prescribed Patient B Rexulti (brexpiprazole), an atypical antipsychotic used for augmentation of depression. Dr. Headen prescribed brexpiprazole despite documenting Patient B had "not been especially bothered by depressive symptoms."

17. Dr. Headen departed from standards of acceptable and prevailing practice by prescribing a benzodiazepine concomitantly to a patient he knew was also taking an opioid. The concomitant use of an opioid and benzodiazepine by a patient puts a patient, such as Patient B, at increased risk of death. Furthermore, Patient B was prescribed a high dose of alprazolam and she had also tested positive for the presence of other benzodiazepines and addictive substances, some of which were not prescribed. Patient B's urine drug screen was positive for alprazolam (unprescribed), clonazepam (unprescribed), buprenorphine, and amphetamines. The aberrant test results were not addressed by Dr. Headen. The positive urine screen was suggestive of a benzodiazepine use disorder and further suggestive of high levels of benzodiazepine in Patient B's system. Although Patient B may have required a taper of alprazolam to avoid withdrawal, prescribing Patient B 90 tablets of alprazolam at 1 mg three times a day was below the standard of care. In sum, Patient B was at high risk of death by accidental overdose because of her concomitant use of opioids and benzodiazepines, the presence of other unprescribed benzodiazepines in her system, and her allergy to Narcan.

18. Dr. Headen also departed from standards of acceptable and prevailing medical practice by prescribing the atypical antipsychotic Rexulti without indication and to Patient B who had a body mass index (BMI) of 38. A BMI of 38 denotes clinical obesity. A known side effect of Rexulti is weight gain. Thus, by prescribing Rexulti to

Patient B unnecessarily increased the harmful of effects of obesity for Patient B.

19. Dr. Headen provided care which departed from standards of acceptable and prevailing medical practice to Patient C. Patient C was a 14-year-old child when he presented to Dr. Headen in March 2019. Patient C, according to intake forms, had a history of two suicide attempts in December 2018 and prior hospitalizations as result of those suicide attempts. However, Dr. Headen in his examination noted that Patient C had no history of suicide attempts, only gestures. Dr. Headen's failure to reconcile this discrepancy in his own records was below standard.

20. Patient C required a higher level of specialized care than what he received from Dr. Headen. Patient C identified as gay since age 6. Patient C took unnecessary risks, got easily bored and was impulsive. When he presented to Dr. Headen, Patient C did seem to care what happened to him and had become withdrawn. There were, however, no documentation in Patient C's history as to current depression, previous depressive episodes, manic episodes, PTSD, or psychotic symptoms. Dr. Headen diagnosed Patient C with Oppositional Defiant Disorder ("ODD"), Disruptive Mood Dysregulation Disorder ("DMDD"), and ADHD combined type. Per the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), ODD and DMDD cannot be concurrently diagnosed.

21. Dr. Headen prescribed Patient C a stimulant, Adderall (dextroamphetamine) without clearing the prescription with the child's pediatrician. This was important because of Patient C's family history of Wolff-Parkinson-White ("WPP") Syndrome, a congenital heart condition which can cause life-threatening arrhythmias.

22. Dr. Headen's diagnoses were below standard because he did not document a more thorough abuse history, a substance use history, depressive symptoms, psychotic symptoms, PTSD symptoms, and manic symptoms. Psychotic symptoms were noted as unable to assess, which in a child with multiple suicide attempts and hospitalizations necessitated Dr. Headen referring the child to a more specialized clinician. Dr. Headen is trained as an adult psychiatrist yet saw children, such as Patient C, with serious mental health problems on an ongoing basis. Dr. Headen failed to disclose to the children's parents the limitations of his training nor did he recommend their child be seen by a pediatric psychiatrist. As to Patient C, this child required close followup from a child psychiatrist given the child's history of recent suicide attempts, two recent hospitalizations, and continual decline. Yet, Dr. Headen made no attempt to refer the child to a higher level of specialized care.

23. Dr. Headen departed from standards of acceptable and prevailing medical practice by prescribing Adderall XR to Patient C for whom he could not fully access the presence or absence of psychotic symptoms. Adderall has an increased risk of causing new onset

psychosis. No treatment is offered directly related to possible depression, which may have been present, for a patient who had a history of recent social withdrawal, suicide attempts, irritability, and poor focus.

24. Patient D presented to Dr. Headen because he was experiencing anxiety. Dr. Headen noted that Patient D reported to be a chronic pain patient who had a history of taking opioids for his pain. Patient D is followed by a pain specialist who prescribed him oxycodone. Before seeing Dr. Headen, Patient D had been discharged from a pain clinic because of a fentanyl overdose. Dr. Headen diagnosed Patient D with Generalized Anxiety Disorder and prescribed him alprazolam. In June 2018, Dr. Headen began prescribing tramadol, 50 mg BID. This dose would later be increased to 50 mg QID. Dr. Headen prescribed tramadol, a Schedule IV narcotic, to Patient D help with his pain despite Patient D having a history of accidental opioid overdosing. Dr. Headen performed regular urine drug screens ostensibly to monitor Patient D's compliance with his medication.

25. Multiple aberrant urine drug screens went unaddressed by Dr. Headen. In April 2018, Patient D tested positive for hydrocodone, which was unaddressed by Dr. Headen. Patient D also tested positive for dextromethorphan and dextrorphan, which are often abused for their hallucinogenic and dissociative properties. In September 2019, Patient D tested positive for the antidepressants Celexa (citalopram) Effexor (venlafaxine), Elavil (amitriptyline), and Pamelor

(nortriptyline HCI), none of which were prescribed nor commented upon by Dr. Headen.

26. In December 2018, Patient D accidentally overdosed on Fentanyl. In January 2019, Dr. Headen resumed prescribing tramadol to Patient D even though Patient D expressed a desire to get off opioids as well as alprazolam. In June 2019, Patient D again experienced an accidental overdose from medications prescribed to him by Dr. Headen. On the same day that Patient D overdosed, Patient D's daughter filed a complaint with the Board.

27. Dr. Headen's care of Patient D fell below standards of acceptable and prevailing medical practice. Dr. Headen failed to address strong evidence of other diagnoses, including two recent opiate overdoses, which would suggest a possible sedative use disorder and an opiate use disorder, moderate. D. Headen failed to document adequately a history of Patient D's alcohol use or prescribed medication which can be abused. Although Dr. Headen ordered extensive lab testing and urine drug screens, he failed to address frequent and multiple aberrant results, such as Patient D having other controlled substances in his system that were not prescribed. Dr. Headen prescribed the benzodiazepine alprazolam concomitantly with an opioid. Dr. Headen documented that he would only prescribe the benzodiazepine to Patient D because Patient D was no longer taking opioids after being discharged from his pain clinic. However, Dr. Headen, apparently without heeding his own warning about the dangers of prescribing both an opioid and

benzodiazepine together, prescribed Patient D an opioid, tramadol. Dr. Headen also ignored his own laboratory test results which showed other drugs in Patient D's system that when combined with the drugs Dr. Headen was prescribing, increased Patient D's risk of serotonin syndrome, a life-threatening condition which can cause fever, muscle rigidity, and seizures.

CONCLUSIONS OF LAW

1. The Board has jurisdiction over Dr. Headen and the subject matter of this case.

2. Dr. Headen's care of Patients A through D, as described above, constitutes unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, within the meaning of N.C. Gen. Stat. § 90-14(a)(6) and grounds exist under this section of the North Carolina General Statutes for the Board to annul, suspend, revoke, condition, or limit Dr. Headen's license to practice medicine or to deny any application he might make in the future.

Based on the foregoing Findings of Fact, Conclusions of Law, the hearing panel enters the following:

ORDER OF DISCIPLINE

1. Dr. Headen's North Carolina medical license is hereby INDEFINITELY SUSPENDED, beginning June 10, 2021.

2. During this period of time between the entry of the Order of Discipline and June 10, 2021, Dr. Headen shall wind down his medical practice. Dr. Headen shall provide written notice to his patients and staff, provide his patients with a copy of their medical records and make referrals, when appropriate, to other physicians.

By Order of the North Carolina Medical Board this the 10th day of May, 2021.

NORTH CAROLINA MEDICAL BOARD

By: _____
Venkata Jonnalagadda, M.D.
President