State of Rhode Island
Department of Health
Board of Medical Licensure & Discipline

IN THE MATTER OF:
David Mysels M.D.
License Number MD 13448
Case # C170958

CONSENT ORDER

The Rhode Island Board of Medical Licensure and Discipline (hereinafter "Board") has reviewed and investigated the above referenced complaint pertaining to Dr. David Mysels (hereinafter "Respondent") through its Investigative Committee.

FINDINGS OF FACT

1. Respondent has been a licensed physician in the State of Rhode Island since September 16, 2010. His primary specialty is Psychiatry.
2. The Board received a complaint reported from Our Lady of Fatima Hospital ("Fatima") about Patient A (alias), who committed suicide on May 22, 2017, the day of discharge from Fatima. On May 23, 2017, there was a newspaper article in the Providence Journal indicating that Patient A had taken his own life by jumping off a bridge.
3. Respondent was the attending physician for Patient A at Fatima.
4. Patient A was transferred to Fatima from Landmark Medical Center on May 21, 2017. Patient A had a long history of behavioral health related diagnoses, including schizoaffective disorder and antisocial personality disorder. Upon admission to Fatima, there was concern regarding homicidal ideation and depression. Patient A was previously admitted to the psychiatric unit at Fatima and Patient A had a history of over 50 prior psychiatric related admissions.
5. Patient A was evaluated by Respondent as well as other health care professionals during the May 21, 2017 admission. Patient A approached the milieu therapist on May 22, 2017 to whom he stated, according to a 10:54 a.m. entry in Patient A's record, *"that if he is*

released from here he will break my father's neck and I will kill him. And it will be your fault for not helping me," and that *"if he is released from here he will kill himself by jumping off a bridge."* The record entry further states, *"Patient appears provocative. Patient reports that he would like the team to give him long term care and that he wants 'to be locked in an insane asylum for the rest of [his] life.'"* Patient A was administratively discharged from the hospital by Respondent at 1:30 p.m. on May 22, 2017.

6. Respondent avers in his response to the Board *"As set forth in the medical records, Dr. Mysels concluded that the patient was demonstrating manipulative behavior, seeking housing placement, and not suicidal ideation consistent with his behavior at his prior admission to [Fatima] when he was seen by Dr. Mysels. Based on his evaluation and the DSM V, [Dr. Mysels] reported that the symptoms were related to manipulative behavior."*
7. There was a Code Grey, which signals combative person (combative or abusive behavior by patients, families, visitors, staff or physicians) called regarding Patient A during the hospitalization due to violent behavior of Patient A while admitted.
8. It is noted in the medical record Patient A was administratively discharged prior to medical consultation.
9. Respondent did arrange for follow up care the next day at Community Care Alliance at 1:00 p.m. with the patient's established mental health community provider.
10. The Board retained an expert to review the matter. Thereafter, on February 11, 2019, the Board provided additional documentation to the expert showing the provision of haloperidol ("haldol") 5 mg injection at 11:45 a.m.. The Board then asked the expert whether Patient A was discharged prematurely. In response to that inquiry, the expert stated that he typically always kept people a minimum of 24 hours following their most recent administration of PRN antipsychotic medication for agitation or psychosis. The expert concluded that as a result, he does not believe the standard of care was met.
11. The Investigative Committee also issued a subpoena for Respondent's Supervisor, a physician who specializes in psychiatry, and conducted an interview with him. The supervising physician was also concerned about the administration of haldol so close to

discharge and so soon after a Code Grey. It was his opinion, that the care was below the acceptable standard of care.

12. The Board advised Dr. Mysels of the opinion of the expert and supervisor, as set forth in paragraphs 12 and 13 above. Thereafter, Dr. Mysels advised the Board that the haldol was not given by injection, but rather by mouth. Dr. Mysels asked that the expert and supervisor described in paragraphs 12 and 13 above be advised of the manner of administration and whether that fact would change their respective opinions. Dr. Mysels advised the Board that he believed it would change the opinion regarding the standard of care as the patient was not so agitated that he could not be given the Haldol PO and, in fact, it was administered PO. Dr. Mysels stated that the patient's condition was consistent with the description in his psychiatric initial evaluation (Patient 1 of 5) where he describes the Code Grey incident referenced in paragraph 7 above:

> PT then began menacingly coming toward writer, "do you see that I'm crazy?!" Writer left [t]he room and called a Code Grey, heard pt throw a chair in the room, but within second he was calmed and walked self to his room. This all appeared to be manipulative and well controlled without evidence of delusion or hallucination or mania.

13. The expert and supervisor identified in paragraphs 12 and 13 above were advised that the haldol was administered PO. Both indicated that it did not change their opinions.
14. The Investigative Committee reviewed the matter and agreed with the expert and the supervisor that the care for Patient A was below the accepted standard of care.
15. Respondent is guilty of unprofessional conduct, as defined by R.I. Gen. Laws § 5-37-5.1(19), which states in relevant part that "unprofessional conduct" includes *"[i]ncompetent, negligent, or willful misconduct in the practice of medicine which includes the rendering of medically unnecessary services, and any departure from, or the failure to conform to, the minimal standards of acceptable and prevailing medical practice in his or her area of expertise as is determined by the board."*

Based on the foregoing, the parties agree as follows:

1. Respondent admits to the jurisdiction of the Board.

2. Respondent acknowledges that this Consent Order reflects the Board's Findings of Fact. Respondent has agreed to this Consent Order and understands that it is subject to final approval of the Board, and this Consent Order is not binding on Respondent until final ratification by the Board. This Consent Order is neither an admission of liability by Respondent nor a concession by the Board that its claims are not well founded.

3. If ratified by the Board, Respondent hereby acknowledges and waives:

   a. The right to appear personally or by counsel or both before the Board;
   b. The right to produce witnesses and evidence on his behalf at a hearing;
   c. The right to cross examine witnesses;
   d. The right to have subpoenas issued by the Board;
   e. The right to further procedural steps except for those specifically contained herein;
   f. Any and all rights of appeal of this Consent Order; and
   g. Any objection to the fact that this Consent Order will be presented to the Board for consideration and review.
   h. Any objection that this Consent Order will be reported to the National Practitioner Data Bank and Federation of State Medical Boards, as well as posted on the Department's public web site.

4. Respondent agrees to a Reprimand on his license.

5. Respondent successfully completed a Continuing Medical Education course with 15 AMA PRA Category 1 Credits on Suicide Management provided by the American Physician Institute for Advanced Professional Studies, Peer-Point Medical Education Institute, LLC within 6 months of the incident described in Finding of Fact 2, as well as 48 CME credits for 2018, 40 for the American Psychiatric Association 2018 APA Annual Meeting and 8 for the 2018 APA Annual Meeting Self-Assessment in Psychiatry on 5/9/18 and 4/5/18, respectively, as well as 55 AMA PRA Category 1 Credits for the February, 2018 educational activity titled "Case Studies, Volume 2: Stahl's Essential Psychopharmacology" through the Neuroscience Education Institute Department

of Continuing Medical Education. Respondent has provided notice of compliance to the Board.

6. Respondent agrees to pay within 90 days of the ratification of this Consent Order an administrative fee to the Board with a check for $3200 dollars made payable to the Rhode Island General Treasurer for costs associated with investigating the above-referenced complaint. Respondent will send notice of compliance with this condition to DOH.PRCompliance@health.ri.gov within 30 days of mailing the above-referenced payment.

7. If Respondent violates any term of this Consent Order after it is signed and accepted, the Director of the Department of Health shall have the discretion to impose further disciplinary action, including immediate suspension of his medical license. If the Director imposes further disciplinary action, Respondent shall be given notice and shall have the right to request a hearing within 20 days of the suspension and/or further discipline. The Director of the Department of Health shall also have the discretion to request a hearing after notice to Respondent of a violation of any term of this Consent Order. The Board may suspend Respondent's license, or impose further discipline, for the remainder of Respondent's licensure period if any alleged violation is proven by a preponderance of evidence.

[Signature Page Follows]

Signed this 7th day of August 2019.

David Mysels M.D.

Ratified this 14th day of August 2019 by the Board of Medical Licensure and Discipline.

Nicole Alexander-Scott, M.D., M.P.H.
Director
Rhode Island Department of Health
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Providence, Rhode Island 02908