Notice to Patients of Dr Mashali

8.29.2013

- Patients who need copies of their medical records should contact Dr Mashali's office directly.
- Patients who need to find another prescriber or receive pain care assistance should contact their primary care provider or use the "Find a doctor" tool on the HEALTH web page: http://health.ri.gov/
- Things to do when a practice closes temporarily or permanently: http://www.health.ri.gov/healthcare/about/closingpractices/
- Patients who were referred to Dr Mashali from a healthcare provider can contact the healthcare provider who referred them to Dr Mashali for ongoing care.
- Emergency departments and urgent care are also an option for care, yet all prescribers will want to see a copy of medical records and will conduct their own evaluation.
- No prescriber will prescribe for a patient without first examining the patient. Patients should not expect a new prescriber to call in a prescription without seeing the patient first, and at the first visit, the new prescriber may offer a different treatment plan.
- For patients who have feel they have a problem with dependence or addiction and would like help: http://www.bhddh.ri.gov/serviceproviders/BH_ProviderSubAbuseList.pdf?489
- The mission of the Board of Medical Licensure and Discipline is "to protect the public through enforcement of standards for medical licensure and ongoing clinical competence."
- Additional resources for patients who want to learn more about pain medication: www.health.ri.gov/painmeds and www.health.ri.gov/paincare
- Additional resources for prescribers regarding responsible opioid prescribing in Rhode Island: www.health.ri.gov/saferx

STATE OF RHODE ISLAND AND PROVIDENCE PLANTATIONS

DEPARTMENT OF HEALTH

BOARD OF MEDICAL LICENSURE AND DISCIPLINE

IN THE MATTER OF:
FATHALLA M. MASHALI, M.D.
License Number MD09332
Controlled Substances Registration Number CMD09332
BMLD Case Number C13-229

SUMMARY SUSPENSION OF PHYSICIAN LICENSE

Fathalla Mashali, M.D. (hereinafter "Respondent") is licensed as a physician in Rhode Island. After investigation and review of the above-numbered complaint, and an expert review of the patients' medical records, the Director of the Department of Health makes the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Respondent is a licensed physician in Rhode Island and was issued his license on November 8, 1996. His primary specialty is anesthesiology, and his secondary specialty is critical care medicine (anesthesiology), and he is board certified in both specialties. His office is located at 6 Blackstone Valley Place, Building 5, Suite 510, Lincoln, Rhode Island. He has hospital privileges at Landmark Hospital.

2. The Office of State Medical Examiners began to observe a pattern of fatal opiate overdoses in patients of the Respondent and reported this concern to the Board of Medical Licensure and Discipline (hereinafter "Board"). While this does not mean

necessarily that the Respondent was or is directly responsible for the deaths of those patients, the report led the Board to seek expert review of Respondent's opiate prescribing practices in the cases of the deceased patients.

3. The Board sought the services of a physician reviewer (hereinafter "reviewer") whose specialty is pain management, which specialty involves the prescription of opiate drugs. The reviewer's report was submitted to the Board on August 27, 2013, and it was reviewed by the investigative committee of the Board on August 28, 2013. The investigative committee advised the Director of the Department of Health to summarily suspend the physician license of Respondent.

4. The reviewer analyzed the medical records of six patients of Respondent who had died with controlled substances in their systems.

5. The reviewer found that Respondent treated Patient A, alias, a female, from the spring of 2011, until the time of her death. The reviewer, after analyzing Respondent's medical records for Patient A, concluded that "the combination with high doses of Valium, again without psychiatric consultation, is reckless." The reviewer noted that "Of all the questionable behaviors demonstrated by [Respondent] in the care of this patient, the most egregious is his continuing to prescribe huge doses of stimulants to a patient without a verified diagnosis, without monitoring her blood pressure or vital signs, apparently without even looking at her to see that she was cachectic.[1] In the course of forty days, from [June 10 to July 20, 2011], a total of 312 Adderall 30 mg pills were prescribed. In my opinion, it can be stated with a reasonable degree of medical certainty that the

[1] Cachexia is defined as the "wasting of the body due to severe chronic illness."

medical care provided by [Respondent] was substantially below the standard of care. His prescribing practices were dangerous."

6. The reviewer analyzed the medical records of Patient B, a female, who began to see Respondent as her pain specialist in early 2010. The reviewer concluded, after analyzing Respondent's medical records for Patient B, that "it can be said with a reasonable degree of certainty that this patient's medical care by [Respondent] was below the standard expected of a pain clinician. The physical exam was cursory at best, the psychiatric comorbidity was virtually ignored, the toxicology screen results were either ignored or not understood, and the five epidural steroid injections appear to have been without benefit or much in the way of indication." The reviewer concluded that, "Despite toxicology screens that suggested non-compliance with the 'narcotic contract,' [Respondent] continued to prescribe opioid medication for the patient, giving her a month's worth of medication at a time."

7. The reviewer analyzed Respondent's medical records for Patient C, a female, who Respondent began to see as a patient in the autumn of 2010. The reviewer concluded that:

> "There are multiple instances when it is clear that the patient has not been compliant with her narcotic contract. There are episodes in which she has run out of medication early, meaning that she was taking more than was prescribed. There were several instances in which her toxicology screens were negative for medications she was prescribed or positive for those she wasn't. [Respondent] continued to write prescriptions despite having evidence in front of him that suggested the patient was non-compliant. His confirmatory toxicology screen, like his "in house" tox screen, was an immunoassay. It simply makes no sense to use an unreliable assay to confirm the results of another unreliable assay. The

confirmatory toxicology screens should have been sent as gas chromatography/mass spectrometry tests. In my opinion, it can be stated with a reasonable degree of medical certainty that [Respondent's] care of this patient was below the standard of care expected for a pain specialist. His casual diagnoses, cursory exams, and inept monitoring placed this patient at considerable risk."

8. The reviewer analyzed the medical records for Patient D, a male, who first saw Respondent as his physician in the summer of 2010, and who died in the spring of 2011. His final tox screen at death was positive for Oxycodone, Oxymorphone, morphine,and Alprazolam. The reviewer noted that:

"The patient's initial tox screen is positive for Amphetamines and Cocaine. There isn't any documentation in the chart that the recreational use of these medications was discussed other than writing on the tox report that the patient would be discharged if he was positive for Cocaine again. It seems unlikely that any pain clinician (or any clinician of any specialty) would prescribe opioids for a patient on the same day that a tox screen came back positive for both Amphetamine and Cocaine. The judgment here is quite poor, and despite [Respondent's] assertion that he would monitor the patient at biweekly intervals, the patient wasn't seen again for four weeks. Knowing that the patient had a history of illicit drug use, [Respondent] gave the patient a month's worth of MS Contin and Percocet on 9/8/2010."

The reviewer concluded:

"The reason that high-risk patients are referred to pain clinicians is because they have to be very closely monitored by someone with the knowledge to do so. [Respondent] dispensed vast amounts of opioids and Benzodiazepines to a patient with multiple urine toxicology screens suggesting that he was not taking the medication as prescribed and/or violating his contract. There is no effort to count

his pills. There was no follow up on the issue of Cocaine abuse. There was no attempt to identify the reason for the patient's absence or what he was prescribed during that period. He even prescribed opioids to the patient after he had had an entirely negative tox screen. In my opinion, it can be said with a reasonable degree of medical certainty that this is well below the expected standard of care for a pain clinician. If this poor judgment is any representation of [Respondent's] routine standard of care, then I must conclude that his continued practice will put more patients at risk for inadvertent overdose."

9. The reviewer analyzed Respondent's medical records for Patient E, a female, who first saw Respondent in the autumn of 2011, and who died in the autumn of 2012. Her final tox screen at death was positive for toxicology was positive for methadone, diphenhydramine, Oxycodone, Carisprodal, Bupropion and Promethazine. The reviewer concluded that:

> "Rather than being followed weekly, as is recommended when Suboxone is first prescribed, she was given a month's supply soon after starting to see [Respondent]. Oddly, his "in house" tox screen didn't test for Suboxone, and his single attempt at a pill count didn't work out. The toxicology screen results were essentially ignored. The patient was repeatedly given a month's supply of opioids despite results that suggested overt breach of the narcotic contract between [Respondent] and his patient. I cannot explain why he continued to prescribe medication in the face of multiple screens positive for Ecstasy or Methadone (when she wasn't prescribed Methadone). In my opinion, it can be stated with a reasonable degree of medical certainty that [Respondent's] care of this patient was far below the standard expected of a pain specialist. His physical exam was cursory, his regard for the patient's comorbidities was non-existent, and his prescribing habits were lavish in the face of very frightening, if inaccurate, toxicology screen results. In my opinion, this standard of care would place any patient at risk."

10. The reviewer analyzed Respondent's medical records for Patient F, a female, who first saw Respondent as her physician in the summer of 2010 and who died in the summer of 2011. Patient F's final tox screen at death was positive for ethyl alcohol, Citalopram, Fentanyl, and Norfentanyl. The reviewer noted that:

> "This case is particularly disturbing since it was repeatedly documented that the patient had a long history of opioid, Cocaine, and alcohol abuse. She reported having been in and out of rehab during the course of her interactions with [Respondent]. Despite his awareness that she had a long history of drug and alcohol abuse, he continued to give increasing doses of opioids often for a month's worth of pills at a time."
>
> The reviewer concluded:
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> "It can be said with a reasonable degree of medical certainty that this level of care is far below the standard that would be expected of a pain clinician. In addition to ignoring toxicology screen results and failing to monitor the patient adequately, [Respondent's] physical examination of the patient was cursory and replicated in each office note. It is not clear that he made any effort to identify the source of her pain, despite the reading of her lumbosacral MRI. This, too, fails to meet the expected standard of care. In my opinion, this patient had multiple 'red flags' pointing to the likelihood that she would be abusing her prescribed drugs. Other than occasionally decreasing the interval between visits, [Respondent] didn't seem to take the risk of prescribing opioids and Klonopin for this patient seriously. During the course of his relationship with her, "new" information was disclosed in which the patient revealed her history of drug abuse. That this information was initially concealed by the patient didn't seem to bother [Respondent] or change his prescribing pattern."

11. Respondent has a pattern of prescribing controlled substances to patients in a manner that does not meet the standards of acceptable practice.

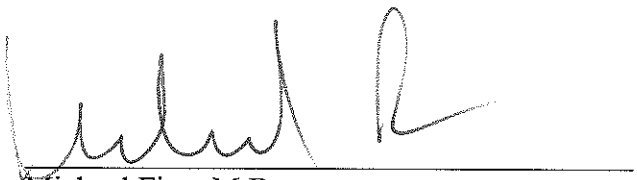
12. Respondent has delivered care below accepted minimal standards, including the inappropriate prescription of narcotics.
13. Respondent is in violation of Rhode Island General Laws § 5-37-5.1(19) and (26) for his failure to adhere to minimum standards of acceptable practice and for violation of state laws concerning standards of practice and prescribing of controlled substances.
14. The public health, safety, or welfare imperatively requires emergency action.

ORDER

1. Based on the foregoing, the Director of the Department of Health has determined that the continuation of the physician license and controlled substances registration of Fathalla Mashali, M.D., constitutes an immediate threat to the health, welfare and safety of the public.
2. Accordingly, the physician license to practice medicine in Rhode Island issued to Fathalla Mashali, M.D., and the controlled substances registration to prescribe controlled substances issued to Fathalla Mashali, M.D., are hereby suspended forthwith pursuant to Rhode Island General Laws § 42-35-14(c).
3. Based on the foregoing, the Director of the Department of Health has determined that the continuation of the medical license and controlled substances registration of Fathalla Mashali, M.D., constitutes an immediate threat to the health, welfare and safety of the public.

4. The suspension of the Respondent's medical license and controlled substances registration shall continue until further Order of the Department of Health and until an administrative hearing or other resolution.
5. Respondent shall continue to be responsible for providing a proper medical home for any of his patients who need controlled substances prescribed to them, and shall continue to be responsible to transfer any medical records of such patients immediately upon request or when needed; and any failure to do so shall constitute grounds for further disciplinary action.
6. The Respondent is entitled to a hearing within ten days in accordance with Rhode Island General Laws § 42-35-14(c).

Signed this 29 day of August, 2013.



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CERTIFICATION OF SERVICE

I hereby certify that a copy of this Summary Suspension Order was served upon the Respondent and was sent electronically and by regular mail to his counsel on the ____ day of August, 2013, at the following addresses:

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