BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of

EHAB F. ABDALAH, M.D.

Case No. MD-16-0856A

INTERIM CONSENT AGREEMENT
FOR PRACTICE RESTRICTION

for the Practice of Allopathic Medicine
In the State of Arizona.

INTERIM CONSENT AGREEMENT

Ehab F. Abdalah, M.D. ("Respondent") elects to permanently waive any right to a hearing and appeal with respect to this Interim Consent Agreement for Practice Restriction and consents to the entry of this Order by the Arizona Medical Board ("Board").

INTERIM FINDINGS OF FACT

1. The Board is the duly constituted authority for the regulation and control of the practice of allopathic medicine in the State of Arizona.

2. Respondent is the holder of License No. 36239 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-16-0856A after receiving a complaint regarding Respondent’s care and treatment of a 49 year-old male patient ("JD") alleging inappropriate prescribing of controlled substances with subsequent patient death.

Patient JD

4. JD established care with Respondent on April 7, 2009 and Respondent started JD on oxycodone 15mg. In June 2009, Respondent prescribed methadone 10mg, before JD requested to go back on Percocet in August 2009.

5. Between February 1, 2013 and October 25, 2013, JD received prescriptions for hydrocodone, clonazepam and oxycodone from a primary care physician. JD's
Controlled Substances Prescription Monitoring Program ("CSPMP") report shows that the prescriptions were written in increasing dosages during this time.

6. JD re-initiated treatment with Respondent on September 16, 2013, when Respondent treated JD with oxycodone and methadone for pain management.

7. JD did not receive any controlled substance prescriptions between February and September, 2014. Between September and October, 2014, JD received three oxycodone prescriptions and a prescription for tramadol from three different prescribers.

8. On November 6, 2014, JD returned to Respondent who continued to treat JD with oxycodone and methadone.

9. On March 17, 2015, JD's wife informed the staff that JD was snorting his medication and he was drinking alcohol. On March 31, 2015, Respondent saw JD who denied his wife's report; however, there is no documentation stating that the wife had called and reported that the patient was snorting his medication or that he spoke with JD regarding the March 17 phone call.

10. JD subsequently underwent inpatient detoxification and was discharged on Suboxone. Between JD's discharge of May, 2015 and November, 2015, he obtained Suboxone from three different providers. On July 15, 2015, Respondent discharged JD as a patient for violating his pain contract.

11. JD re-established care with Respondent's practice for two months beginning in May, 2015 when he was issued prescriptions for methadone and oxycodone under the DEA number for one of the Nurse Practitioners employed by Respondent. At the same time JD was receiving Suboxone from his primary care physician. Billing records for these dates attributed JD's care to Respondent.

12. JD again re-established care with Respondent in March, 2016. At the time of his initial visit, JD had not received any Suboxone for several months, and had not
received any prescribed opioids for over a month. Another Nurse Practitioner employed
by Respondent prescribed JD oxycodone twice in that month. Respondent saw JD on
April 11, 2016 and prescribed oxycodone 10/325 #90. On May 11, 2016, Respondent's
Nurse Practitioner prescribed JD oxycodone 10/325 #60 and methadone 10 mg #60.

13. On May 19, 2016, JD was found dead. His cause of death was listed as
methadone and oxycodone intoxication.

Patients EE, LM and RB

14. Patient EE, an established female patient, was treated by Respondent for
chronic pain related to multiple medical conditions. Respondent prescribed EE
medications including Percocet and Fentanyl patches, and provided lumbar epidural
injections and facet joint blocks.

15. Patient LM, a 43 year-old female patient, established care with Respondent
in May, 2012 for pain management. Respondent's treatment included lumbar epidural
injections, as well as medication management including Gabapentin, Tramadol, Percocet
and later Fentanyl, Morphine sulfate and Oxycodone.

16. Patient RB, a 58 year-old female, established care with Respondent in
March, 2013. Respondent's treatment of RB included medication management with
Oxycodone and Flexeril, as well as Lumbar epidural injections.

Deviations from the Standard of Care

17. A Medical Consultant ("MC") who reviewed Respondent's care of these
patients found that Respondent demonstrated a pattern of rapidly escalating the daily
morphine equivalent dosing ("MED") of opioids when starting extended-release opioids.
The MC found that when Respondent initiated Fentanyl for EE along with continuation of
Percocet, this represented a 320% MED increase. Similarly for patient LM, Respondent's
decision to adjust her dosages of Fentanyl and Percocet represented a 237% MED increase in LM’s opioid regimen.

18. For all patients reviewed, the MC found instances where Respondent’s procedure notes are incomplete or blank for dates that controlled substances were prescribed.

19. The MC noted multiple deviations from the standard of care including failure of oversight and management for Patient JB. Additionally, the MC found multiple instances where Respondent’s documentation put patients at risk. Lastly, the MC found that Respondent’s escalation of opioid dosages and failure to address aberrant urine drug screens deviated from the standard of care.

20. Actual harm was identified in that Patient JD died of methadone and oxycodone toxicity. All patients were at risk for potential harm including medication abuse and diversion.

21. The aforementioned information was presented to the investigative staff, the medical consultant and the lead Board member. All reviewed the information and concur that the interim consent agreement to restrict Respondent’s controlled substance prescribing pending the outcome of a formal interview or formal hearing is appropriate.

22. The investigation into this matter is pending Board review.

INTERIM CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

2. Pursuant to A.R.S. § 32-1405(C)(25) the Executive Director has authority to enter into a consent agreement when there is evidence of danger to the public health and safety.
3. Pursuant to A.A.C. R4-16-504, the Executive Director may enter into an interim consent agreement when there is evidence that a restriction is needed to mitigate imminent danger to the public's health and safety. Investigative staff, the Board's medical consultant and the lead Board member have reviewed the case and concur that an interim consent agreement is appropriate.

**INTERIM ORDER**

IT IS HEREBY ORDERED THAT:

1. Respondent is prohibited from prescribing controlled substances in the State of Arizona until Respondent has retained a practice monitor as set forth herein. Respondent shall submit the name of a practice monitor who is an Arizona physician licensed and in good standing with the Board. The practice monitor shall be responsible for ensuring that Respondent's controlled substance prescribing practices are in accordance with current guidelines; namely that Respondent is utilizing appropriate patient assessments, responsible dosing of controlled substances and conscientious patient oversight. Respondent shall agree to allow the monitor to view his interactions with any and all patients and patient records as deemed appropriate by the monitor. The monitor shall provide written reports to the Board on a monthly basis or at any time the monitor has concerns regarding Respondent's safety to practice. Respondent shall be responsible for all expenses relating to the practice monitor and preparation of the monthly reports.

2. Respondent may request, in writing, release and/or modification of this Interim Consent Agreement. The Executive Director, in consultation with and agreement of the lead Board member and the Chief Medical Consultant, has the discretion to determine whether it is appropriate to release Respondent from this Interim Consent Agreement.

3. The Board retains jurisdiction and may initiate new action based upon any violation of this Interim Consent Agreement, including, but not limited to, summarily
suspending Respondent's license.

4. Because this is an Interim Consent Agreement and not a final decision by the Board regarding the investigation, it is subject to further consideration by the Board.

5. This Interim Consent Agreement shall be effective on the date signed by the Board’s Executive Director.

DATED this 2nd day of February, 2018.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Executive Director

RECITALS

Respondent understands and agrees that:

1. The Board, through its Executive Director, may adopt this Interim Consent Agreement, or any part thereof, pursuant to A.R.S. § 32-1405(C)(25) and A.A.C. R4-16-504.

2. Respondent has read and understands this Interim Consent Agreement as set forth herein, and has had the opportunity to discuss this Interim Consent Agreement with an attorney or has waived the opportunity to discuss this Interim Consent Agreement with an attorney. Respondent voluntarily enters into this Interim Consent Agreement and by doing so agrees to abide by all of its terms and conditions.

3. By entering into this Interim Consent Agreement, Respondent freely and voluntarily relinquishes all rights to an administrative hearing on the matters set forth herein, as well as all rights of rehearing, review, reconsideration, appeal, judicial review or
any other administrative and/or judicial action, concerning the matters related to the Interim Consent Agreement.

4. Respondent understands that this Interim Consent Agreement does not constitute a dismissal or resolution of this matter or any matters that may be currently pending before the Board and does not constitute any waiver, express or implied, of the Board’s statutory authority or jurisdiction regarding this or any other pending or future investigations, actions, or proceedings. Respondent also understands that acceptance of this Interim Consent Agreement does not preclude any other agency, subdivision, or officer of this State from instituting civil or criminal proceedings with respect to the conduct that is the subject of this Interim Consent Agreement. Respondent further does not relinquish his/her rights to an administrative hearing, rehearing, review, reconsideration, judicial review or any other administrative and/or judicial action, concerning the matters related to a final disposition of this matter, unless he/she affirmatively does so as part of the final resolution of this matter.

5. Respondent acknowledges and agrees that upon signing this Interim Consent Agreement and returning it to the Board’s Executive Director, Respondent may not revoke his/her acceptance of this Interim Consent Agreement or make any modifications to it. Any modification of this original document is ineffective and void unless mutually approved by the parties in writing.

6. Respondent understands that this Interim Consent Agreement shall not become effective unless and until it is signed by the Board’s Executive Director.

7. Respondent understands and agrees that if the Board’s Executive Director does not adopt this Interim Consent Agreement, he will not assert in any future
proceedings that the Board’s consideration of this Interim Consent Agreement constitutes bias, prejudice, pre-judgment, or other similar defense.

8. Respondent understands that this Interim Consent Agreement is a public record that may be publicly disseminated as a formal action of the Board, and that it shall be reported as required by law to the National Practitioner Data Bank.

9. Respondent understands that this Interim Consent Agreement does not alleviate his responsibility to comply with the applicable license-renewal statutes and rules. If this Interim Consent Agreement remains in effect at the time Respondent’s allopathic medical license comes up for renewal, he/she must renew his license if Respondent wishes to retain his/her license. If Respondent elects not to renew his license as prescribed by statute and rule, Respondent’s license will not expire but rather, by operation of law (A.R.S. § 32-3202), become suspended until the Board takes final action in this matter. Once the Board takes final action, in order for Respondent to be licensed in the future, he must submit a new application for licensure and meet all of the requirements set forth in the statutes and rules at that time.

10. Respondent understands that any violation of this Interim Consent Agreement constitutes unprofessional conduct under A.R.S. § 32-1401(27)(r) ("[v]iolating a formal order, probation, consent agreement or stipulation issued or entered into by the board or its executive director under this chapter.").

\[\text{Signature}\]

DATED: \[\text{2/2/2018}\]

EHAB F. ABDALAH, M.D.

EXECUTED COPY of the foregoing e-mailed this \[\text{2nd}\] day of \[\text{February}\], 2018 to:
Maria Nutile  
Nutile Law and Associates  
7395 S Pecos Rd, Suite 103  
Las Vegas, NV 89120  
Attorney for Respondent  

ORIGINAL of the foregoing filed  
this 2nd day of February 2018 with:  

Arizona Medical Board  
1740 W. Adams St., Suite 4000  
Phoenix AZ 85007  

 Марию Болер  
Board staff