

1 BEFORE THE ARIZONA MEDICAL BOARD

2 In the Matter of

3 **EHAB F. ABDALAH, M.D.**

4 Holder of License No. 36239  
5 For the Practice of Allopathic Medicine  
6 In the State of Arizona.

Case No. MD-16-0856A

**ORDER FOR LETTER OF  
REPRIMAND AND PROBATION;  
AND CONSENT TO THE SAME**

7 Ehab F. Abdalah, M.D. ("Respondent") elects to permanently waive any right to a  
8 hearing and appeal with respect to this Order for a Letter of Reprimand and Probation;  
9 admits the jurisdiction of the Arizona Medical Board ("Board"); and consents to the entry of  
10 this Order by the Board.

11 **FINDINGS OF FACT**

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

14 2. Respondent is the holder of license number 36239 for the practice of  
15 allopathic medicine in the State of Arizona.

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

19 **Patient JD**

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

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

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

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

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

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

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

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

22          12.    JD again re-established care with Respondent in March, 2016. At the time  
23 of his initial visit, JD had not received any Suboxone for several months, and had not  
24 received any prescribed opioids for over a month. Another Nurse Practitioner employed  
25 by Respondent prescribed JD oxycodone twice in that month. Respondent saw JD on

1 April 11, 2016 and prescribed oxycodone 10/325 #90. On May 11, 2016, Respondent's  
2 Nurse Practitioner prescribed JD oxycodone 10/325 #60 and methadone 10 mg #60.

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

5 14. A review of Respondent's billing records for Patient JD shows that  
6 Respondent billed for treatment provided by the NP under his own name, in violation of  
7 Medicare guidelines.

### 8 **Patients EE, LM and RB**

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

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

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

### 20 **Deviations from the Standard of Care**

21 18. A Medical Consultant ("MC") who reviewed Respondent's care of these  
22 patients found that Respondent demonstrated a pattern of rapidly escalating the daily  
23 morphine equivalent dosing ("MED") of opioids when starting extended-release opioids.  
24 The MC found that when Respondent initiated Fentanyl for EE along with continuation of  
25 Percocet, this represented a 320% MED increase. Similarly for patient LM, Respondent's

1 decision to adjust her dosages of Fentanyl and Percocet represented a 237% MED  
2 increase in LM's opioid regimen.

3 19. For all patients reviewed, the MC found instances where Respondent's  
4 procedure notes are incomplete or blank for dates that controlled substances were  
5 prescribed.

6 20. The standard of care for the treatment of chronic non-cancer pain requires a  
7 physician to perform a thorough evaluation, risk assessment, routine monitoring and re-  
8 evaluation of the patient during the course of treatment. Respondent deviated from the  
9 standard of care by failing to oversee/monitor patient JD during the course of his  
10 treatment.

11 21. The standard of care requires the proper training and oversight of physician  
12 extenders and medical assistants as well as implementation of policies or procedures on  
13 hand to establish a culture of patient safety and monitoring in the practice. Respondent  
14 deviated from the standard of care in his treatment of patient JD in that there was a lack  
15 of proper training and oversight of physician extenders and medical assistants as well as  
16 no policies or procedures on hand to establish a culture of patient safety and monitoring  
17 in the practice.

18 22. The standard of care in high risk patients with a history of substance abuse  
19 requires a physician to attempt to optimize non-opioid options prior to initiating them as a  
20 part of the treatment plan. When making changes in an opioid regimen or initiating a long-  
21 acting medication, the standard of care requires initiation at the lowest possible dose with  
22 gradual increase over the course of several weeks, making sure not to start a dose of  
23 medication that far exceeds the dose that the patient is being changed from. Respondent  
24 deviated from the standard of care in his treatment of patients JD and RB in that there is a  
25 pattern of initiating long-acting opioids or changing opioid regimens that result in  
dangerous increases in the daily opioid dose being prescribed to the patient.

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

4                                   **Procedural History**

5         24. Effective February 2, 2018, Respondent entered into an Interim Consent  
6 Agreement for Practice Restriction ("ICA") prohibiting him from prescribing controlled  
7 substances until he retained the services of a Board-approved practice monitor.  
8 Respondent is in compliance with the terms of the ICA.

9         25. On April 23-25, 2018, Respondent completed a Board approved intensive,  
10 in-person continuing medical education ("CME") course in controlled substance prescribing  
11 for a total of 27 credit hours.

12         26. On April 26-27, 2018 Respondent completed a Board approved intensive, in-  
13 person CME course in medical recordkeeping for a total of 17 credit hours.  
14

15                                   **CONCLUSIONS OF LAW**

16         a. The Board possesses jurisdiction over the subject matter hereof and over  
17 Respondent.

18         b. The conduct and circumstances described above constitute unprofessional  
19 conduct pursuant to A.R.S. § 32-1401(27)(e)("Failing or refusing to maintain adequate  
20 records on a patient.").

21         c. The conduct and circumstances described above constitute unprofessional  
22 conduct pursuant to A.R.S. § 32-1401(27)(r)("Committing any conduct or practice that is or  
23 might be harmful or dangerous to the health of the patient or the public.").

24         d. The conduct and circumstances described above constitute unprofessional  
25 conduct pursuant to A.R.S. § 32-1401(27)(w)("Obtaining a fee by fraud, deceit or  
misrepresentation.").

1 e. The conduct and circumstances described above constitute unprofessional  
2 conduct pursuant to A.R.S. § 32-1401(27)(jj) (“Exhibiting a lack of or inappropriate  
3 direction, collaboration or direct supervision of a medical assistant or a licensed, certified  
4 or registered health care provider employed by, supervised by or assigned to the  
5 physician.”).

6 **ORDER**

7 IT IS HEREBY ORDERED THAT:

8 1. Respondent is issued a Letter of Reprimand.

9 2. Respondent is placed on Probation for a period of 2 years with the following  
10 terms and conditions:

11 **a. Continuing Medical Education**

12 Respondent shall within 6 months of the effective date of this Order obtain no less  
13 than 10 hours of Board staff pre-approved Category I CME in an intensive, in-person  
14 course for billing. Respondent shall within **thirty days** of the effective date of this Order  
15 submit his request for CME to the Board for pre-approval. Upon completion of the CME,  
16 Respondent shall provide Board staff with satisfactory proof of attendance. The CME  
17 hours shall be in addition to the hours required for the biennial renewal of medical  
18 licensure.

19 **b. Chart Reviews**

20 Within 30 days after the effective date of this Order, Respondent shall enter into a  
21 contract with a Board-approved monitoring company to perform periodic chart reviews at  
22 Respondent's expense. The chart reviews shall involve current patients' charts for care  
23 rendered after completion of the CME identified in Findings of Fact 25-26. Based upon the  
24 chart reviews, the Board retains jurisdiction to take additional disciplinary or remedial  
25 action.

1                   **c. Obey All Laws**

2           Respondent shall obey all state, federal and local laws, all rules governing the  
3 practice of medicine in Arizona, and remain in full compliance with any court ordered  
4 criminal probation, payments and other orders.

5                   **d. Tolling**

6           In the event Respondent should leave Arizona to reside or practice outside the  
7 State or for any reason should Respondent stop practicing medicine in Arizona,  
8 Respondent shall notify the Executive Director in writing within ten days of departure and  
9 return or the dates of non-practice within Arizona. Non-practice is defined as any period of  
10 time exceeding thirty days during which Respondent is not engaging in the practice of  
11 medicine. Periods of temporary or permanent residence or practice outside Arizona or of  
12 non-practice within Arizona, will not apply to the reduction of the probationary period.

13                   **e. Probation Termination**

14           Prior to the termination of Probation, Respondent must submit a written request to  
15 the Board for release from the terms of this Order. Respondent's request for release will  
16 be placed on the next pending Board agenda, provided a complete submission is received  
17 by Board staff no less than 30 days prior to the Board meeting. Respondent's request for  
18 release must provide the Board with evidence establishing that he has successfully  
19 satisfied all of the terms and conditions of this Order, and must be accompanied by two  
20 consecutive favorable chart reviews. The Board has the sole discretion to determine  
21 whether all of the terms and conditions of this Order have been met or whether to take any  
22 other action that is consistent with its statutory and regulatory authority.

24           3.     The ICA is terminated on the effective date of this Order.

25           4.     The Board retains jurisdiction and may initiate new action against  
Respondent based upon any violation of this Order. A.R.S. § 32-1401(27)(s).

1 DATED AND EFFECTIVE this 13<sup>th</sup> day of July, 2018.

2 ARIZONA MEDICAL BOARD

3 By Patricia E. McSorley  
4 Patricia E. McSorley  
5 Executive Director

6 **CONSENT TO ENTRY OF ORDER**

7 1. Respondent has read and understands this Consent Agreement and the  
8 stipulated Findings of Fact, Conclusions of Law and Order ("Order"). Respondent  
9 acknowledges he has the right to consult with legal counsel regarding this matter.

10 2. Respondent acknowledges and agrees that this Order is entered into freely  
11 and voluntarily and that no promise was made or coercion used to induce such entry.

12 3. By consenting to this Order, Respondent voluntarily relinquishes any rights to  
13 a hearing or judicial review in state or federal court on the matters alleged, or to challenge  
14 this Order in its entirety as issued by the Board, and waives any other cause of action  
15 related thereto or arising from said Order.

16 4. The Order is not effective until approved by the Board and signed by its  
17 Executive Director.

18 5. All admissions made by Respondent are solely for final disposition of this  
19 matter and any subsequent related administrative proceedings or civil litigation involving  
20 the Board and Respondent. Therefore, said admissions by Respondent are not intended  
21 or made for any other use, such as in the context of another state or federal government  
22 regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or  
23 any other state or federal court.

24 6. Upon signing this agreement, and returning this document (or a copy thereof)  
25 to the Board's Executive Director, Respondent may not revoke the consent to the entry of  
the Order. Respondent may not make any modifications to the document. Any



1 modifications to this original document are ineffective and void unless mutually approved  
2 by the parties.

3 7. This Order is a public record that will be publicly disseminated as a formal  
4 disciplinary action of the Board and will be reported to the National Practitioner's Data  
5 Bank and on the Board's web site as a disciplinary action.

6 8. If any part of the Order is later declared void or otherwise unenforceable, the  
7 remainder of the Order in its entirety shall remain in force and effect.

8 9. If the Board does not adopt this Order, Respondent will not assert as a  
9 defense that the Board's consideration of the Order constitutes bias, prejudice,  
10 prejudgment or other similar defense.

11 10. Any violation of this Order constitutes unprofessional conduct and may result  
12 in disciplinary action. A.R.S. § § 32-1401(27)(s) ("[v]iolating a formal order, probation,  
13 consent agreement or stipulation issued or entered into by the board or its executive  
14 director under this chapter.") and 32-1451.

15 11. Respondent acknowledges that, pursuant to A.R.S. § 32-2501(16), he  
16 cannot act as a supervising physician for a physician assistant while his license is on  
17 probation.

18 12. ***Respondent has read and understands the conditions of probation.***

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20 \_\_\_\_\_  
EHAB F. ABDALAH, M.D.

DATED: June 25, 2018  
\_\_\_\_\_

21  
22 EXECUTED COPY of the foregoing mailed  
23 this 13<sup>th</sup> day of July, 2018 to:

24 Maria Nutile  
25 Nutile Law and Associates  
7395 S Pecos Rd, Suite 103  
Las Vegas, NV 89120  
Attorney for Respondent

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ORIGINAL of the foregoing filed  
this 13<sup>th</sup> day of July, 2018 with:

Arizona Medical Board  
1740 West Adams, Suite 4000  
Phoenix, Arizona 85007

Mary Babey  
Board staff