STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATE OF NEBRASKA ex rel., DOUGLAS J. PETERSON, Attorney General, Plaintiff, v. SHOIAB, MOHAMMAD, Defendant.	160360 MD FINDINGS OF FACT AND CONCLUSIONS OF LAW; ORDER

STATEMENT OF THE CASE

A Petition for Disciplinary Action was filed in this matter on February 26, 2016, alleging unprofessional conduct and a practice of negligent conduct on the part of the Defendant with respect to his treatment of three patients. On March 2, 2016, an Order for Temporary Suspension was entered against the Defendant's license to practice medicine and surgery.

SUMMARY OF THE HEARING

This matter came on for hearing before Susan Strohn, Department of Health and Human Services (DHHS) Hearing Officer, on March 15 and 17, 2016, in Lincoln, Nebraska. Appearing were Mindy Lester, Assistant Attorney General, on behalf of the State of Nebraska; Mohammad Shoiab, M.D., Defendant, and James Snowden and Melanie Whittamore-Mantzios, Defendant's attorneys. Testimony and exhibits were received into evidence.

FINDINGS OF FACT

1. Proper notice of this hearing was provided to the parties.

2. Defendant holds license #20931 to practice medicine and surgery issued by DHHS on September 22, 1998.

3. At all times material herein, Defendant was a board-certified psychiatrist employed at Bryan Medical Center (BMC).

4. Between November 2013 and January 2014, Patients A, B, and C, all of whom had advanced dementia, were admitted to BMC and treated in the Senior Mental Health Unit by Defendant and other physicians. The treatment plans for Patients A, B and C included orders for anti-psychotic and anti-depressant medications, and sleeping medications.

5. Defendant's treatment of Patients A, B and C included combinations of medications in low doses to treat symptoms of agitation, aggression, sundowning syndrome, sleep issues, depression, delusions, and hallucinations.

6. On February 26, 2016, the State of Nebraska filed a Petition for Disciplinary Action, alleging unprofessional conduct and a practice of negligent conduct on the part of the Defendant with respect to his treatment of Patients A, B, and C.

7. Three board-certified psychiatrists who have practiced in an inpatient setting testified that Defendant's treatment of Patients A, B and C met the standard of care for a psychiatrist practicing in an inpatient setting.

CONCLUSIONS OF LAW

Jurisdiction is based upon Neb. Rev. Stat. §§38-176 (Reissue 2008) and 38-186 (Cum. Supp. 2014). A credential to practice may be disciplined for "(6)(d) [p]ractice of the profession in a pattern of incompetent or negligent conduct;" and "(23) [u]nprofessional conduct as defined in section 38-179." Neb. Rev. Stat. §38-178 (Cum. Supp. 2014). Unprofessional conduct is defined as "any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession..." and "(15) [s]uch other acts as may be defined in rules and regulations." Neb. Rev. Stat. §38-179 (Reissue 2008).

> Unprofessional conduct means any departure from or failure to conform to the standards of acceptable and prevailing practice of medicine and surgery or the ethics of the profession, regardless of whether a person, patient, or entity is injured, but does not include a single act of ordinary negligence. Unprofessional conduct also means conduct that is likely to deceive or defraud the public or is detrimental to the public interest. Unprofessional conduct includes but is not limited to:
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> ...
>
> (32)Conduct or practice outside the normal standard of care in the State of Nebraska which is or might be harmful or dangerous to the health of the patient or the public, not to include a single act of ordinary negligence

172 NAC 88-010.02.

After a hearing has been conducted regarding discipline of a credential, the Chief Medical Officer "may dismiss the action or impose any of the following sanctions: (1) Censure; (2) Probation; (3) Limitation; (4) Civil penalty; (5) Suspension; or (6) Revocation." Neb. Rev. Stat. §38-196 (Reissue 2008). The State's burden of proof is by clear and convincing evidence in disciplinary proceedings: "that amount of evidence which produces in the trier of fact a firm belief or conviction about the existence of a fact to be proved." *Wright v. Davis*, 243 Neb. 931, 936-37, 503 N.W.2d 814, 818 (1993).

The evidence does not support a finding, by clear and convincing evidence, that Defendant's treatment of Patients A, B and C constituted unprofessional conduct or a practice of negligent conduct. The Petition for Disciplinary Action should be dismissed.

ORDER

The Petition for Disciplinary Action filed on February 26, 2016, is hereby DISMISSED with prejudice.

DATED: March 23, 2016

Thomas J. Safranek, M.D.
Acting Chief Medical Officer
Division of Public Health
Department of Health and Human Services

NOTICE

Pursuant to the Administrative Procedure Act, NEB. REV. STAT. § 84-901 *et seq.*, this decision may be appealed by filing a petition in the district court of the county where the action is taken within thirty days after the service of the final decision by the agency.

CERTIFICATE OF SERVICE

The undersigned certifies that on March 23, 2016, a copy of the foregoing was sent by United States certified mail, postage prepaid, return receipt requested, and/or electronically to the following:

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STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATE OF NEBRASKA ex rel. DOUGLAS J. PETERSON, Attorney General,	)	**160360 MD**
Plaintiff,	)	**ORDER FOR TEMPORARY SUSPENSION OF LICENSE TO PRACTICE MEDICINE AND SURGERY**
vs.	)	
SHOIAB, MOHAMMAD	)	
Defendant.	)	

THIS MATTER came on for consideration before the Nebraska Department of Health and Human Services Public Health Division's Chief Medical Officer on Plaintiff's Petition: Disciplinary Action and Temporary License Suspension ("Petition") and upon the affidavit in support of the request for temporary suspension. The Chief Medical Officer finds that there is reasonable cause to believe that grounds exist under Neb. Rev. Stat. §§ 38-183 (Reissue 2008) and 38-178 (2014 Cum. Supp.) for the suspension of the license of the Defendant to practice as a physician on the basis that the Defendant's continued practice at this time would constitute an imminent danger to public health and safety.

IT IS THEREFORE ORDERED:

1. The license of the Defendant, Mohammad Shoiab, to practice as a physician is suspended effective upon service of this Order upon the Defendant in accordance with Neb. Rev. Stat. § 38-183 (Reissue 2008).

2. Pursuant to Neb. Rev. Stat. § 38-183, the hearing on the merits of the allegations of the Petition shall be held. A separate Notice of Hearing shall be issued by the HHS Division of Public Health to be served upon the Defendant along with the Order

and the Petition. The Defendant shall have the opportunity to appear and defend against the Petition at such time and place. The Defendant is further notified that he may present such witnesses and such evidence at said time and place as he may care to present in answer to the allegations of the Petition, and he may be represented by legal counsel at said hearing.

3. The investigative report and supporting documents attached to the affidavit of Katherine Krueger are hereby sealed and shall remain a non-public record pursuant to Neb. Rev. Stat. § 38-1,106 (Reissue 2008).

4. The Douglas County, Nebraska, Sheriff is appointed, pursuant to 184 NAC 006.01E, to personally serve the Defendant with copies of this Order and the Petition.

DATED this 2nd day of March, 2016.

BY: Thomas J. Safranek MD

Thomas J. Safranek, M.D.
Acting Chief Medical Officer
Division of Public Health
Department of Health and Human Services

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATE OF NEBRASKA ex rel. DOUGLAS J. PETERSON, Attorney General,	)	160360 MD
Plaintiff,	)	NOTICE OF HEARING
vs.	)	
SHOIAB, MOHAMMAD	)	
Defendant.	)	

A Petition for: Disciplinary Action was filed with the Director on February 26, 2016, in the above captioned matter.

The Director has set this matter presented by said Petition for hearing on Tuesday, March 15, 2016, at 9:00 a.m. Central Time. Report to the DHHS Division of Public Health hearing room located in the Gold's Building, 1033 O Street, Suite 113, Lincoln, Nebraska.

You shall have the opportunity to appear and defend against said Petition at said time and place. You are further notified that you may present such witnesses and such evidence at said time and place as you may care to present in answer to the charge of said Petition and that you may be represented by legal counsel at said hearing. Hearings are conducted according to Neb. Rev. Stat. §§ 38-186, 38-196 and 84-901 et seq., and the Rules of Practice and Procedure to the Department, 184 NAC 1, (a copy of which can be obtained from http://www.dhhs.ne.gov). If auxiliary aides or reasonable accommodations are needed for participation in the hearing please call the Hearing Office, (402) 471-7237, or for persons with hearing impairments (402) 471-9570 TDD, or the Nebraska Relay System, 711 TDD, prior to the hearing date.

DATED this 2nd day of March, 2016.

Susan Strohn
Hearing Officer

STATE OF NEBRASKA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF PUBLIC HEALTH

STATE OF NEBRASKA ex rel. DOUGLAS J. PETERSON, Attorney General,	)	
Plaintiff,	)	**PETITION FOR: DISCIPLINARY ACTION AND TEMPORARY LICENSE SUSPENSION**
vs.	)	
MOHAMMAD SHOIAB, MD,	)	
Defendant.	)	

The Plaintiff alleges as follows:

ALLEGATIONS COMMON TO ALL CAUSES OF ACTION

1. Jurisdiction is based on Neb. Rev. Stat. §§ 38-183 and 38-184 (Reissue 2008) and 38-186 (2014 Cum. Supp.).

2. At all times relevant herein, the Defendant, Mohammad Shoiab, MD, has been the holder of a license (#20931) issued by the Department of Health and Human Services Division of Public Health ("Department") to practice as a physician.

3. The Department is the agency of the State of Nebraska authorized to enforce the provisions of the Uniform Credentialing Act regulating the practice of medicine and surgery.

4. The Nebraska Board of Medicine and Surgery considered the investigation of this matter and made a disciplinary recommendation to the Attorney General, which recommendation has been considered. Such matters are privileged pursuant to Neb. Rev. Stat. §§ 38-1,105 and 38-1,106 (Reissue 2008).

5. T Defendant was employed as a psychiatrist at B.M.C., a hospital in Lincoln, Nebraska; at all times relevant herein, Defendant managed patients on multiple wards, including the geriatric psychiatric inpatient unit.

6. On January 18, 2014, Patient A was admitted to the Geriatric Psychiatric Inpatient Unit at B. M. C., Lincoln, Nebraska, for confusion, difficulty with self-care and unsafe behaviors under emergency protective custody. Defendant was Patient A's treating psychiatrist while the patient was hospitalized. Prior to admission, Patient A was not taking any psychotropic medications and had never taken any psychotropic medications; the only medications Patient A was taking upon admission were amlodipine 2.5 mg, one time daily and latanoprost .0005% 1 drop in both eyes daily. Defendant ordered nine psychotropic medications for Patient A which so over-sedated her as to cause her to no longer eat or drink; the ordered psychotropic medications included three injectable antipsychotics administered nineteen (19) times during her stay, and six prescriptions upon discharge. Patient A was discharged on February 7, 2014, to a long term health care facility on hospice care. Defendant advised the long term health care facility that Patient A was expected to have days or weeks remaining to live.

a. The Defendant ordered the following medications for Patient A while Patient A was hospitalized:

    i. January 18, 2014:

        1. Lorazepam (Ativan) 0.5 mg every 6 hours as needed;
        2. Lorazepam (Ativan) 1 mg every 6 hours as needed;
        3. Lorazepam (Ativan) 0.5 mg intramuscular injection every 6 hours as needed;

4. Lorazepam (Ativan) 1 mg intramuscular injection every 6 hours as needed;

ii. January 19, 2014:

1. Lorazepam (Ativan) 0.5 mg every 6 hours as needed.

iii. January 27, 2014:

1. Olanzapine (Zyprexa) 5 mg intramuscular injection twice daily as needed;
2. Olanzapine (Zyprexa) 5 mg twice daily as needed

iv. February 2, 2014:

1. Eszopicolone (Lunesta) 3 mg at bedtime;
2. Palperidone (Invega) 1.5 mg at bedtime

v. February 4, 2014:

1. Divalproex Sprinkle (Depakote Sprinkle) 125 mg three times daily
2. Lorazepam (Ativan) 0.25 mg three times daily;

b. The Defendant ordered the following medications for Patient A upon discharge:

i. Divalproex Sprinkle (Depakote Sprinkle) 125 mg, three times daily;

ii. Eszopiclone (Lunesta) 3 mg, at bedtime;

iii. Lorazepam (Ativan) 0.25 mg, three times daily;

iv. Paliperidone (Invega) 1.5 mg, at bedtime

c. L.W., M.D., Patient A's treating psychiatrist after discharge from B.M.C., discontinued all psychotropic medications prescribed by the Defendant

except for Remeron to help with appetite and low dose Ativan, necessary to manage psychotropic withdrawal side effects. Following the cessation of the medications, L.W., M.D.'s treatment records for Patient A include the following information: Patient A's treating physician reports that oversedation greatly improved. There is no nothing medical to explain the severe decline and near death of Patient except the polypharmacy and oversedation which occurred at B.M.C.

7. T.M., M.D., an Associate Professor of Psychiatry in the Division of Geriatric Psychiatry for the University of Nebraska Medical Center and consultant of the Department reviewed investigative materials regarding the Defendant, including Patient A's medical records, and opined the following:

a. The Defendant's ready employment of medication clearly led to a deterioration in level of alertness and physical and cognitive function;

b. Patient A was so over-sedated by the medication prescribed by the Defendant Patient A was eventually unable to eat or drink;

c. Though the medications themselves were at lower dosages, together, they increased the load into her central nervous system;

d. Any potential benefit of the medications chosen were outweighed by the level of sedation caused at the dosage chosen;

e. Cholinesterase was not appropriate for a patient who was not eating and at the thought to be at the last levels of dementia;

f. Lunesta was not an appropriate prescription for a patient at this point;

g. All of the prescribed medications should have been stopped as each alone and clearly together, could have led to or worsened Patient A's condition;

h. Patient A's pulmonary concerns should have led Defendant to reconsider prescribing alprazolam and donepezil;

i. No time was provided to for valuable assessment of whether a particular agent was effective or not;

j. The Patient's deterioration upon admission to B.M.C. was from over-sedation due to polypharmacy;

k. Defendant failed to consider what caused Patient A's behaviors;

l. There is no evidence that Defendant made an effort to determine whether the facility patient C lived at was the source of Patient A's symptoms;

m. There was no discussion in the patient's file as to what led to the behaviors;

n. There was no evidence that the provider sought out information from the facility or approached the patient's caregivers with consideration of environmental stressors in mind;

o. No effort was made after this patient became over-sedated to eliminate medication, especially in light of the severe morbidity caused by the polypharmacy treatment plan; and

p. Defendant's treatment of Patient A was not within current standards of practice in geriatric psychiatry.

8. Patient B was admitted to the Geriatric Psychiatric Inpatient Unit at B. M. C. in Lincoln, Nebraska, on November 27, 2013. Upon admission, Patient B had diagnoses of Dementia with behavioral disturbances; Defendant was Patient B's treating

psychiatrist. While hospitalized, Defendant ordered Patient B large doses of Haldol/Ativan by mouth and by intramuscular injection until he was fully tranquilized and lost his ability to walk or feed himself. One week prior to admission, Patient B was able to walk, talk, and engage in activities with his family.

a. Upon admission, Patient B was already prescribed certain medications, including but not limited to:
    i. Citalopram (Celexa), 40mg daily;
    ii. Divalproex (Depakote sprinkles), 125 mg capsule, 2 capsules, three times daily;
    iii. Haloperidol, 2 mg every four hours as needed;
    iv. Haloperidol, 2 mg four times daily;
    v. Lorazepam (Ativan), 1 mg, topical every six hours as needed;
    vi. Quetiapine, 25 mg twice daily;
    vii. Quetiapine (Seroquel) 25 mg four times a day; and
    viii. Trazodone 50 mg tablet daily.
b. The Defendant ordered the following medications for Patient B while Patient B was hospitalized:
    i. November 27, 2013:
        1. Ativan Cream 1 mg every six hours (from Patient's own supply); and
        2. Divalproex Sprinkle (Depakote Sprinkle) 250 mg three times daily.
    ii. November 28, 2013:

1. Haldol 5mg by mouth or injection, every six hours as needed
2. Lorazepam (Ativan) 1 mg by mouth or injection, every six hours as needed

iii. December 2, 2013:

1. Memantine (Namenda) 5 mg twice daily;
2. Risperidone 0.25 mg three times daily;
3. Lorazepam (Ativan) 0.25 mg twice daily;
4. Citalopram (Celexa) 10 mg by mouth daily

iv. December 3, 2013:

1. Citalopram (Celexa) 10 mg by mouth daily;
2. Lorazepam (Ativan) 0.25 mg three times daily as needed;

v. December 5, 2013:

1. Lorazepam 0.25 mg by mouth daily;

c. The Defendant prescribed the following medications for Patient B upon discharge:

1. Citalopram (Celexa) 10 mg by mouth daily;
2. Lorazepam 0.25 mg by mouth daily;
3. Lorazepam (Ativan) 0.25 mg three times daily as needed;
4. Memantine (Namenda) 5 mg twice daily; and
5. Risperidone 0.25 mg three times daily.

d. Patient B was discharged to a long term care facility on December 5, 2013, where Patient B died on February 11, 2014.

9. T.M., M.D., an Associate Professor of Psychiatry in the Division of Geriatric Psychiatry for the University of Nebraska Medical Center and consultant of the Department reviewed investigative materials regarding the Defendant, including Patient B's medical records, and opined the following:

a. Defendant's continued use of haloperidol and risperidone to treat Patient B was inappropriate;

b. Patient B may have been in a drug-induced Parkinsonism, perhaps from long-term use of an antipsychotic, which could have been addressed by a period off medication altogether to see if there was improvement in condition;

c. Defendant's use of large doses of Haldol and Lorazepam to treat Patient B caused over-sedation with clear risks for falls and aspiration;

d. The patient was inappropriately discharged on five medications all from separate classes, to wit:

   i. Ativan Cream 1 mg/Lorazepam (Ativan) by mouth

   ii. Divalproex Sprinkle (Depakote Sprinkle)

   iii. Memantine

   iv. Risperidone

   v. Citalopram

e. Memantine was inappropriately used for a patient felt to be at the end stages of dementia;

f. There is no evidence showing Defendant considered what led to Patient B's behaviors;

g. There was no evidence that Defendant sought out information from the facility or approached the patient's caregivers seeking information regarding potential environmental stressors;

h. Defendant failed to attempt to eliminate medication after this patient became over-sedated in light of the severe morbidity caused by the polypharmacy treatment plan;

i. Defendant's treatment of Patient B was not within current standards of practice in geriatric psychiatry.

10. On November 23, 2013, Patient C was admitted to the Geriatric Psychiatric Inpatient Unit at B.M.C. in Lincoln, Nebraska. Upon admission, Patient C was diagnosed with Dementia. Defendant was Patient C's treating psychiatrist. Patient C had previously been prescribed and was taking a low dose of quetiapine (25 mg, at bedtime). Defendant ordered a course of medications, as set forth herein below, which led to the rapid deterioration of functioning and over-sedation of Patient C. Patient C was discharged on December 13, 2013, on hospice care to a long term care facility in a comatose like state.

a. The Defendant ordered the following medications for Patient C while Patient C was hospitalized:

i. November 23, 2013:

1. Lorazepam (Ativan) 0.5 mg every 6 hours as needed;
2. Lorazepam (Ativan) 1 mg every 6 hours as needed;
3. Lorazepam (Ativan) 0.5 mg intramuscular injection every 6 hours as needed;

4. Lorazepam (Ativan) 1 mg intramuscular injection every 6 hours as needed;

ii. November 24, 2013:

1. Memantine (Namenda) 5 mg twice daily

iii. November 25, 2013:

1. Trazodone (Desyrel) 50 mg at bedtime

iv. December 2, 2013:

1. Sertraline (Zoloft) 25 mg daily;

v. December 4, 2013:

1. Risperidone 0.25 mg twice daily;
2. Risperidone 0.5 mg at bedtime;

vi. December 7, 2013:

1. Divalproex Sprinkle (Depakote Sprinkle) 125 mg three times daily;

vii. December 8, 2013:

1. Eszopiclone (Lunesta) 1 mg at bedtime

viii. December 10, 2013:

1. Alprazolam (Xanax) .25 mg daily

b. The Defendant prescribed the following medications for Patient B upon discharge:

i. Memantine (Namenda) 5 mg twice daily;

ii. Risperidone 0.25 by mouth daily;

iii. Risperidone 0.5 mg by mouth at bedtime

iv. Eszoplicone (Lunesta) 1 mg at bedtime;

v. Divalproex Sprinkle (Depakote Sprinkle) 125 mg three times daily;

vi. Alprazolam (Xanax) 0.25 mg

vii. Sertraline 25 mg daily

viii. Trazodone 50 mg by mouth at bed time

11. T.M., M.D., an Associate Professor of Psychiatry in the Division of Geriatric Psychiatry for the University of Nebraska Medical Center and consultant of the Department reviewed investigative materials regarding the Defendant, including Patient C's medical records, and opined the following:

a. Defendant caused Patient C to go into a drug-induced delirium which should have led to a medical admission to a hospital rather than discharge to a long-term care facility;

b. Defendant's treatment of Patient C caused Patient C to become significantly over-sedated, which led to gross loss of function;

c. Patient C's diagnosed deterioration from dementia was in fact iatrogenic delirium from medications prescribed by Defendant;

d. There is no evidence Defendant considered what led to Patient C's behaviors;

e. There was no evidence that Defendant sought out information from the facility or approached the patient's caregivers for information regarding potential environmental stressors;

f. The Defendant failed to make a valuable assessment of whether a particular agent was effective or not;

g. Defendant made no effort after this patient became over-sedated to eliminate medication, especially in light of the severe morbidity caused by the polypharmacy treatment plan

h. Defendant's treatment of Patient C was not within current standards of practice in geriatric psychiatry.

FIRST CAUSE OF ACTION

12. Paragraphs 1 through 11 are incorporated herein by reference.

13. Neb. Rev. Stat. § 38-178(6)(d) (2015 Cum. Supp.) provides that a professional license may be disciplined for practice of the profession in a pattern of negligent conduct.

14. The Defendant's overmedication of Patient's A, B, and C constitutes the practice of the profession in a pattern of negligent conduct which is grounds for discipline.

SECOND CAUSE OF ACTION

15. Paragraphs 1 through 14 are incorporated herein by reference.

16. Neb. Rev. Stat. § 38-178(23) (2015 Cum. Supp.) provides that a professional license may be disciplined for unprofessional conduct as defined in section 38-179 (Reissue 2008).

17. Neb. Rev. Stat. § 38-179 (Reissue 2008) defines unprofessional conduct as "any departure from or failure to conform to the standards of acceptable and prevailing practice of a profession...(15) such other acts as may be defined in rules and regulations."

18. The Regulations Governing the Licensure of Medicine and Surgery and Osteopathic Medicine and Surgery, 172 NAC 88-010.02 (2013), define unprofessional conduct as "any departure from or failure to conform to the standards of acceptable and prevailing practice of medicine and surgery or the ethics of the profession, regardless of

whether a person, patient, or entity is injured, but does not include a single act of ordinary negligence. Unprofessional conduct also means conduct that is likely to deceive or defraud the public or is detrimental to the public interest. Unprofessional conduct includes but is not limited to: ... (32) Conduct or practice outside the normal standard of care in the State of Nebraska which is or might be harmful or dangerous to the health of the patient or the public, not to include a single act of ordinary negligence".

19. The Defendant's treatment of Patient's A, B and C constitutes unprofessional conduct which is grounds for discipline.

PRAYER FOR RELIEF

WHEREFORE, the Plaintiff prays that the Chief Medical Officer temporarily suspend the Defendant's license to practice as a physician pursuant to Neb. Rev. Stat. § 38-183 (Reissue 2008), set this Petition for: Disciplinary Action and Temporary License Suspension for hearing, enter an order for appropriate disciplinary action pursuant to Neb. Rev. Stat. § 38-196 (Reissue 2008), and tax the costs of this action to the Defendant.

STATE OF NEBRASKA, ex rel.
DOUGLAS J. PETERSON,
Attorney General,
Plaintiff,

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By: Mindy L. Lester

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