

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine

Adjudicatory Case No. 2023-008

In the Matter of)
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)
Raafat Attia Hanna, M.D.)
_____)

STATEMENT OF ALLEGATIONS

The Board of Registration in Medicine (Board) has determined that good cause exists to believe the following acts occurred and constitute a violation for which a licensee may be sanctioned by the Board. The Board therefore alleges that Raafat Attia Hanna, M.D. (Respondent) has practiced medicine in violation of law, regulations, or good and accepted medical practice as set forth herein. The investigative docket number associated with this order to show cause is Docket No. 19-280.

Biographical Information

1. The Respondent graduated from the Faculty of Medicine, Ain Shams University, Cairo in 1984. He has been licensed to practice medicine in Massachusetts under certificate number 72108 since January 17, 1990. He is board-certified in Internal Medicine and specializes in Endocrinology. The Respondent was affiliated with Beth Israel Deaconess (BID)-Plymouth and Cape Cod Healthcare in Plymouth until he retired and relocated to Florida.

Patient A

2. Patient A is a female born in 1958 who saw the Respondent for an initial appointment on November 29, 2011.

3. At her initial appointment the Respondent documented Patient A had a history of gastroesophageal reflux and anxiety. The Respondent agreed to issue a refill of Patient A's prescription for alprazolam, a benzodiazepine, which a prior physician prescribed to treat her anxiety.

4. The Respondent also diagnosed Patient A at her initial appointment with lumbar sprain/strain. However, he failed to include details in the "History of Present Illness" or "General Examination" sections of his medical note to support this diagnosis.

5. Standard initial treatment for lumbar strain/sprain includes physical therapy, over the counter creams or patches and conservative use of anti-inflammatory medications, such as ibuprofen.

6. On November 29, 2011, the Respondent did not recommend any of the standard initial treatments for lumbar strain/sprain and instead prescribed Patient A Percocet, a narcotic analgesic.

7. On December 12, 2011, Patient A telephoned Respondent's office requesting a refill for Percocet and Respondent advised that he would not prescribe more Percocet. On January 23, 2012, Patient A inquired by telephone with regard to whether Respondent would prescribe Vicodin for her back pain. Respondent declined, advising the patient that he did not prescribe chronic pain medications. On April 3, 2012, Patient A requested Percocet for carpal tunnel and Respondent advised that he would not prescribe Percocet.

8. The Respondent saw Patient A for a follow-up appointment on August 7, 2012, at which time she reported experiencing continued back pain.

9. The Respondent's note from August 7, 2012 did not include the details of Patient A's subjective complaint in the section entitled "History of Present Illness." Additionally, his

note for the physical examination was a verbatim copy of the examination he performed on November 29, 2011.

10. On August 24, 2012, Patient A called the Respondent's office and requested a prescription for Percocet. The Respondent instructed his staff to inform Patient A she needed to go to a pain clinic. He also declined to issue her the prescription. However, on November 5, 2012, the Respondent agreed to provide a short-term prescription of Percocet for Patient A.

11. On December 14, 2012, Patient A was transported to BID-Plymouth after a 11-year-old child she had been caring for as a nurse observed her faint.

12. Patient A was administered Narcan on December 14, 2012 and her condition immediately improved.

13. Patient A completed a urine toxicology screen on December 14, 2012, which was positive for the presence of cocaine, benzodiazepines, opiates, and oxycodone.

14. Patient A's daughter contacted the Respondent on December 14, 2012 expressing concern about Patient A continuing to receive prescriptions for alprazolam given the circumstances surrounding her hospitalization and noted a prescription Patient A filled on December 11, 2012 was already missing thirty pills.

15. Starting on June 13, 2013, the Respondent prescribed Patient A regular refills of alprazolam despite knowing the circumstances of her December 2012 hospitalization.

16. On December 17, 2013, Patient A again complained of back pain during an appointment with the Respondent who diagnosed her with lumbar strain/sprain.

17. On April 14, 2014, Respondent referred Patient A to the Pain Clinic at Beth Israel Deaconess Hospital-Plymouth. On July 14, 2014, Respondent referred Patient A to Keith Scarfo, D.O. for Pain Management.

18. Respondent also issued a prescription for Percocet for Patient A during an office visit on January 30, 2015. On that date, he failed to document a physical examination of Patient A's back despite providing her a prescription for continued pain in this area.

19. On April 6, 2015, the Respondent noted in Patient A's medical record she was undergoing an MRI of her back that week but later failed to record the results of same.

20. The Respondent issued Patient A multiple prescriptions for Percocet between March and May 2015 for back pain.

21. On June 9, 2015, the Respondent referred Patient A to another physician and noted the MRI of her back was completed a month earlier but failed to record the findings.

22. On June 11, 2015, Patient A called the Respondent requesting more pain medication. The Respondent instructed his staff to inform Patient A she would not be receiving any additional pain medication prescriptions from him.

23. On September 10, 2015, the Respondent prescribed Patient A Flexeril for back pain during an office visit where she complained of same.

24. On December 10, 2015, during an office visit the Respondent prescribed Patient A Ambien to help her sleep and refilled her alprazolam prescription.

25. On June 12, 2017, Patient A advised Respondent's office that the pain specialist suggested that she obtain her medications from Respondent as her back condition was "chronic." Patient A was advised that Respondent would not prescribe her pain medications.

26. On July 31, 2017, the Respondent switched Patient A's sleep medication from Ambien to flurazepam after she reported experiencing bad dreams. He also prescribed Patient A Fioricet for migraines.

27. Patient A's pharmacist called the Respondent on August 1, 2017 to discuss his decision to prescribe Patient A two different benzodiazepines (alprazolam and flurazepam). The Respondent then changed the prescription for flurazepam to trazodone.

28. On June 20, 2018, Patient A was hospitalized with confusion and memory loss. A urine toxicology screen she provided at that time was positive for benzodiazepines and cocaine.

29. On July 5, 2018, Patient A attended an office visit with her son who raised concerns that her memory loss was related to alcohol consumption and "taking pills." At that time, the Respondent referred Patient A to a neurologist.

30. The Respondent's treatment of Patient A on diverse dates between November 29, 2011 and July 2018 was negligent and fell below the standard of care in the following ways:

- a. The Respondent failed to address clear signs Patient A was suffering from a substance use disorder;
- b. The Respondent failed to document an adequate physical examination and/or ancillary tests to evaluate her unspecified low back pain;
- c. The Respondent erred by prescribing Percocet, a narcotic analgesic, for the management of Patient A's nonspecific chronic low back pain; and
- d. The Respondent erred by continuing to prescribe Patient A multiple medications with abuse potential without addressing her apparent substance abuse issues.

Legal Basis for Proposed Relief

Pursuant to G.L. c. 112, §5, eighth par. (c) and 243 CMR 1.03(5)(a)3, the Board may discipline a physician upon proof satisfactory to a majority of the Board, that he engaged in conduct that places into question the Respondent's competence to practice medicine, including but not limited to gross misconduct in the practice of medicine, or practicing medicine

fraudulently, or beyond its authorized scope, or with gross incompetence, or with gross negligence on a particular occasion or negligence on repeated occasions.

The Board has jurisdiction over this matter pursuant to G.L. c. 112, §§ 5, 61 and 62. This adjudicatory proceeding will be conducted in accordance with the provisions of G.L. c. 30A and 801 CMR 1.01.

Nature of Relief Sought

The Board is authorized and empowered to order appropriate disciplinary action, which may include revocation or suspension of the Respondent's license to practice medicine. The Board may also order, in addition to or instead of revocation or suspension, one or more of the following: admonishment, censure, reprimand, fine, the performance of uncompensated public service, a course of education or training or other restrictions upon the Respondent's practice of medicine.

Order

Wherefore, it is hereby **ORDERED** that the Respondent show cause why the Board should not discipline the Respondent for the conduct described herein.

By the Board of Registration in Medicine,



Julian N. Robinson, M.D.
Board Chair

Date: 2/2/2023