

COMMONWEALTH OF MASSACHUSETTS

Middlesex, SS.

Board of Registration in Medicine  
Adjudicatory Case No. 2021-012

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In the Matter of )  
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JOSEPH M. TOSHACH, M.D.  
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**CONSENT ORDER**

Pursuant to G.L. c. 30A, § 10, Joseph M. Toshach, M.D. (Respondent) and the Board of Registration in Medicine (Board) (hereinafter referred to jointly as the "Parties") agree the Board may issue this Consent Order to resolve the above-captioned adjudicatory proceeding. The Parties further agree this Consent Order will have all the force and effect of a Final Decision within the meaning of 801 CMR 1.01(11)(d). The Respondent admits to the findings of fact specified below and agrees the Board may make the conclusions of law and impose the sanction set forth below in resolution of investigative Docket No. 20-112.

**Findings of Fact**

1. The Respondent was born on February 15, 1965 and graduated from New York Medical College in June 1990. The Respondent is certified in Pediatrics by the American Board of Pediatrics. The Respondent has been licensed to practice medicine in Massachusetts under certificate number 237163 since August 6, 2008, in Maine since June 22, 1993, in New Hampshire since 2011 and New Jersey since 2017.

2. On November 7, 2019 the New Hampshire Board of Medicine ("New Hampshire Board") reprimanded the Respondent's license to practice medicine, assessed a \$1,000 administrative fine and \$2,000 in investigative and prosecution costs, and ordered the Respondent to complete continuing medical education for at least four hours in the area of history taking, evaluating, and assessing the headache patient when it accepted the Respondent's

Settlement Agreement (“New Hampshire Settlement Agreement”). The New Hampshire Settlement Agreement is attached hereto as Attachment A and incorporated herein by reference.

3. On May 1, 2016 at 10:15 a.m. thirteen-year-old Patient A was brought to Concord (NH) Hospital Emergency Department, where she was diagnosed with a migraine headache, prescribed and administered pediatric doses of migraine medications at 11:45 a.m., and ordered to undergo an outside brain MRI within three days of discharge.

4. The Respondent was called into the ED at 3:30 p.m. for a pediatric consult where he encountered Patient A asleep, did not wake her and relied on the ED physician’s earlier neurological assessment, and attributed Patient A’s somnolence to the sedating effects of the medication and reported lack of sleep the night before.

5. At 8:40 p.m. the Respondent was asked to admit Patient A to the pediatric floor and was informed of an elevation in Patient A’s temperature at 9:00 p.m. Patient A was admitted to the pediatric floor at 10:00 p.m. and at 10:53 p.m. Patient A was obtunded with dried blood in both nostrils, non-verbal, but able to squeeze a nurse’s hand and open her eyes upon request.

6. At 12:53 a.m. on May 2, 2016 Patient A was less responsive and her pupils were unequal. The Respondent arrived at Patient A’s bedside and ordered an urgent head CT scan, before which Patient A suffered cardiac arrest requiring resuscitation.

7. A head CT scan revealed the presence of a 3.8 cm mass in the fourth ventricle, mass effect, brainstem and cerebellar compression, and irreversible downward herniation. Patient A was transferred to Dartmouth Hitchcock Hospital for neurosurgery, from which Patient A never regained consciousness and died on May 6, 2016.

8. On September 10, 2018 a medical malpractice settlement was made related to the care of Patient A on May 1, 2016 at Concord Hospital.

9. The Respondent stipulated if a disciplinary hearing took place the New Hampshire Board Hearing Counsel would have proved the Respondent engaged in professional misconduct in violation of RSA 329:17, VI (c), and or/Med 501.01 (a), and/or Med 501 (e) (1).

10. The New Hampshire Board found the Respondent engaged in professional misconduct in violation of RSA 329:17, VI (c), and or/Med 501.01 (a), and/or Med 501 (e) (1).

#### Conclusions of Law

A. The Respondent has violated 243 CMR 1.03(5)(a)(12) in that he has been disciplined in another jurisdiction by the proper licensing authority for reasons substantially the same as those set forth in G.L. c. 112, § 5 or 243 CMR 1.03(5), specifically:

1. The Respondent engaged in conduct that undermines the public confidence in the integrity of the medical profession. *See* Raymond v. Board of Registration in Medicine, 387 Mass. 708 (1982); Levy v. Board of Registration in Medicine, 378 Mass. 519 (1979).
2. The Respondent engaged in conduct which places into question the physician's competence to practice medicine. *See* 243 CMR 1.05(a)(3).
3. The Respondent committed misconduct in the practice of medicine. *See* 243 CMR 1.03(5)(a)(18).
4. The Respondent committed malpractice. *See* G.L. c. 112 §61; 243 CMR 1.03(5)(a)(17).

#### Sanction and Order

The Respondent's license is hereby Reprimanded. This sanction is imposed for each violation of law listed in the Conclusion section and not a combination of any or all of them.

### Execution of this Consent Order

Complaint Counsel, the Respondent, and the Respondent's counsel agree that the approval of this Consent Order is left to the discretion of the Board. The signature of Complaint Counsel, the Respondent, and the Respondent's counsel are expressly conditioned on the Board accepting this Consent Order. If the Board rejects this Consent Order, in whole or in part, then the entire document shall be null and void; thereafter, neither of the parties nor anyone else may rely on these stipulations in this proceeding.

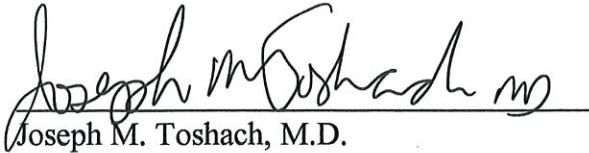
As to any matter in this Consent Order left to the discretion of the Board, neither the Respondent, nor anyone acting on his behalf, has received any promises or representations regarding the same.

The Respondent waives any right of appeal that he may have resulting from the Board's acceptance of this Consent Order.


The Respondent shall provide a complete copy of this Consent Order with all exhibits and attachments within ten (10) days by certified mail, return receipt requested, or by hand delivery to the following designated entities: any in- or out-of-state hospital, nursing home, clinic, other licensed facility, or municipal, state, or federal facility at which the Respondent practices medicine; any in- or out-of-state health maintenance organization with whom the Respondent has privileges or any other kind of association; any state agency, in- or out-of-state, with which the Respondent has a provider contract; any in- or out-of-state medical employer, whether or not the Respondent practices medicine there; the state licensing boards of all states in which the Respondent has any kind of license to practice medicine; the Drug Enforcement Administration Boston Diversion Group; and the Massachusetts Department of Public Health Drug Control Program. The Respondent shall also provide this notification to any such designated entities with which the Respondent becomes associated in the year following the date

of imposition of this reprimand. The Respondent is further directed to certify to the Board within ten (10) days that he has complied with this directive.


The Board expressly reserves the authority to independently notify, at any time, any of the entities designated above, or any other affected entity, of any action it has taken.

  
Joseph M. Toshach, M.D.  
Licensee

1/20/21  
Date

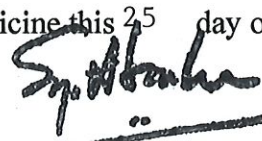
  
Amy E. Goganian  
Attorney for the Licensee

1/22/21  
Date

  
Patrick G. Fitzgerald  
Complaint Counsel

1/22/2021  
Date

So ORDERED by the Board of Registration in Medicine this 25<sup>th</sup> day of March, 20 21.

  
George Abraham, M.D.  
Board Chair

**New Hampshire Settlement Agreement  
dated November 7, 2019**

**State of New Hampshire  
Board of Medicine  
Concord, New Hampshire 03301**

In the Matter of:  
**Joseph M. Toshach, MD**  
**License No.: 15423**  
(Misconduct Allegations)

**SETTLEMENT AGREEMENT**

In order to avoid the delay and expense of further proceedings and to promote the best interests of the public and the practice of medicine, the New Hampshire Board of Medicine ("Board") and Joseph M. Toshach, MD ("Respondent"), a physician licensed by the Board, do hereby stipulate and agree to resolve certain allegations of professional misconduct now pending before the Board according to the following terms and conditions:

1. Pursuant to RSA 329:17, I; RSA 329:18; RSA 329:18-a; and Medical Administrative Rule ("Med") 206 and 210, the Board has jurisdiction to investigate and adjudicate allegations of professional misconduct committed by physicians. Pursuant to RSA 329:18-a, III, the Board may, at any time, dispose of such allegations by settlement and without commencing a disciplinary hearing.
2. The Board first granted Respondent a license to practice medicine in the State of New Hampshire on October 5, 2011. Respondent holds license number 15423.
3. On or about January 27, 2017, the Board received notice of a medical malpractice lawsuit filed in Merrimack Superior Court against Respondent's employer and others. The lawsuit alleged that the Respondent and others were negligent in the care and treatment of a thirteen-year-old girl ("Patient") who died after they allegedly failed to

diagnose and treat a brain tumor while treating the Patient at the Concord Hospital on May 1-2, 2016.

4. In response to this, the Board conducted an investigation and obtained information from various sources pertaining to Respondent's treatment of the Patient, first in the Emergency Department ("ED") of the Concord Hospital and later on the pediatric floor, on May 1<sup>st</sup> and 2<sup>nd</sup>, 2016.
5. Respondent stipulates that if a disciplinary hearing were to take place, Hearing Counsel would prove that Respondent engaged in professional misconduct, in violation of RSA 329:17, VI (c), and/or Med 501.01 (a), and/or Med 501.02 (e) (1), based upon the following facts:
  - A. Patient arrived at the ED at approximately 10:15 a.m. on May 1, 2016. Based upon the history given by Patient and her family, and the examination conducted of the Patient, the treating ED physician diagnosed migraine and ordered pediatric doses of migraine medications (compazene, Benadryl, and toradol). These were administered to Patient at approximately 11:45 a.m. This ED physician also ordered an out-patient MRI of the brain, to occur within three days of Patient's discharge.
  - B. At approximately 3:30 p.m., Respondent was called in to the ED for a pediatric consult for Patient. Respondent's consult note indicates that he did not wake Patient to conduct an assessment of her. Respondent relied upon the normal neurological findings recorded by the initial ED physician, and concluded that Patient's somnolence was due to the sedating effects of the



medications combined with a lack of sleep the night before, or was possibly behavioral in nature. This last conclusion was based upon nursing notes with regard to observations of the Patient and her family. Respondent recommended continued observation in the ED.

- C. Nursing notes documented that, at approximately 6:40 p.m., Patient needed “max[imum] assistance” in going to and from the bathroom. A later nursing note indicated that, at 7:30 p.m., Patient was “responsive to strong physical and verbal stimuli,” and that a second ED physician, who had taken over Patient’s care from the original physician, was notified, and later came to the Patient’s bedside to re-evaluate her. Respondent was not notified of these developments at the time.
- D. Respondent saw Patient again at approximately 8:40 p.m., and was asked to admit her to the pediatric floor for overnight observation. Respondent’s notes from this encounter indicate that Patient “stirs with stimuli . . . but does not wake to verbal command.” Respondent did not wake Patient to conduct a neurological examination. Respondent did not order a CT scan of Patient’s brain to rule out a neurological cause for her somnolent state.
- E. At shortly after 9:00 p.m., while Patient was still in the ED, her temperature was noted to be elevated. Tylenol was administered to Patient rectally because of her continued somnolent state. Respondent and the second ED physician were both notified of this by nursing staff.

- F. Patient was transferred to the pediatric floor at approximately 10:00 p.m. Nursing notes made at 10:53 p.m. indicated that Patient was "obtunded," and had dried blood in both nostrils. In addition, Patient was non-verbal, but was able to squeeze the nurse's hand and open her eyes when requested. At 12:56 a.m., Patient's pupils were unequal, and she was noted to be less responsive. Respondent was notified of this change. At some point after this notification, Respondent was present at Patient's bedside. However, at approximately 1:30 a.m., Patient went into cardiac arrest, and had to be revived. An emergent CT of the brain, which Respondent had ordered before Patient went into cardiac arrest, revealed the presence of the brain tumor.
- G. A consulting neurologist was called in, and he was of the opinion that it was too late to reverse the damage the tumor had caused. Nevertheless, he undertook treatment to reduce the pressure in Patient's brain, and ordered her transferred to Dartmouth Hitchcock for brain surgery. However, Patient never regained consciousness and died a few days later.
6. The Board finds that Respondent committed the acts as described above and concludes that, by engaging in such conduct, Respondent violated RSA 329:17, VI (c), and/or Med 501.01 (a), and/or Med 501.02 (e) (1).
7. Respondent acknowledges that this conduct constitutes grounds for the Board to impose disciplinary sanctions against Respondent's license to practice as a physician in the State of New Hampshire.

8. Respondent consents to the Board imposing the following discipline, pursuant to RSA 329:17, VII:
  - A. Respondent is **REPRIMANDED**.
  - B. Respondent is required to meaningfully participate in a program of **CONTINUING MEDICAL EDUCATION** for at least 4 hours in the area of history taking, evaluating, and assessing the headache patient. These hours shall be in addition to the hours required by the Board for renewal of licensure and shall be completed within one (1) year from the effective date of this *Settlement Agreement*. Within fifteen (15) days of completing these hours, Respondent shall notify the Board and provide written proof of completion.
  - C. Respondent is assessed an **ADMINISTRATIVE FINE** in the amount of one thousand dollars (\$1,000.00). Respondent shall pay this fine in full within thirty (30) days of the effective date of this *Settlement Agreement*, as defined further below, by delivering a money order or bank check, made payable to "Treasurer, State of New Hampshire," to the Board's office at 121 South Fruit Street, Suite 301, Concord, New Hampshire, 03301.
  - D. Respondent is assessed **INVESTIGATIVE AND PROSECUTION COSTS** in the amount of two-thousand dollars (\$2,000.00), pursuant to RSA 332-G:11. Respondent shall pay these costs in full within thirty (30) days of the effective date of this *Settlement Agreement*, as defined further below, by delivering a money order or bank check, made payable to "Treasurer, State of New Hampshire," and containing the memo "Investigative costs; RSA 332-G:11,"

to the Board's office at 121 South Fruit Street, Suite 301, Concord, New Hampshire, 03301.

- E. Respondent shall bear all costs of the discipline required by this *Settlement Agreement*, but he shall be permitted to share such costs with third parties.
- F. The Board may consider Respondent's compliance with the terms and conditions herein in any subsequent proceeding before the Board regarding Respondent's license.
- G. Within ten (10) days of the effective date of this agreement, as defined further below, Respondent shall furnish a copy of the *Settlement Agreement* to any current employer for whom Respondent performs services as a physician or work which requires a medical degree and/or medical license or directly or indirectly involves patient care, and to any agency or authority which licenses, certifies or credentials physicians, with which Respondent is presently affiliated.
- H. For a continuing period of one (1) year from the effective date of this agreement, Respondent shall furnish a copy of this *Settlement Agreement* to any employer to which Respondent may apply for work as a physician or for work in any capacity which requires a medical degree and/or medical license or directly or indirectly involves patient care, and to any agency or authority that licenses, certifies or credentials physicians, to which Respondent may apply for any such professional privileges or recognition.

9. Respondent's breach of any terms or conditions of this *Settlement Agreement* shall constitute unprofessional conduct pursuant to RSA 329:17, VI (d), and a separate and sufficient basis for further disciplinary action by the Board.
10. Except as provided herein, this *Settlement Agreement* shall bar the commencement of further disciplinary action by the Board based upon the misconduct described above. However, the Board may consider this misconduct as evidence in the event that similar misconduct is proven against Respondent in the future. Additionally, the Board may consider the fact that discipline was imposed by this Order as a factor in determining appropriate discipline should any further misconduct be proven against Respondent in the future.
11. This *Settlement Agreement* shall become a permanent part of Respondent's file, which is maintained by the Board as a public document.
12. Respondent voluntarily enters into and signs this *Settlement Agreement* and states that no promises or representations have been made to him other than those terms and conditions expressly stated herein. Furthermore, no improper influence, coercion, or duress has contributed to Respondent's decision to sign this *Settlement Agreement*.
13. The Board agrees that in return for Respondent executing this *Settlement Agreement*, the Board will not proceed with the formal adjudicatory process based upon the facts described herein.
14. Respondent understands that his action in entering into this *Settlement Agreement* is a final act and not subject to reconsideration or judicial review or appeal.

15. Respondent has had the opportunity to seek and obtain the advice of an attorney of their choosing in connection with his decision to enter into this agreement.
16. Respondent understands that the Board must review and accept the terms of this *Settlement Agreement*. If the Board rejects any portion, the entire *Settlement Agreement* shall be null and void. Respondent specifically waives any claims that any disclosures made to the Board during its review of this *Settlement Agreement* have prejudiced his right to a fair and impartial hearing in the future if this *Settlement Agreement* is not accepted by the Board.
17. Respondent is not under the influence of any drugs or alcohol at the time he signs this *Settlement Agreement*.
18. Respondent certifies that he has read this document titled *Settlement Agreement*. Respondent understands that he has the right to a formal adjudicatory hearing concerning this matter and that at said hearing he would possess the right to confront and cross-examine witnesses, to call witnesses, to present evidence, to testify on his own behalf, to contest the allegations, to present oral argument, and to appeal to the courts. Further, Respondent fully understands the nature, qualities and dimensions of these rights. Respondent understands that by signing this *Settlement Agreement*, he waives these rights as they pertain to the misconduct described herein.
19. This *Settlement Agreement* shall take effect as an Order of the Board on the date it is signed by an authorized representative of the Board.

**FOR RESPONDENT**

Date: 9/18/19

Joseph M. Toshach, MD  
Joseph M. Toshach, MD  
Respondent

Date: 9/20/19

Melissa M. Hanlon  
Melissa M. Hanlon, Esq.  
Counsel for Respondent

**FOR THE BOARD/\***

This proceeding is hereby terminated in accordance with the binding terms and conditions set forth above.

Date: November 7, 2019

Penny Taylor  
(Signature)  
PENNY TAYLOR  
(Print or Type Name)  
Authorized Representative of the  
New Hampshire Board of Medicine

/\* David Conway, MD & Nina Gardner, Board members, recused.