FILED
April 22, 2015
NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

STATE OF NEW JERSEY
DEPARTMENT OF LAW & PUBLIC SAFETY
DIVISION OF CONSUMER AFFAIRS
STATE BOARD OF MEDICAL EXAMINERS

In The Matter Of:

Mohamed Kawam Jabakji, M.D.
License No. 25 MA06054400

ORDER OF
TEMPORARY SUSPENSION
OF LICENSE

This matter was initially opened before the New Jersey State Board of Medical Examiners on March 10, 2015, upon the filing of a Verified Administrative Complaint ("Complaint") and an Order to Show Cause seeking, among other things, the entry of an Order temporarily suspending or otherwise limiting the license of Mohamed Kawam Jabakji, M.D. ("Respondent") to practice medicine and surgery in the State of New Jersey. The six count Complaint alleges that Respondent indiscriminately prescribed controlled substances and exhibited gross and repeated acts of negligence in his care of six patients (identified by their initials only, in order to protect confidentiality).

For the reasons set forth in greater detail below, we find that the Attorney General has palpably demonstrated a clear and imminent danger to the public were Respondent to continue to practice pending adjudication of the charges. At this stage of

the proceeding, the record demonstrates that the care provided to these six patients included a lack of screening, examination and testing by Respondent which was needed to appropriately treat the conditions he diagnosed and needed prior to prescribing and continuing to prescribe controlled substances and other medications. The record further demonstrates a pattern of indiscriminate prescribing of controlled substances.

PROCEDURAL HISTORY

The Verified Complaint filed on March 10, 2015 alleges that Respondent violated multiple provisions of the statutes and regulations governing medical practice in New Jersey when providing care to six patients, to include allegations that he engaged in gross and/or repeated acts of negligence and that he indiscriminately prescribed to each patient. The Complaint was supported by Respondent's medical records for each patient, prescription profiles for each patient and an expert report dated March 9, 2015, prepared by Antonios J. Tsompanidis, D.O., which reviewed and commented upon Respondent's care of each of the six patients. Deputy Attorney General David Puteska also submitted a letter brief, dated March 10, 2015, in support of the application for temporary suspension.

On March 12, 2015, the Board acknowledged that Respondent was unable to prescribe controlled substances as his New Jersey and DEA controlled substances registrations were in

surrendered/suspended status and granted Respondent's request for an adjournment of the March 25, 2015 hearing (to April 8, 2015) to afford Respondent's counsel additional time to prepare for the hearing. On March 27, 2015, the Board denied Respondent's request for adjournment of the April 8, 2015 hearing date.[1]

On April 1, 2015, Respondent filed an Answer to the Complaint, generally denying all substantive allegations. Counsel for Respondent also submitted a letter brief, a certification of Respondent and a certification of Respondent's legal counsel in opposition to the Order to Show Cause. Copies of "Office Procedures for Prescribing Controlled (Classified) Medications", a "Pain Management Agreement" and a portion of J.A.'s patient record were included as exhibits to the certification of Respondent. Six (6) prior Board Orders and expert reports prepared on behalf of Dr. Kawam by Kamran Tasharofi, M.D. and David R. Adin, D.O. were included as exhibits to the certification of Respondent's counsel. [2]

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[1] The Board President denied Respondent's request for an adjournment to allow additional time for discovery after consideration of Respondent's written request and the Attorney General's opposition. A temporary suspension hearing is a summary proceeding and there is ordinarily no discovery. Nonetheless, in this matter, counsel for the State represented that there was already extensive discovery completed and that the items sought by counsel for Respondent were unrelated to the pending action before the Board.

[2] All exhibits offered by both the A.G. and counsel for Respondent were entered into evidence without objection. A complete list of all exhibits is attached to this Order as Appendix A.

A hearing on the application for the temporary suspension of Respondent's license was held on April 8, 2015. Deputy Attorney General David Puteska appeared for complainant John Hoffman, Acting Attorney General of New Jersey. Todd Mizesky, Esq. and Jason Silberman, Esq. of Frier Levitt appeared on behalf of Respondent. It was represented that, upon the advice of counsel, Respondent did not appear due to the pendency of a criminal matter.

SUMMARY OF EVIDENCE PRESENTED AT HEARING

The Attorney General's application for temporary suspension was supported by documents that had been appended to the certification of DAG Puteska (submitted initially as verification for the Complaint), which documents were all entered into evidence without objection.[3] In addition to the six individual patient records and the prescriptive records, the Attorney General's case was supported by the written expert report of Antonios J. Tsompanidis, D.O. dated March 9, 2015 and copies of Orders documenting the surrender and/or suspension of Respondent's New Jersey and DEA controlled substance registrations.

Dr. Tsompanidis's curriculum vitae indicates he is a physician licensed in New Jersey since 1995 and is Board

[3] DAG Puteska, without objection from Respondent's counsel, submitted an amended patient record for patient J.A. to include a portion of the record not previously produced as part of the Verified Complaint filed in this matter.

Certified in Family Medicine and Osteopathic Manipulative Treatment with recertification in 2005 and 2014. Dr. Tsompanidis reviewed the treatment records and prescription profiles for each of the six patients. In his report (P-3), he observed generally that:

> Dr. Kawam's medical notes are grossly incomplete and lack basic documentation both initially and throughout the course of treatment i.e. pertinent history, examination findings, assessment, pain scale monitoring and treatment plans to justify the prescribing of the narcotic medications. When narcotics are prescribed, there are multiple instances where either 1. Amounts are not written or 2. Medications, dosages and amounts were not written (the word "refills" is only written). In fact, of the charts reviewed, there are no physical examinations documented and there are occasional completely blank encounter forms.
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> [P-3 at page 3].

Dr. Tsompanidis then individually analyzed Respondent's treatment of each of the six patients. He notes that, with respect to patient J.H.1 (Count I), it was a gross deviation from accepted practice for Respondent to continue to prescribe controlled substances despite time lapses of one to seven months between office visits which should raise "immediate concern" that the patient is engaged in diversionary activity and seeking medication from other providers. Respondent did not address the time lapses in the patient record. (P-3 at 4 and 5).

With respect to patient A.H. (Count II), Dr. Tsompanidis again opines that Respondent's treatment posed harm to A.H. and is a gross deviation from accepted practice. (P-3 at 4 and 5-6). Respondent notes in the patient record that, in October 2012, the patient denied seeing or receiving a prescription from another doctor. Respondent did not give A.H. a prescription that day and placed a note in the chart stating "will never see patient again." Nonetheless, 10 months later in August 2013, Respondent saw A.H. again and prescribed Oxycodone. By February 2014, the patient record reflects that A.H. is early for her refills, yet Respondent prescribed Oxycodone on 2/5/14 and again on 2/26/14. In June 2014, Respondent accessed the Prescription Monitoring Program ("PMP") records, which showed "multiple inconsistencies in her prescriptions as well as obvious narcotic diversionary activity" including multiple prescribers, unfilled prescriptions and the use of three different addresses when filling her narcotic prescriptions, and yet, Respondent continued to treat and prescribe controlled substances for A.H. Dr. Tsompanidis also opines that Respondent's prescription of albuterol every 1 - 3 months for asthma is a deviation from the standard of care as albuterol is meant as a "rescue medication" for mild/moderate asthma. (P-3 at 9).

Upon review of the patient record for J.H.2(Count III), Dr. Tsompanidis finds Respondent's care of patient J.H.2 was also

grossly negligent and notes that Respondent continued to prescribe controlled substances for this patient despite a lack of documentation in the record addressing narcotic diversionary activity such as time lapses between visits, seeing multiple providers and unfilled prescriptions. (P-3 at 4 and 6-7). Dr. Tsompanidis also expresses the opinion that Respondent's care of J.H.2 deviated from the standard of care in that "there is no documentation of asthma symptoms, severity of exacerbations to determine what the best treatment plan is. Again, the lack of documentation coupled with sporadic medication is a deviation from the standard of care." (P-3 at 9).

With regard to patient G.F. (Count IV), Dr. Tsompanidis again concludes there are gross deviations from accepted medical guidelines and practice. (P-3 at 4 and 7). He notes that Respondent did not adequately address concerns of narcotic abuse and diversion and continued to prescribe Oxycodone 30mg on a monthly basis. G.F., A.H. and J.H.2 share the same address of record and each exhibit diversionary behavior - failure of the Respondent to follow-up shows "poor judgment and lack of action." Dr. Tsompanidis also opines that Respondent deviated from the standard of care in his medical treatment of G.F. in that (1) he did not order or record any testing such as endoscopy for this patient with a diagnosis of Gastroesophageal Reflux Disease, (2) "there is no documentation of symptoms to

warrant further intervention or assess the usefulness of the prescription of Advair for the diagnosis of asthma, (3) no physical exam was done/recorded on September 25, 2012 prior to making the diagnosis of an eye infection and the prescription of Gentamycin. (P-3 at 9).

In Dr. Tsompanidis's opinion, Respondent's care of J.A. (Count V), is grossly negligent. (P-3 at 4 and 7-8). Respondent stopped prescribing controlled substances to J.A. in June 2011 and referred her to pain management. She returned to his office approximately two years later in July 2013 and Respondent resumed prescribing Percocet and Xanax. Dr. Tsompanidis opines that Respondent should have suspected diversion and, at minimum, accessed the PMP for controlled substance prescription information prior to again beginning to write narcotics prescriptions. A report from Silverscript prescriber services dated September 19, 2013 "clearly shows gross abuse and narcotic diversion activity of this patient," including narcotic and Xanax prescriptions from multiple providers during the same time period. Respondent continued to write narcotic and Xanax prescriptions for J.A. until January 2014, when he did access the PMP, which similarly indicated diversionary behavior. According to Dr. Tsompanidis, Respondent's care of J.A.'s diagnosed medical conditions was also grossly negligent:

> J.A. has diagnoses of Diabetes, Hyperlipidemia, Coronary artery disease and hypertension per the record. Dr. Kawam has refilled medications related to these diseases however did not address her hypertension on several occasions which should not be ignored in a patient with other concomitant diseases… the other serious medical issue is that Dr. Kawam prescribed Naprosyn (anti-inflammatory) for this patient who is taking Plavix which is contraindicated.
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> [P-3 at 9-10].

Dr. Tsompanidis opined that Respondent's care of S.P. (Count VI), also deviated from accepted medical practice based upon failure to have the patient enter a written pain contract or consult the PMP when the patient showed diversionary behavior, including seeking early refills. (P-3 at 4 and 8).

Dr. Tsompanidis ultimately concluded as to all six patients that

> Dr. Kawam's actions grossly deviate from the accepted medical standard for both pain and medical management. He is egregious in his gross lack of documentation except for consistently documenting the amount of money paid for the visit. He consistently failed to provide initial or follow-up treatment plans of physical examination findings to justify his narcotic prescriptions. He failed to document the narcotics he was prescribing in either quantity or completely by writing only "refills." He failed to justify increases in narcotic medications. He failed to consider diversion and/or abuse in his patients with suspicious behavior or questionable lapses in their histories. He continued to prescribe narcotics to patients whose PMP reports clearly indicated that the patient was receiving multiple medications from multiple providers. He failed to institute the PMP reports on patients with

> diversionary activity. He failed to do urine drug screens and institute narcotic agreements. He failed to document medical conditions and he carelessly did not follow-up with serious medical issues. He carelessly prescribed medication with potential life threatening interactions. He failed to dismiss or remove patients appropriately once it was documented that he would no longer see them. He failed to maintain legible records. All of these reasons listed above lead me to the conclusion that Dr. Kawam's actions pose a threat to his patients, pose imminent danger to his patients and the public and constitute gross negligence.
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> [P-3 at 10].

The DAG argued that both Dr. Tsompanidis's expert opinion and the patient records standing alone palpably demonstrate an appalling lack of good medical judgment and a pattern of indiscriminate prescribing and should fully support a determination that Respondent's practice presents clear and imminent danger to the public health, safety and welfare.

Respondent's defense was based on his own written certification (R-1) and that of his attorney (R-2) as well as two expert reports (R-2, Exhibits A & B). Respondent did not testify, nor did he call any witnesses.

In his certification dated April 1, 2015, Respondent argued that the six patient files that form the basis of the Verified Complaint are not a representative sampling of his treatment of over 1300 patients over his 25 year career. He claimed that he "serves a patient population predominantly from poor, minority

and underserved communities" and that such patients often cannot afford the same medications or testing procedures that more affluent patients can. (R-1 at 2). He further claimed that pain related controlled substance prescriptions constituted 20% or less of his overall prescription volume and he:

> never prescribed CDS to anyone knowing or even suspecting that they intended to use the CDS for inappropriate or improper reasons… they were "doctor shopping"… they suffered from a drug addiction. I have terminated many patients whom I suspected of engaging in such conduct or whom I believed suffered from drug addiction.
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> [R-1 at 3].

Respondent provided a copy of his "Office Procedures for Prescribing Controlled (Classified) Medications", which he claimed he followed. (R-1, Exhibit 1). He also provided a copy of a "Pain Management Agreement" which he would "often require patients to whom I prescribed pain-related CDS to sign." (R-1 at 4 and R-1, Exhibit 2). Respondent represented in his certification, but provided no corroborating proof, that he routinely reviews the terms of the Agreement with all of his patients that are prescribed CDS and he has terminated patients who do not abide by the written or oral Agreement. (R-1 at 4).

Respondent asserted that he "always reviews a patient's history when examining the patient" and "always performs a physical examination of the patient - regardless of how often I

have seen that patient in the past." He would "only prescribe medication based upon a patient's medical need and my best professional judgment… (and) routinely considered non-narcotic treatments before prescribing CDS." (R-1 at 4-5).

Respondent's certification then addressed each of the six patient records. In each case he relied heavily on self-evaluation forms filled out by his patients to justify his claim that he conducted a "comprehensive history and physical." He pointed to conclusory diagnoses in the patient records to justify treatment protocols and his prescribing of both controlled and non-controlled substances. For example, Respondent states that "J.H.2 was suffering from asthma, the determination of which required a physical examination of the patient, such as listening to the patient's lungs." (R-1 at 10). Yet, a review of the patient record reflects no findings from such an examination. (P-6 at 1048).

Respondent also made unsupported statements in an apparent attempt to justify his continued prescription of controlled substances to patients who exhibited diversionary behavior. For example, regarding patient J.A., Respondent claimed that he did not receive the Silverscript letter alerting him that J.A. was receiving narcotic prescriptions from multiple providers until months after it was issued. Similarly, he claimed that "I do not prescribe patients more than 60 pills per month of any pain

medication. To the extent that the PMP reflects otherwise, this is an error or the result of prescription fraud/forgery." (R-1 at 5 and 18).

Dr. Kamran Tasharofi, M.D. provided a report as Respondent's expert. (R-2, Exhibit A). His curriculum vitae indicates he is Board Certified in Internal Medicine and Surgery with re-certification in 2013. Dr. Tasharofi reviewed the Verified Complaint, the report of the Attorney General's expert, and the treatment records and prescription profiles for each of the six patients named in the Verified Complaint. He also met with and discussed each patient with Respondent.

Dr. Tasharofi summarized each of the six patient records and generally concluded that Respondent "provided medical care and exhibited professional medical judgment within the accepted standards of medical practice for Internal Medicine." (R-2, Exhibit A at 2). Dr. Tasharofi acknowledged that there were certain "record-keeping and notation deficiencies" in the six patient charts but goes on to state that Respondent "clearly references each patient's symptoms, records the appropriate diagnoses and provides and cites to clinically appropriate treatments, including medications for the conditions documented." (R-2, Exhibit A at 2). Dr. Tasharofi cited to the challenges that lower income patients have in financing urine screens and diagnostic testing such as MRI's. (R-2,Exhibit A at

5). Finally, Dr. Tasharofi argued that prescribing Naprosyn in conjunction with Plavix is not contraindicated and that "these two drugs are often used under close observation by many doctors without hesitation, so long as the patient is being monitored regularly." (R-2, Exhibit A at 5).

Dr. David Adin, D.O. also provided an expert report on behalf of Respondent. (R-2, Exhibit B). His curriculum vitae indicates he is Board Certified in both Pain Management and Physical Medicine and Rehabilitation. Dr. Adin reviewed the Verified Complaint, the report drafted by the Attorney General's expert, and the treatment records and prescription profiles for each of the six patients. He also discussed the matter with the Respondent for approximately 20 minutes.

Dr. Adin observed generally that Respondent "provided medical care and exhibited professional medical judgment within accepted pain treatment guidelines and standards of care for pain and medical treatment in the State of New Jersey." (R-2, Exhibit B at 1-2). He noted that Respondent "appropriately avoided prescribing opiate analgesics at total daily MME[4] levels greater than 100-105. (R-2, Exhibit B at 2). Dr. Adin also noted that Respondent

> acknowledged making attempts to refer patients to pain management specialists… but he was generally unsuccessful in locating

[4] Morphine Milligram Equivalent

> one who would see his patients as his patients mostly lacked health coverage and the financial means to see additional doctors.
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> [R-2, Exhibit B at 2].

He concluded that the conditions that Respondent was treating likely warranted the need for pain medication, but did not comment on whether appropriate histories and physicals were done by Respondent to warrant these diagnoses. (R-2, Exhibit B at 3). Dr. Adin acknowledged that Respondent "did not give substantial weight to time lapses between visits, unfilled prescriptions issued for CDS, and different addresses listed on the PMP when filling narcotics." Dr. Adin stated: "these indications are not typical methods of drug diversion and can arise for many legitimate reasons." (R-2, Exhibit B at 4).

Counsel for Respondent argued that this case should be recognized to be one that is primarily about Respondent's failure to have maintained adequate records, as distinguished from his failure to have properly treated any of the six patients. His position was that there may be instances where Respondent's handwriting was illegible or where an exam was not explicit, but the recordation of height, weight, etc. show that a physical exam was in fact done. He further argued that, in four of the six patients, Respondent initially reduced the dosage of controlled substances prescribed. He reminded the

Board that two experts found Respondent's conduct to be within the standard of care - especially when one considers that his patient population is a poor, minority and underserved population where urine screens and other testing is out of reach financially. Five of the six patients had no insurance and could not afford specialists.

Counsel also argued that because this is a record-keeping case, and because Respondent's New Jersey and DEA controlled substance registrations are in surrendered/suspended status, the State has failed to palpably demonstrate an imminent harm to the public were Respondent allowed to continue practicing medicine. Finally, he argued that temporary suspension of Respondent's license under the facts presented would be a deviation from Board precedent.

FINDINGS

We find, using our medical expertise, that cause to support a determination that Respondent's continued practice would present clear and imminent danger exists upon our independent review of the patient records and the other evidence presented in this matter.

At this stage of the proceeding, we find the Attorney General's expert, to include his analysis of each individual case, to provide compelling support for the action we herein order. Dr. Tsompanidis's report and conclusions are supported

by the patient records and are corroborated by our own medical expertise. At this juncture, we adopt Dr. Tsompainidis's conclusions regarding the deviations from the standard of care and gross negligence exhibited by Respondent in his treatment of each patient named in the six count Verified Complaint.

The record before the Board demonstrates and we find that:

1. Respondent repeatedly failed to properly evaluate his patients. Without limitation, examples include Respondent's repeated failures to perform complete and appropriate physical examinations and other investigational efforts (such as imaging studies, use of pain scales, etc.) that would substantiate his ultimate diagnoses. We conclude that Respondent readily accepted whatever explanation his patient gave him to justify a diagnosis or a need for a controlled substance prescription without conducting an independent physical exam or requiring screening.

2. Respondent repeatedly failed to closely and properly monitor patients during the course of treatment.[5] Without limitation, examples include his repeated failures to monitor blood pressure and to order and follow-up on appropriate laboratory tests, such as urine screens and imaging studies. He

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[5] We are disturbed by Respondent's reliance on the argument that because many of his patients are from a lower socio-economic status Respondent should accept that a lower standard of medical care in unavoidable. We are aware, for example, that urine screens can be obtained at any hospital or can be paid for through charity care.

repeatedly failed to document the patients' response to treatment including adverse effects of medication.

3. Respondent repeatedly indiscriminately prescribed narcotics without a diagnosis that would warrant narcotic treatment and failed to attempt to lower the dosage of narcotic prescriptions over time. Even where Respondent may have lowered the dosage allegedly prescribed by a prior treating physician, there is no reliable information in the patient records to justify the prescription or to indicate that Respondent continued to attempt to lower the dosage over time.

4. Respondent's monitoring and screening of patients for possible misuse or diversion of prescribed drugs and/or for use of illegal drugs was virtually non-existent, yet he repeatedly continued to indiscriminately prescribe narcotics both with and without patients entering into written pain contracts. We find that Respondent did not routinely screen his patients even when they exhibited diversionary behavior (e.g. unfilled prescriptions issued for CDS, different addresses listed on the PMP, requests for early refills, inexplicable lapses of time between office visits, evidence of multiple prescribers and multiple patients exhibiting drug seeking behavior with the same place of residence).

DISCUSSION

It is evident that Respondent's patients were not getting the care they needed for serious medical conditions and that Respondent indiscriminately prescribed controlled substances to patients who exhibited diversionary behavior with little to no medical justification. The very real threat Respondent's continued practice presents is vividly demonstrated by his care and treatment of patient J.A. (Count V). The patient record for J.A. indicates that she suffered from a leg ulcer - but there is no indication that Respondent ever conducted an examination of the ulcer. (P-8 at 2339). Respondent's treatment of J.A.'s hypertension was woefully inadequate, as he failed to address the condition or even measure her blood pressure on several occasions. (See e.g. P-8 at 2357, 2364, 2363 and 2361). Although Respondent recorded a possible diagnosis of peripheral vascular disease in the patient record on July 10, 2013, his patient record for that visit shows no work up to support this diagnosis and Respondent did not even check off appropriate boxes on his own pre-printed form. (P-8 at 2352). There is no follow-up on Respondent's note in the patient record to check hemoglobin A1C[6] and no assessment to explain why the test was ordered. (P-8 at 2352). The patient records reflect that Respondent prescribed both Plavix and Naprosyn, medications that when taken together may cause excessive bleeding, to J.A.

[6] The A1C test is a blood test that provides information about a person's average levels of blood glucose over the past 3 months.

without appropriate close monitoring. Finally, a simple diagnosis of "back pain" is insufficient to warrant initial or continued prescription of controlled substances without further work up.

Respondent's treatment of patient G.F. (Count IV) is also illustrative of his lack of sound medical judgment. For example, there is no documented complaint, history or physical exam in the patient record to warrant a diagnosis of Gastroesophageal reflux disease - and no adequate treatment for this condition. (P-7 at 468). Respondent failed to consider that G.F.'s frequent falls might be the result of too much medication and does not do a work up for vertigo to rule out other conditions, instead choosing to continue to prescribe pain medications.

Another example of Respondent's poor medical judgment and repeated deviations from the standard of care, exists in the lack of any documented complaint, history and physical exams to warrant diagnoses of asthma for A.H., J.H.2 and G.F. - yet these patients were prescribed inhalers. (See generally, P-5, P-6, and P-7). All three resided at the same address and all three displayed suspicious and diversionary behavior. We are aware in our medical expertise that inhalers are known to enhance the effects of many controlled substances.

We find, at this stage of the proceeding, that Respondent's certification is generally self-serving and without support in the record before us.[7] As noted above, Respondent claimed without corroboration that he did not receive Silverscript correspondence alerting him that J.A. was receiving narcotic prescriptions from multiple providers until months after it was issued. He also makes a blanket allegation of error or prescription fraud in any case where the PMP might reflect that Respondent prescribed more than 60 pills per month of any pain medication to an individual patient. Respondent claimed that the six patient records submitted in support of the Verified Complaint in this matter are not a representative sampling of his patient care. Yet, he did not submit even one patient record showing his claimed appropriate medical treatment and prescription practices in similar cases. Respondent submitted a copy of an undated document reflecting what he claimed were the procedures he followed when prescribing controlled substances (R-1, Exhibit 1), but the patient records before us do not substantiate this claim. Respondent claims that he often required patients to whom he prescribed controlled substances to

[7]Respondent's certification in this matter appears to be contradicted by the patient records. It also seems that Respondent's experts relied, at least in part, upon Respondent's certification and/or communication directly with Respondent. We were advised that, upon advice of counsel, Respondent did not testify at the hearing due to a pending criminal matter. Accordingly, we do not have the benefit of either cross-examination or direct questioning of Respondent regarding the many inconsistencies and unsubstantiated statements in Respondent's certification.

sign a "Pain Management Agreement" and that he routinely orally reviewed the terms of the agreement with all patients receiving controlled substance prescriptions. (R-1 at 4 and R-1 Exhibit 2). The written agreement is included in only one of the six patient records in this case and there is no indication in that record or the records of the other five patients that any pain management agreement was even discussed.

Similarly, neither expert report submitted on Respondent's behalf is persuasive or credible. We find nothing in these documents which would cause us to reject or even discount any of Dr. Tsompanidis' opinions. Despite the claims of Respondent and his experts to the contrary, the histories and physicals contained in Respondent's patient records fail to meet the standard of even a first year medical student: the reason for the patient's visit is often blank or indicates "refills"; often no vital signs and no examination is recorded; there are progress notes that include only the date of the visit, the controlled substance provided and the fee for the visit. (See e.g. P-4 at 1014; P-6 at 1029, 1031, 1035; P-7 at 0434 0436; P-8 at 2356; P-9 at 1287).[8] Respondent relies on a self-evaluation form completed by the patient to supply the "history and physical" to support his diagnosis and prescriptions of

[8] These citations to the patient record are meant to be only an illustration of the myriad instances in which Respondent's patient records fall far short of the standard of care.

controlled substances. Self-evaluation forms completed by the patient are frequently utilized to obtain aspects of the patient's history and complaints. These forms are meant to be a starting point in the evaluation of the patient and utilized in conjunction with the physician's own history taking and physical exam. A self-evaluation form with no further history and physical exam does not support the diagnoses made by Respondent or his utilization of long term prescribing of controlled substances. There is insufficient documentation in any of the patient records currently before us to support the conclusion that Respondent conducted comprehensive examinations.

Dr. Tasharofi opines that Plavix and Naprosyn "are often used under close observation by many doctors without hesitation." (R-2, Exhibit A at 5). However, there was no "close observation" on the record before us. Additionally, in our professional expertise, Plavix and Naprosyn are generally contraindicated and should not be prescribed with any regularity and certainly not without extreme caution. Any doctor who prescribes Plavix and Naprosyn should be very concerned about serious side effects (increased risk of bleeding) and should follow the patient closely. Respondent prescribed these medications concurrently without a proper physical exam and subsequent appropriate monitoring. It is of further concern

that, in his certification, Respondent makes the statement that these drugs are "often used in tandem."

In our medical expertise, time lapses between visits, unfilled prescriptions issued for CDS, different addresses listed on the PMP when filling narcotics, and multiple family members at the same address are typical indicators of drug seeking behavior. Dr. Adin's blanket statement to the contrary is inexplicable at best. As noted above, Dr. Adin also concluded that the conditions that Respondent was treating likely warranted the need for pain medication, but he did not even comment on whether appropriate histories and physicals were done by Respondent to warrant these diagnoses.

Respondent baldly asserted that the Attorney General "cherry picked" patient records that were not illustrative of his much larger practice. We find that six instances of gross and dangerous practices are a sufficient basis for concluding at this juncture of the proceeding that continued practice of Respondent would pose an imminent danger to patients given the pervasive poor medical judgment and indiscriminate prescribing of controlled substances that has been demonstrated.

Respondent's counsel argued that there is no imminent threat to allowing Respondent to continue to practice medicine because Respondent's New Jersey and DEA controlled substance registrations have been inactive for eight months. This

argument is disingenuous. The consent order of surrender of Respondent's New Jersey controlled substance registration clearly states that Respondent may seek a hearing to request reinstatement of his registration or modification of his Consent Order at any time and that he will be granted a hearing. In fact, Respondent requested such a hearing within weeks of surrendering his controlled substance registration.

Finally, Respondent's counsel argued that the immediate temporary suspension of Respondent's license based on the record before us would not be consistent with prior Board actions. We find this to be wholly incorrect as we have many times in the past issued Orders of Temporary Suspension when the proffered evidence clearly demonstrates, as it does in this case, that a licensee's conduct is reflective of such poor medical judgment that the public's health safety and welfare would be placed at risk of harm if the licensee were permitted to continue to practice pending a plenary hearing.

CONCLUSION

For the reasons detailed above, we find pursuant to N.J.S.A. 45:1-22 that the Attorney General has palpably demonstrated a clear and imminent danger to the public were Respondent to continue to practice pending adjudication of the charges. The Board finds that the conduct imports such a lack of sound medical judgment that its foreseeable consequences

cannot be confined to the individual incidents set forth in the Complaint. Rather, the pattern of conduct that has been established appears to be indicative of a more general and fundamental incapacity presenting undue risk to the public.

In our deliberations, we considered whether any action short of the full, immediate temporary suspension of respondent's license could be crafted to allow respondent to continue to engage in medical practice while affording adequate protection to his patients and the public at large. To that end, we considered whether Respondent might be allowed to continue to practice with a formal restriction prohibiting him from prescribing any CDS[9], or with other possible limitations, restrictions and/or monitoring.

Ultimately, however, we are convinced that nothing short of a temporary suspension would be adequately protective of the public interest. The manifest issues that we have identified on the record before us reflect not only on the poor choices Respondent made regarding the prescribing of controlled substances, but ultimately are reflective of gaping deficits in fundamental medical practice and standards of care concerning his judgment, diagnosis, care and treatment. We are convinced that his record keeping, treatment and judgment deficiencies

[9] Respondent's New Jersey and DEA controlled substance registrations were surrendered in August 2014. He is currently seeking the reinstatement of his New Jersey registration.

cannot be presently remediated through monitoring or by the crafting of limitations on practice, and therefor conclude that our paramount obligation to protect the public interest dictates the entry of an order of temporary suspension of license.[10]

WHEREFORE it is on this 22 day of April, 2015

ORDERED:

1. The license of respondent Mohamed Kawam Jabakji, M.D., to practice medicine and surgery in the State of New Jersey is hereby temporarily suspended and respondent shall cease and desist from the practice of medicine and surgery in the State of New Jersey, effective April 22, 2015, pending the completion of plenary proceedings (as evidenced by the entry of a final order of the Board) in this matter.

2. During the period from the oral announcement of this order on the record on April 8, 2015 to April 22, 2015, the date on which the temporary suspension shall take effect, Dr. Kawam Jabakji, M.D. shall not accept any new patients and shall make arrangements for transfer of care of all his patients.

3. Respondent shall comply with the Directives applicable to disciplined licensees of the Board, whether or not attached hereto.

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[10] Recognizing that Respondent's New Jersey and DEA controlled substance registrations are surrendered at this time and that he may not prescribe controlled substances, and for the benefit of patients who had no notice of these proceedings and/or who may be in treatment with Respondent, Respondent was afforded a two week period to wind down his practice and transfer patients, during which period he is not permitted to accept new patients.

NEW JERSEY STATE BOARD
OF MEDICAL EXAMINERS

By: 

Karen Criss, R.N., C.N.M.
Vice President