BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **MARCIA A. MASTRIN, M.D** Holder of License No. 31029 For the Practice of Medicine In the State of Arizona.	**Case No. MD-17-0567A** **ORDER FOR SURRENDER OF LICENSE AND CONSENT TO THE SAME**

Marcia A. Mastrin, M.D. ("Respondent"), elects to permanently waive any right to a hearing and appeal with respect to this Order for Surrender of License; admits the jurisdiction of the Arizona Medical Board ("Board") as well as the facts stated herein; and consents to the entry of this Order by the Board.

FINDINGS OF FACT

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

2. Respondent is the holder of license number 31029 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-17-0567A after receiving a complaint regarding Respondent's care and treatment of a 29 year-old female patient ("JH") alleging concern about Respondent's prescribing practices after JH was admitted to an Emergency Room for an accidental overdose of hydrocodone prescribed by Respondent.

4. A Medical Consultant ("MC") who reviewed Respondent's care of JH and three other patients noted deviations from the standard of care with regard to Respondent's controlled substance prescribing practices for all four patients. The MC stated that Respondent's deviations from the standard of care included initiation and escalation of opioid medication therapy without proper evaluation and continuation of patients on high dose opioid therapy without proper management and re-evaluation. Additionally, the MC

found that Respondent failed to properly monitor for or address patient non-compliance and aberrant urine drug screens indicative of medication misuse or diversion.

5. Actual harm was identified in that patients were noted to have developed opioid tolerance and dependence.

6. There was the potential for patient harm in that the patients were at unreasonable risks for the potential adverse outcomes related to opioid medications.

7. Additionally, the MC noted that Respondent's documentation was largely illegible.

8. Effective May 28, 2018, Respondent entered into an Interim Consent Agreement for Practice Restriction prohibiting her from prescribing controlled substances pending the outcome of the investigation.

9. On June 11, 2018, the Board received an additional complaint regarding Respondent's care and treatment of three patients of Respondent who had overdosed on opioids. Additionally, the complaint identified five other patients who had died within 30 days of receiving an opiate prescription from Respondent. Based on the complaint, Board staff requested MC review of Respondent's care and treatment of an additional three patients from this complaint.

10. Patient GL was a 37 year-old female with a past medical history of chronic back pain, depression, hypertension, bipolar disorder, and fibromyalgia. GL began treatment with Respondent in September 2015. Respondent continued to see GL on a monthly basis until April 2017. GL's medication list included Baclofen, Fentanyl, oxycodone, gabapentin, Reglan, Trazodone, Clonidine, and Cymbalta. On April 30, 2017, GL became unresponsive at her home. GL was found to have five Fentanyl patches on her body and was transported to the hospital where she expired. A urine drug screen ("UDS") was positive for opiates and

benzodiazepines. GL's cause of death was listed as mixed drug toxicity, including Oxycodone, Diazepam, Fentanyl and Baclofen.

11. Patient SJ was a 38 year-old female with a history of low back pain, alcohol abuse, and prescription medication abuse. SJ began treatment with Respondent in August 2016. Respondent continued to see SJ on a monthly basis until May 2017. SJ's medication list included Vicodin, Valium, Baclofen, Phenergan, and Clonidine. On May 5, 2017, SJ was found unresponsive at her home and was pronounced dead at the scene. SJ's cause of death was listed as acute polydrug toxicity, including Fentanyl and Oxycodone.

12. Patient PT was a 33 year-old male with a history of neck pain with left arm paresthesia and abdominal pain secondary to previous abdominal surgery and resulting adhesions. PT had also been previously discharged from a pain management provider for having illicit drugs present on a urine drug screen. PT began treatment with Respondent in March 2014. Respondent continued to see PT on a monthly basis until October 2015. PT's medication list included morphine sulphate extended release ("MSER"), oxycodone, and Soma. Respondent obtained UDSs on PT, but aberrant results were not addressed until an oral fluid screen from October 19, 2015 showed cocaine, heroin, morphine and benzodiazepine, and PT was discharged from the practice. On November 6, 2015, PT died of acute opiate (Heroin) intoxication.

13. An MC who reviewed Respondent's care and treatment of GL, SJ, and PT identified deviations from the standard of care for all three patients including failing to have a comprehensive treatment plan, establish goals or document meaningful improvement on opioids, failing to query the CSPMP database prior to prescribing controlled substances, failing to address aberrant urine drug screen results prior to prescribing controlled substances and by prescribing opioids for chronic use with no clear disease state.

14. Actual harm was identified for patients GL and SJ in that they expired from polydrug toxicity including medications prescribed by Respondent. With regard to PT, actual patient harm was identified in that Respondent's prescribing practices contributed to PT's opioid use disorder, which did eventually lead to his death after Respondent terminated care.

15. On February 9, 2007, in case MD-05-0031A, Respondent entered into a Consent Agreement for Decree of Censure for improper treatment of opioid addiction, improper prescription of Buprenorphine in an unapproved form, and for inadequate medical records.

16. Respondent has requested surrender of her license.

CONCLUSIONS OF LAW

1. The Board possesses jurisdiction over the subject matter hereof and over Respondent.

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

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

4. The Board possesses statutory authority to enter into a consent agreement with a physician and accept the surrender of an active license from a physician who admits to having committed an act of unprofessional conduct. A.R.S. § 32-1451(T)(2).

ORDER

IT IS HEREBY ORDERED THAT Respondent immediately surrender License Number 31029, issued to Marcia A. Mastrin, M.D., for the practice of allopathic medicine in the State of Arizona, and return her certificate of licensure to the Board.

DATED and effective this 12th day of November, 2021.

ARIZONA MEDICAL BOARD

By: Patricia E. McSorley
Patricia E. McSorley
Executive Director

CONSENT TO ENTRY OF ORDER

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

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

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

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

5. All admissions made by Respondent are solely for final disposition of this matter and any subsequent related administrative proceedings or civil litigation involving the Board and Respondent. Therefore, said admissions by Respondent are not intended or

made for any other use, such as in the context of another state or federal government regulatory agency proceeding, civil or criminal court proceeding, in the State of Arizona or any other state or federal court.

6. Upon signing this agreement, and returning this document (or a copy thereof) to the Board's Executive Director, Respondent may not revoke the consent to the entry of the Order. Respondent may not make any modifications to the document. Any modifications to this original document are ineffective and void unless mutually approved by the parties.

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

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

9. ***Respondent has read and understands the terms of this agreement.***

MARCIA A. MASTRIN, M.D.

Dated: 11/2/2021

EXECUTED COPY of the foregoing mailed by US Mail this 12th day of November, 2021 to:

Mandi J. Karvis, Esq.
Wicker Smith O'Hara McCoy & Ford
1 North Central Ave, Suite 885
Phoenix, Arizona 85004
Attorney for Respondent

ORIGINAL of the foregoing filed this 12th day of November, 2021 with:

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

Michelle Robles
Board staff

#9832646