BEFORE THE ARIZONA MEDICAL BOARD

In the Matter of **ROBERT A. WILLIAMS, M.D.** Holder of License No. 12287 For the Practice of Allopathic Medicine In the State of Arizona.	Case No. MD-13-0930A **FINDINGS OF FACT, CONCLUSIONS OF LAW AND ORDER FOR DECREE OF CENSURE AND PROBATION**

The Arizona Medical Board ("Board") considered this matter at its public meetings on June 11, 2014 and October 7, 2015. Robert A. Williams, M.D. ("Respondent") appeared with legal counsel Calvin Raup, Esq., before the Board for a Formal Interview pursuant to the authority vested in the Board by A.R.S. § 32-1451(H). The Board voted to issue Findings of Fact, Conclusions of Law and Order after due consideration of the facts and law applicable to this matter.

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 12287 for the practice of allopathic medicine in the State of Arizona.

3. The Board initiated case number MD-13-0930A after receiving a complaint regarding Respondent's care and treatment of a 53 year-old female patient ("SA"). The complaint alleged inappropriate prescribing.

4. SA had a long history of panic disorder with associated agoraphobia and was prone to some psychotic features including paranoid delusions that may have also resulted in some intractable insomnia. SA was first admitted to a psychiatric hospital in October of 2010 which was associated with administration of excessive amounts of klonopin and Ativan to treat recurrent panic attacks and social withdrawal. SA was experiencing

benzodiazepine withdrawal on admission, which may have complicated her hospital course.

5. In his response to the complaint, Respondent indicated that he began seeing SA again in October of 2010 after she was discharged from the hospital. Respondent's first chart notes, however, are dated January of 2011.

6. Respondent wrote prescriptions for SA at the end of 2010 for controlled substances including Adderall, Klonopin, and Ativan. There are no corresponding chart notes associated with these prescriptions. Respondent indicated that SA had a hypermetabolic state that mandated excessively high dosages of benzodiazepines prescribed monthly. He also expressed concern that SA may have been a suicide risk if not prescribed these mega dosages of controlled substances. There is no documentation to suggest that SA had any suicidal ideations in the past or present or had any past suicide attempts.

7. The first Medical Consultant ("First MC") found multiple deviations from the standard of care including the fact that there was no evidence that Respondent was regularly checking the Controlled Substance Prescription Monitoring Program ("CSPMP"), and that there were gaps in SA's chart where months went by with no progress notes and yet prescriptions for controlled substances were filled monthly under Respondent's name. The First MC further noted that there was no documentation of urine drug screens having been done either routinely or randomly to monitor medication compliance. The First MC noted that combining medications that are overtly sedating with stimulant medications is generally not advisable. After review and consideration of Respondent's response to the First MC's findings, the First MC recommended obtaining a second psychiatrist to evaluate the case.

8. Based upon that recommendation, this matter was forwarded to a second MC ("Second MC") for a new quality of care review. The Second MC agreed with the first MC's assessment and found that Respondent's care of SA was deficient in numerous areas. The Second MC observed that SA was given excessive amounts of benzodiazepines. The Second MC noted that over the years, SA developed physiologic tolerance and dependence. The Second MC further noted that Respondent admitted in his response to the Board that he exceeded standard dosages of two benzodiazepines given simultaneously, which the Second MC regarded as unacceptable practice. The Second MC stated that Respondent failed to recognize the symptoms of anxiolytic/sedative intoxication, failed to recognize SA's potential for controlled substance diversion, and failed to obtain informed consent for any of the medications.

9. The Second MC additionally found that Respondent's notes over a five-year period were substandard and nearly impossible to decipher. The Second MC stated that Respondent failed to monitor SA with appropriate lab and EKG studies despite the well-known adverse metabolic and cardiac effects of medications prescribed. The Second MC stated as well that Respondent failed to follow up on potentially dangerous abnormalities, and that he provided 3-5 refills on both benzodiazepines despite SA having enough refills on a monthly basis to cover her until her next appointment. Further, the Second MC noted that Respondent obtained blood pressures and pulses at his visits with SA, but that he discontinued this practice after starting SA on high-dose Amphetamine Salts. The Second MC observed that Respondent failed to institute non-pharmacologic interventions in treating SA, failed to adequately follow up on SA's more severe psychosocial stressors, and failed to explore the possibility of other illicit drug use.

10. According to the First MC, the standard of care requires a physician to: (1) perform regular urine drug screens on patients who are on any controlled substances; (2)

see patients regularly when they are on controlled substances and not provide long-term refills; and (3) query the CSPMP at each visit or in between visits for patients who are high risk for doctor shopping. Respondent deviated from the standard of care for Patient SA: (1) by failing to perform regular drug screens to monitor SA's medication compliance; (2) by failing to see SA regularly while prescribing large quantities of Klonopin and Ativan together and often providing multiple refills; and (3) by failing to query the CSPMP at any time for this patient who was at high risk for doctor shopping.

11. According to the First MC, Respondent's treatment of SA resulted in her suffering actual harm. The first MC's opinion was based, in part, on the fact that SA's drug dependency lead to the obvious need to eventually taper off of the excessively high dosages with the requisite withdrawal discomfort and unpleasant experience of a re-hospitalization to monitor the withdrawal process.

12. According to the First MC, Respondent's treatment of SA could have led to her fatality. The first MC noted that prescribing such large dosages of benzodiazepines along with the patient's other opioid prescriptions from other physicians could have resulted in depression of the central nervous system and suppression of her breathing drive. SA was at high risk for overdosing and without the proper monitoring, she could easily have overdosed.

13. According to the Second MC the standard of care requires a physician to: (1) avoid prescribing excessive amounts of benzodiazepines, avoid providing excessive refills for a patient until their next appointment, and to obtain informed consent for the prescribed medications; (2) recognize the symptoms of anxiolytic/sedative intoxication and the patient's potential for medication diversion; (3) monitor the patient with appropriate lab and EKG studies and to follow up on potentially dangerous abnormalities; (4) continue obtaining the patient's blood pressures and pulses, especially after the initiation of high-

dose Amphetamine Salts; (5) institute non-pharmacologic interventions; and (6) adequately follow up on more severe psychosocial stressors and to explore the patient's possible illicit drug use. Respondent deviated from the standard of care: (1) by giving SA excessive amounts of benzodiazepines and giving 3-5 refills on both benzodiazepines despite SA already having enough refills on a monthly basis to cover her until her next appointment, and failing to obtain SA's informed consent for the medications; (2) by failing to recognize the symptoms of anxiolytic/sedative intoxication and SA's potential for controlled substance diversion; (3) by failing to monitor SA with appropriate lab and EKG studies despite the well-known adverse metabolic and cardiac effects of the prescribed medications, and by failing to follow up on potentially dangerous abnormalities; (4) by discontinuing the taking of blood pressures and pulses after initiating high-dose Amphetamine Salts; (5) by failing to institute non-pharmacologic interventions; and (6) by failing to adequately follow up on SA's more severe psychosocial stressors and by failing to explore possible illicit drug use.

14. According to the Second MC, Respondent's treatment of SA resulted in her suffering actual harm. The Second MC's opinion was based, in part, on SA's physiologic dependence on two controlled substances without clinical justification; her two motor vehicle accidents; her impaired financial judgment; her living in a continual state of impaired cognition, her poor concentration, her ongoing lethargy, her poor motivation and impaired coordination; and two psychiatric hospitalizations.

15. According to the Second MC, excessive medication, potential suicide, potentially fatal cardiac arrhythmias without EKG monitoring, potentially serious metabolic disturbances not properly monitored by basic lab testing, potentially fatal disorders ignored and assumed to be medication effects that are not referred for a basic medical work up, danger to others from impaired driving, potentially lethal combination of opiates and high

dose benzodiazepines, and potentially fatal adverse effects if requiring emergency general anesthesia all could have led to SA's fatality.

16. During a Formal Interview on this matter on June 11, 2014, Respondent testified that he had completed a medical recordkeeping course offered by the Physician Assessment and Clinical Education ("PACE") Program at University of California San Diego as well as additional online courses in medical recordkeeping for a total of 75 hours of Continuing Medical Education ("CME"), implemented electronic health records and hired a record keeper for self-audits. Additionally, Respondent testified that he completed a PACE prescribing course for an additional 27 hours in CME. Respondent further testified that he incorporated changes recommended by PACE into his practice regarding controlled substance prescribing.

17. During the same Formal Interview, Board members acknowledged that patients with SA's presentation were difficult to care for, and stated that at times, high dosages of medications could be necessary in order to obtain therapeutic value; however, in the event that this type of therapy is initiated, a physician should engage in close and careful ongoing monitoring of the patient. Board members expressed concern that it appeared that Respondent failed to engage in the necessary monitoring for Patient SA, and that Respondent's care, while well-intentioned, was very alarming. Board members noted that Respondent provides care to patients that other psychiatric providers are unable to manage.

18. Based on the information and evidence presented at the June 11, 2014 Formal Interview, the Board voted to have Respondent complete a comprehensive assessment at a Board approved facility, and to have Board staff query Respondent's CSPMP on a biweekly basis to determine whether there was significant ongoing prescribing issues.

19. Respondent completed an assessment with the Center for Personalized Education for Physicians ("CPEP"") on September 29-30, 2014. Respondent was found to have generally adequate medical knowledge with significant gaps in psychopharmacology, sleep and substance abuse disorders. CPEP also concluded that Respondent demonstrated inadequate clinical judgment and reasoning and inadequate documentation in charts submitted for review. The CPEP report noted that Respondent was making efforts to improve his documentation after June of 2014. However, significant deficiencies remained in documentation. Respondent's cognitive function scores were particularly low in the areas of memory and attention. CPEP recommended that Respondent undergo comprehensive neuropsychological testing. CPEP also recommended that Respondent establish a relationship with an experienced educational preceptor with same day review of all patients for whom controlled substances are initiated, weekly review of patients for whom non-controlled substances are prescribed as well as for for patients treated for sleep disorders. CPEP additionally recommended CME and self-study in topics of demonstrated need, and coaching regarding documentation.

20. On December 1, 2014, Respondent underwent a neuropsychological evaluation. Respondent's neuropsychological functioning was found to be within the borderline range of normal limits with specific personal weaknesses in the areas of verbal memory and auditory attention compared to age norms. The evaluator recommended that Respondent undergo coordinated medical assessment and treatments recommended by his healthcare professionals to treat signs and symptoms that may be secondary to medical status and that Respondent should undergo re-evaluation in six months.

21. Respondent underwent a repeat neuropsychological evaluation on August 10, 2015 with the same evaluator. In his report, the evaluator concluded that Respondent had similar presentation to the previous evaluation completed on December 1, 2014. The

evaluator further concluded that Respondent did not exhibit any significant decline in his cognitive function. The evaluator concluded to a reasonable degree of neuropsychological certainty that Respondent's cognitive status may have a negative effect on functional capacity in his occupation as a psychiatrist in solo practice and consequently, rendered Respondent unable to practice medicine in a manner conducive to public safety.

22. Board staff obtained medical records on twenty five (25) of Respondent's patients based on review of CSPMP data as requested by the Board. Ten of those charts were reviewed by a MC who identified deviations from the standard of care for medical recordkeeping and controlled substances prescribing in seven charts including prescribing high doses of sedatives and anxiolytics, failure to identify risk factors for abuse or overuse of medications including ongoing alcohol abuse, and prescribing stimulants and sedatives in unconventional combination. The MC identified potential and actual harm to the patients as a result including risk of overdose and in one patient, actual overdose.

23. During the October 7, 2015 Formal Interview, Respondent testified that his recordkeeping practices had improved, and that he was willing to work with the Board regarding any additional actions necessary that would allow him to continue to practice. In response to concerns expressed by Board members regarding Respondent's treatment of sleep disordered patients, Respondent testified that he felt that the CPEP evaluation was academically oriented and performed at the level of a sleep specialist, but admitted during further questioning that many of his patients suffer from and were treated by him for sleep disorders. When asked about the findings of cognitive decline on neuropsychological testing, Respondent testified that he did not feel that his cognitive function had declined, pointing to a 90% patient success rate. Respondent testified that he had modified and reduced the hours of his practice to half days, four days a week.

24. Board members expressed concern regarding the ongoing problematic medical recordkeeping and controlled substance prescribing patterns demonstrated by the additional chart reviews. Board members were also concerned with the results of the CPEP evaluation and the deficiencies identified and confirmed in the initial and repeat neuropsychological evaluations. Board members again confirmed their conclusion that actual patient harm had occurred.

25. Based on the information and evidence presented at the October 7, 2015 Formal Interview, the Board made a finding that immediate action was necessary to protect the public health, safety and welfare.

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) ("[F]ailing 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)(q) ("[A]ny conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.").

ORDER

IT IS HEREBY ORDERED THAT:

1. Respondent is issued a Decree of Censure.

2. Respondent's license is placed on probation for a minimum period of three years with the following terms and conditions:

a. **Practice Restriction and Practice Monitor**

Respondent shall immediately cease prescribing controlled substances until he has retained the services of a practice monitor, who shall be approved by Board staff, for the purposes of reviewing Respondent's charts and prescribing practices. Respondent shall provide a copy of this Order to the practice monitor and furnish the Board with a written acceptance from the practice monitor stating that the monitor has read the Order and agreed to provide monitoring services as stated herein to the Respondent at the Respondent's expense. The practice monitor shall perform concurrent review of all controlled substances prescribing on a daily basis and review all other prescribing on a weekly basis. The practice monitor shall report to the Board on a monthly basis and shall immediately report any concerns with Respondent's prescribing practices.

b. **Chart Reviews**

Board staff or its agents shall conduct quarterly chart reviews. Based upon the chart review, the Board retains jurisdiction to take additional disciplinary or remedial action. The quarterly chart reviews shall involve current patients' charts. Respondent shall bear all costs associated with the chart reviews.

c. **Continuing Medical Education**

In order to satisfy the requirement for Continuing Medical Education ("CME") required for Respondent's biennial renewal of medical licensure, Respondent shall obtain CME in areas of need identified by CPEP; specifically, psychopharmacology, sleep disorders and substance abuse disorders, as well as medical recordkeeping. Prior to taking any CME, Respondent shall submit the course to Board staff for pre-approval. Upon completion of the CME, Respondent shall provide Board staff with satisfactory proof of attendance.

d. **Obey All Laws**

Respondent shall obey all state, federal and local laws, all rules governing the practice of medicine in Arizona, and remain in full compliance with any court ordered criminal probation, payments and other orders.

e. Tolling

In the event Respondent should leave Arizona to reside or practice outside the State or for any reason should Respondent stop practicing medicine in Arizona, Respondent shall notify the Executive Director in writing within ten days of departure and return or the dates of non-practice within Arizona. Non-practice is defined as any period of time exceeding thirty days during which Respondent is not engaging in the practice of medicine. Periods of temporary or permanent residence or practice outside Arizona or of non-practice within Arizona, will not apply to the reduction of the probationary period.

3. Prior to the termination of Probation, Respondent must submit a written request to the Board for release from the terms of this Order. Respondent's request for release will be placed on the next pending Board agenda, provided a complete submission is received by Board staff no less than 14 days prior to the Board meeting. Respondent's request for release must provide the Board with evidence establishing that he has successfully satisfied all of the terms and conditions of this Order. The Board has the sole discretion to determine whether all of the terms and conditions of this Order have been met or whether to take any other action that is consistent with its statutory and regulatory authority.

4. The Board retains jurisdiction and may initiate new action based upon any violation of this Order. A.R.S. § 32-1401(27)(r).

NOTICE OF FINAL AGENCY ACTION

Respondent is hereby notified that this order is immediately effective and is a final agency action for purposes of judicial review. A.A.C. R4-16-103(B).

DATED AND EFFECTIVE this 9th day of October, 2015.

ARIZONA MEDICAL BOARD

By Patricia E. McSorley
Patricia E. McSorley
Executive Director

EXECUTED COPY of the foregoing mailed this 9th day of October, 2015 to:

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EXECUTED COPY of the foregoing mailed this 9th day of October, 2015 to:

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ORIGINAL of the foregoing filed this 9th day of October, 2015 with:

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Mary Bobley
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